STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 03/01/2013

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SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted on 03/01/13. Event #KHXM11	F 000	Sanford Health and Rehab requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is March 29, 2013. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to engage a resident in an activity for 1 of 3 sampled residents reviewed for activities (Resident #90). Findings included: Resident #90 was readmitted into the facility on 12/29/12. Diagnoses included Depression, Alzheimer's, and Lack of Coordination. The 14 day minimum data set (MDS) completed on 1/12/13 indicated Resident #90 had memory problems with short and long term memory. The MDS indicated total dependence of one person physical assist for locomotion off the unit. The care plan completed on 1/11/13 stated, "Resident will be able to attend cognitively stimulating activities such as, but not limited to; current events, bible study, and choir visits." A review of the activity log revealed Resident #90 attended a social interaction activity on 2/25/13.	F 248	F 248 The staff member responsible for filling out the activity log for resident #90 was in-serviced by the Activity Director on 3/18/13 regarding the importance of following the activity plan of care for each resident and completely filling out the activity log. Resident #90 is attending activities per her care plan and it is being appropriately documented. The activity logs were reviewed by the Activity Director to ensure all residents are attending activities per their plan of care, care plans will be revised as necessary	3/29/13

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

Richard C. Stevenson | Administrator | 3/20/13

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.

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F 248	Continued From page 1 A review of the February 2013 calendar of events revealed activities were scheduled on 2/26/13 at 8:00 AM 1:1 (one to one) visits, 12:00 PM monthly luncheon, 2/27/13 at 8:00 AM 1:1 visits, 10:30 AM devotions with (guest), 2:30 PM fancy nails, 2/28/13 at 8:00 AM 1:1 visits, 10:30 AM exercise/noodle ball, 2:30 PM 1:1 visits/bingo. On 2/27/13 at 9:50 AM, Resident #90 was observed in the bed, while a devotion activity occurred in the dining room on the same hallway. On 2/27/13 at 11:10 AM, Resident #90 was observed in the bed, while a musical activity occurred in the dinning room on the same hallway. In an interview on 3/1/13 at 10:00 AM, the activity director indicated on 2/27/12 at 9:50 AM, 11:10 AM, Resident #90 should have attended one of the activities. The activity director (AD) stated she was in a facility care plan conference at the time of the activities, and that it was an oversight that Resident #90 attended neither activity. The AD added that she and the activity assistant were responsible for assisting all the residents throughout the facility to the activity programs. The AD indicated it was a challenge for her and the activity assistant ensuring that all the residents throughout the facility attended the scheduled activities. She concluded at times the nursing assistants assisted but the primary responsibility was for her and the activity assistant to physically take the residents. In an interview on 3/1/13 at 12:26 PM, the activity assistant confirmed he and the activity director were responsible for assisting all the residents	F 248	The system for logging activities was reviewed and revised by the Activity Director to assist with identification of residents who are not attending activities. An Activity/Log Documentation Audit Tool will be utilized for three months by the Activity Director on a daily basis x1 month and weekly basis x2 months to ensure all residents are attending activities per their care plan and attendance is documented per policy. Compliance will be monitored by the monthly QA committee for three months or until resolved. Additional education/training will be provided for any issues identified. Continued compliance will be monitored through random record reviews and through the facility's Quality Assurance Program.	

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F 248	Continued From page 2 who needed assistance to the scheduled activities. He stated it was overlooked that Resident #90 did not attend devotion or the musical activity on 2/27/13. In an interview on 3/1/13 at 12:30 PM, the director of nursing stated she expected daily interaction with the residents and activities could take place in or out of the room dependent upon the resident's assessment.	F 248		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F 329 The Behavior Monitoring sheets for resident's #59 and #90 have been reviewed and updated by the Director of Nursing to identify specific target behaviors related to each resident. The pharmacy consultant will review the medication regimen of all residents by 3/29/13 to determine if any drug is used in excessive dose (including duplicate therapy), excessive duration, without adequate monitoring, in the presence of adverse consequences, or without indication and make recommendations as necessary. The nursing staff were in-serviced March 19th through March 21st By the Assistant Director of Nursing/Staff Development Coordinator (ADON/SDC) regarding monitoring for side effects, what's abnormal behavior, behavior documentation, importance of behavior documentation, and importance of documenting during dose changes of psychotropic drugs.	3/29/13

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F 329	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to indicate medical justification for the continued use of antipsychotic medication for 2 of 11 sampled residents reviewed for unnecessary medications (Resident#59, #90). The findings included: 1. Resident#59 was admitted to the facility on 7/21/2011 with diagnoses of Dementia without behavioral disturbances, Psychosis and Lack of coordination. Resident #59 was also admitted with the prescription of Geodon 20 milligram (mg) at bed time. Quarterly Minimum Data Set (MDS) dated 11/26/2012 indicated that Resident #59 had no short or long term memory problems. The MDS also indicated the resident was taking antipsychotic and antidepressant medications. The quarterly MDS also assessed the resident with no indications of psychosis, no physical or verbal behaviors and no behaviors of rejection of care. A care plan dated 12/4/2012 identified the resident's problem as using psychotropic medications. The goal included Resident #59 would not experience any adverse reactions of prescribed psychotropic medications. The approaches included observation for antipsychotic medication's side effects; administration of antipsychotic medication as prescribed;and pharmacy to monitor for continued need for the drug. Review of the physician order for February 2013 indicated the resident was taking Geodon 20	F 329	The pharmacy will provide a list monthly of all residents receiving psychotropic medications. The identified residents will be reviewed monthly by the behavior committee for documentation to justify use, presence of adverse consequences, identify residents who may require dose reductions, and evaluate residents who have received dose reductions. The pharmacy consultant will further review the residents' drug regimens monthly for unnecessary drugs and make recommendations as necessary. A Psychotropic Medication Documentation/Dose Reduction Audit Tool will be utilized for three months by the Social Service Director or Designee to ensure the residents receiving psychotropic medications will have documentation at least bi-weekly related to their medication, and dose reductions are attempted per regulation. Compliance will be monitored by the monthly QA committee for three months or until resolved. Additional education/training will be provided for any issues identified. Continued compliance will be monitored through random record reviews and through the facility's Quality Assurance Program.	

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F 329	Continued From page 4 milligram (mg)1capsule by mouth every day at 5pm. Review of the"Documentation of Behavior"flow sheets for the months of April 2012 to February 2013 revealed no behaviors indicated for use of the Geodon antipsychotic medication. Review of the Nurse's notes beginning April 2012 and ending February 2013 revealed no behavioral problems were documented. Further review of the Nurse's notes revealed antipsychotic medication Geodon was stopped between March 20, 2012 and April 8, 2012. During this period no behaviors were indicated in the nurse's notes or in the resident's behavioral sheet. Further review of the nurse ' s notes revealed the medication Geodon was restarted on April 9,2012. Observations of Resident #59 on 2/26/13 at 9:00 AM revealed he was sitting in the chair beside his bed and no behavioral problems were observed. Observations on 2/28/13 at 9:44 AM of Resident #59 revealed he was in bed and no behavioral problems were observed. Interview with Nurse Assistant (NA) # 1 on 2/28/13 at 3: 20 PM revealed she had worked with Resident # 59 for over a year. She (NA # 1) stated she had not observed any behavioral problems by the resident. She added the resident was very cooperative during his care. Interview with Nurse # 1on 2/28/13 at 3: 30 PM revealed the resident was put back on Geodon in April 2012 after a family member requested the medication to be put back. Nurse # 1 further	F 329		

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F 329	Continued From page 5 added the resident was shaking during the time the medication was discontinued but she did not observe any behavioral symptoms like hallucination, delusions or refusal of care. A phone interview with the pharmacist on 3/1/13 at 9:59 AM revealed he had also noticed that behavioral problems were not being indicated on Resident # 59's behavioral sheet. The Pharmacist also indicated he will work with the facility so they can begin indicating the resident's behavioral symptoms on the behavioral sheet to support the use of the antipsychotic medication. Interview on 3/1/13 at 3:15 PM with Director of Nursing (DON) revealed the facility will improve in documentation of resident's behavioral symptoms. She added that, especially during the period when the medication was stopped, behavioral symptoms should be indicated in the nurse's notes or behavioral sheet to justify the continuing use of the antipsychotic medication. 2. Resident #90 was readmitted into the facility on 12/29/12. Diagnoses included Depression, Alzheimer's and Agitation. The 14 day minimum data set (MDS) completed on 1/12/13 indicated Resident #90 had short and long term memory problems. There were no indicated problems with mood, rejection of care, physical/behavior concerns, or psychosis. Behavioral symptoms not directed toward others were indicated as have occurred 1 to 2 days. Antipsychotic medication was indicated as received. The care plan completed on 1/11/13 stated, "Resident takes psychotropic medication Risperdal related to	F 329		

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F 329	Continued From page 6 diagnoses of Alzheimer's." Approaches read, "Review the continued need for drug per facility protocol." According to Lexicomp's Drug information Handbook 13th edition (2005-2006), page 1325 read in part, Risperdal is used for "Treatment of schizophrenia; treatment of acute mania or mixed episodes associated with bipolar I (one) disorder. Unlabeled/investigational use: behavioral symptoms associated with dementia in elderly. Warning precautions: low to moderately sedation, use in caution with disorders where central nervous system depression is a feature." A review of the "consultant pharmacist communication to the physician" dated 1/21/13 revealed no indicated behavior for the justification of Risperdal. The physician response to the pharmacy recommendation was not signed or acknowledged. A review of the medication administration record (MAR) revealed Risperdal 0.5 milligrams (mg) one tablet at bedtime was administered for anxiety on January 1, 2013 through January 17, 2013. A review of the MAR revealed on January 18, 2013 Risperdal 0.5 mg was discontinued and Risperdal 0.25 mg was ordered at bedtime and administered for anxiety on January 18, 2013 through February 28, 2013. A review of the "psychoactive medication monthly flow record" for behavioral symptoms for the month of December 2012, January 2013, February 2013, and March 1, 2013 revealed no	F 329		

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F 329	Continued From page 7 targeted behavioral symptoms. A review of the medical record revealed no abnormal involuntary movement scale (AIMS) assessment. A review of the social worker note completed on 1/5/13 in part read "No moods present, patient often yells out mumbled words and sentences loudly being socially inappropriate only about once a week. Resident is typically very quiet." A review of the nurses' notes from 12/29/12 through 3/1/13 revealed no combative or psychotic behaviors that supported the continued use of Risperdal. On 2/26/13 at 11:44 AM, Resident #90 was observed sitting in the wheelchair with her eyes closed. On several verbal commands the resident did not respond, did not open her eyes or move any extremities. Resident #90 was observed in a sleepy state. On 2/27/13 at 9:50 AM, Resident #90 was observed in the bed. On verbal command the resident opened her eyes slowly, and then closed them back in a drowsy state. On 2/27/13 at 11:51 AM, Resident #90 was observed out of the bed in the wheelchair with her eyes closed. On verbal command the resident slowly opened her eyes and wiped her mouth with her hand, in a drowsy state. In an interview on 2/27/13 at 3:00 PM, Nurse #3 who worked twelve-hour days stated she had not observed any behavior problems with Resident	F 329		

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F 329	Continued From page 8 #90. She stated Resident #90 was compliant with the care provided by the nursing staff. In an interview on 2/27/13 at 3:05 PM, NA (nursing assistant) #7 who worked second shift indicated she had not observed any combative behaviors when working with Resident #90. In an interview on 2/28/13 at 12:45 PM, NA #6 who worked first shift stated Resident #90 was compliant with showers, bed baths, and that she had observed no combative behaviors. In an interview on 3/1/13 at 11:32 AM, the director of nursing (DON) stated she did not see a supporting diagnosis for the use of Risperdal. She added that she expected any specific behavior symptoms to be reflected on the behavioral monitoring record or nursing notes, and the consultant pharmacist recommendation to have been reviewed and signed by the physician. The DON concluded she could not find an AIMS assessment completed per her chart review.	F 329		
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;	F 441	F 441 The facility staff were in-serviced on February 28th regarding isolation precautions related to resident #93. Isolation supplies were moved from the closet to a Personal Protective Equipment (PPE) door hanger on the resident's door. The physician was in-serviced on 3/14/13 by the Director of Nursing regarding isolation precautions and the CDC/SPICE recommendations for re culturing stool specimens and removing of Isolation Precautions	3/29/13

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F 441	Continued From page 9 (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. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to educate facility staff and follow contact precautions for 1 of 1 resident's (resident #93) who cultured positive and symptomatic for clostridium difficile. Findings included: The facility Clostridium Difficile policy indicated that the following for management: 1. The resident ' s physician shall order	F 441	related to C. Difficile. Isolation regarding resident #93 was discontinued on 3/14/13 secondary to resident having formed stools x48 hours. Resident #93 will not be re cultured for C. Difficile unless he becomes symptomatic per CDC/SPICE recommendations. An audit was completed by the Director of Clinical Services on February 28th for any resident in the facility on anti infective drugs, the reason/organism for the drug, and if Isolation Precautions were necessary and appropriate. All facility staff will be re in-serviced by the ADON/SDC March 19th through March 21st regarding Infection Control, the different types of Isolation Precautions, and the PPE needed for each type of precautions. The licensed nurses will also be in-serviced during that time regarding isolation precautions related to specific organisms, initiating isolation precautions, and the duration of isolation precautions. The facility Infection Control Policy was revised by the Director of Clinical Services on 3/14/13. The licensed nurses will be in-serviced by the ADON/SDC March 19th through March 21st regarding completing an infection worksheet when a resident is showing new signs and symptoms of infection and noting on the 24 hour report sheet. The 24 hour reports and physician orders will be reviewed daily by Director of Nursing or Designee for	

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F 441	Continued From page 10 treatment as necessary 2. Treatment with antibiotics may be ordered as indicated for infected residents. 3. The resident will be in a private room with a private bathroom. 4. The resident will not socialize with other residents outsides the resident's room. 5. The proper isolation sign will be placed outside the resident's room. 6. Proper PPE equipment will be placed outside the resident's room This same policy also stated the following precautions: Standard Precautions 1. Hand washing and adherence to standard precautions 2. Thorough hand washing before donning and immediately after glove are removed. 3. Thorough hand washing between caring for residents. 4. Use of gloves when caring for individuals whenever contact with wounds, sores, stool, mucous membranes or other body substances. 5. Use gloves whenever care activities may generate splashes and sprays. 6. Mask and eye protection during any activities that may generate splashes for sprays. The policy references equipment as follows: 1. Equipment should be dedicated for the person infected with a bacterial infection whenever possible. (thermometers, stethoscopes, commodes, etc) 2. Non-dedicated or non disposable equipment shall be disinfected after every use by EPA registered disinfectant or bleach solution 1:1000	F 441	any residents presenting signs and symptoms of infection, any new antibiotics, and any new orders for lab work or x-rays related to signs and symptoms of infection. The ADON/SDC will monitor to ensure an Infection Worksheet was completed, a Culture and Sensitivity (C&S) was completed and returned if ordered, the physician was notified and the antibiotic is appropriate according to the C&S, appropriate Isolation Precautions were initiated if necessary and monitoring nursing documentation so isolation precautions is discontinued per policy. The ADON/SDC will be responsible for logging the infection on the Infection Log, identify trends and in-service as necessary. The Director of Nursing and the ADON/SDC will follow up with nursing staff as needed. A Isolation Precaution Audit tool will be utilized by the ADON/SDC randomly three times a week for a period of three months of residents with isolation precautions to determine if facility staff are following appropriate isolation precautions. The ADON/SDC will follow up with facility staff as necessary. A QA monitoring tool will be utilized by the Director of Nursing of all residents placed on isolation charts monthly for a period of three months to determine if isolation	

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F 441	Continued From page 11 dilution. Housekeeping and laundry recommendations on this policy read: 1. Linen and personal clothing: minimal handling of soiled linen should be stressed. A gown and gloves should be worn. Soiled linens and clothing should be bagged in special laundry bags in the resident's room then washed with laundry detergent in warm water and dried in a hot dryer. 2. Ensure the personal items and all household surfaces are cleaned and disinfected after every use or exposure to the individual using an EPA registered disinfectant. 3. Infectious waste should be bagged in the room in which it was created. The policy indicated the following for removing Isolation Precautions: 1. A resident can be removed from isolation once the resident has completed the appropriate course of antibiotics as prescribed by the physician. 2. The resident is no longer symptomatic (no loose, foul smelling stools). 3. Ordered by the physician 4. Refer to the CDC website The facility policy dated 2/9/13 entitled: Control of Suspected Norovirus and Clostridium Difficile Outbreaks in Long Term Care Facilities indicated the following for management: Specific control measures: 1. Strict hand hygiene for C-Dff. Using soap and warm water for at least 15 seconds and not to rely on alcohol based sanitizers. Resident #93 was readmitted to the facility on	F 441	precautions were initiated and discontinued per policy. The Director of Nursing and or designee will present the results of those audits to the Quality Assurance Committee monthly for monitoring of continued compliance for three months for review and recommendations. Additional education/training will be provided for any issues identified. Continued compliance will be monitored through random record reviews and through the facility's Quality Assurance Program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 03/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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	Continued From page 12 1/18/13 with the diagnosis of Clostridium Difficile. Readmission orders included Vancomycin and Flagyl as ordered and resident #93 was to be placed on contact precautions. These two medications are antibiotics often prescribed to treat clostridium difficile. A review of resident #93's quarterly Minimum Data Set dated 2/16/13 indicated that he was cognitively intact, required extensive assistance with his activities of daily living and that he was frequently incontinent of bowel and bladder. Resident #93 was care planned 1/18/13 for clostridium difficile with interventions to include wash hands before and after working with resident #93 and empty linen in proper receptacle. This care plan was reviewed again on 2/20/13 with no new updates of interventions. A record review indicated that a stool specimen was obtained on 1/30/13 which cultured negative for clostridium difficile. There were orders to discontinue the Vancomycin and Flagyl. The contact precautions were discontinued on 2/4/13. A review of the laboratory results dated 2/7/13 indicated resident #93 tested positive again for clostridium difficile. Vancomycin and Flagyl were restarted for 2 weeks and he was again put on contact precautions. On 2/14/13, a stool sample was tested but not for clostridium difficile. There was no evidence that another sample was obtained or that the facility attempted to have the specimen tested for clostridium difficile. A review of the nursing notes indicated that resident # 93 was symptomatic.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 03/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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	Continued From page 13 On 2/25/13 at 4:00 PM, a sign was observed taped next to door which read: contact precautions: don gloves and gown. See nurse before entering. There was no supplies (gown or gloves) located outside the room. On 2/27/13 at 8:30 AM, the resident clinical coordinator stated resident #93 was on contact precautions until he finished his Vancomycin on 4/10/13 but she was unable to confirm that resident #93 was not symptomatic. On 2/27/13 at 10:10 AM, nursing assistant (NA) #3 stated awareness that resident #93 had clostridium difficile and that there was a red container for trash inside room and separate laundry hamper in his room NA #3 stated that the personal protective equipment (PPE) was kept in close across the hall. NA #3 opened closed and there was no supplies noted inside the closet. NA #3 stated she received no special training regarding hand washing with soap and water but rather used hand sanitizer kept in pocket. On 2/27/13 at 10:15 AM, the physical therapist (PT) stated he did therapy with resident # 93 in his room. The PT stated he wore gloves if he planned to touch the resident. He stated the PPE supplies where kept in closet across the hall and washing with soap and water was recommended. On 2/27/13 at 10:25 AM, nurse #1 stated she was unsure if the contact precautions were still in use since she thought resident # 93 cultured negative the previous week on 2/14/13. Nurse #1 stated that there was a cart in hallway with the PPE supplies but administration did not like the cart in the hallway. Next, nurse #1 stated there was an	F 441		

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	345534	A. BUILDING _____ B. WING _____	C 03/01/2013

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SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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F 441	Continued From page 14 over the door supply holder added to resident #93's door but that would not allow for the door to close properly. That was when administration moved the over the door supply holder to the closet across the hall. Nurse #1 stated she had not received any special training about caring for a resident with clostridium difficile. Nurse #1 stated she either used soap and water or hand sanitizer to wash her hands before and after care for all residents. On 2/27/12 at 12:27 PM, the resident care coordinator stated that staff should wear gown and gloves when care is provided care and that sanitizer was not an acceptable practice for hand washing. She stated that resident # 93's last culture for clostridium difficile was positive and that contact precaution should be adhered as long as he was still symptomatic. On 2/27/13 at 1:50 PM, NA #4 was observed answering resident #93's call light. NA #4 asked the other staff on the hallway where the PPE supplies were then she retrieved a mask and gloves from closet. She left the door open to resident # 93's room while she removed the sheets from the bed. The sheets were observed in contact with her clothing while she removed them and place the dirty linen in a hamper kept inside the room. She removed her gloves and mask and left the room to gather clean linen to put on resident #93's bed. The door was noted to be left open and NA #4 did not wash her hands when she left the room to get the sheets. She put on another mask and gloves and put clean sheets on the bed. She removed the gloves and mask, closed the door to the room and washed her hands with soap and water. On interview, NA	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 03/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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F 441	Continued From page 15	F 441		

#4 stated she had not received any special training on hand washing practices with clostridium difficile. NA # 4 stated there were no gowns in the closet so she only used the mask and gloves to change the linen. NA #3 stated to NA #4 that she had placed a new pack of gowns in resident #93's room earlier in the day. NA #3 stated she also stocked the closet with mask and gloves. Both NA #3 and NA #4 were unaware if PPE should be kept outside the isolation room.

On 2/27/13 at 2:05 PM, nurse #1 indicated she used a wrist blood pressure device and temporal thermometer on all of her residents to include resident # 93. Nurse #1 stated she used a germicide wipe after each use. A review of the germicidal wipes used did not reference killing clostridium difficile.

On 2/27/13 at 2:20 PM, the director of nursing (DON) stated she had only been at facility for 5 days and did not know who was responsible to instituting and oversight of resident on any sort of transmission precautions.

On 2/27/13 at 3:15 PM, housekeeping supervisor stated he had a facility policy that he could use a bleach solution to clean resident #93's room and that he clothes were washed separately in a bleach solution. He stated that the PPE for his staff was on their housekeeping carts. He stated that there were gowns, gloves and mask available on all of the housekeeping carts.

On 2/27/13 at 3:47 PM the regional director of clinical services stated that isolation stops 48 hours after formed stools for clostridium difficile

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	345534	A. BUILDING _____ B. WING _____	C 03/01/2013

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F 441	Continued From page 16	F 441		

On 2/28/13 at 10:30 AM, resident # 93's physician stated the reason no culture for clostridium difficile sample obtained on 2/14/13 was an oversight and that it was he intention that the stool sample was to be tested for clostridium difficile. The physician stated he would expect contact precautions to include gown and glove be used but he did not know of any special instructions with regard to hand washing. The physician stated isolation stops after 2 negative cultures for clostridium difficile. The physician stated a new medical director started on 12/1/12. The physician stated he intended to treat resident # 93 as long as he was having symptoms. He stated he consulted with the floor nurses when he made his rounds to determine if resident # 93 was still having loose foul smelling stools.

On 3/1/13 at 9:20 AM, NA #6 entered resident # 93's room without a gown or gloves. She closed the door. She did not wash her hands before entering another resident's room. NA # 6 stated she should where a gown and glove if she anticipated any contact with stool but that did not occur. She stated she should have washed her hands with soap and water before entering another resident's room.

On 3/1/13 at 9:40 AM, nurse #2 stated that resident # 93 had two episodes of loose stools last evening and had one episode this morning. There was foul odor noted per nurse #2. A review of the nursing notes verified that resident #93 had loose stools with foul odor.

On 3/1/13 at 10:20 AM, housekeeper #1 was observed on the 200 hall. She stated she cleaned resident # 93's room last and that she used a

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	345534	A. BUILDING _____ B. WING _____	C 03/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 17 bleach solution to clean the room. She stated her PPE supplies were in her cart and that she used a gown and gloves when entered his room. She stated her supervisor had instructed the housekeeping staff that they must use soap and water to wash their hands after cleaning resident # 93's room. On 3/1/13 at 11:00 AM, the administrator stated his expectation would be that they follow their policy regarding infections and clostridium difficile. On 3/1/13 at 11:45 AM, the DON stated she would expect the staff to follow the precautions put in place to prevent the spread of infections. She stated they should wear the gloves when entering the room and if they expected to have to provide incontinence care, they should wear gown and gloves. The DON stated the staff should wash their hands with soap and water and the supplies should be accessible to staff outside the room.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING 01 - 400 HALL B. WING _____	03/26/2013

APR 11 2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS 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 in the special care area only, and is equipped with an automatic sprinkler system in all areas. CFR#: 42 CFR 483.70 (a) NOTE: There were no Life Safety Code Deficiencies Noted in this (400 hallway) portion of the facility during the survey.	K 000		

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

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.

BPAS 943118

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING 02 - (300 HALLWAY & SERVICE HALL) B. WING _____	03/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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K 000	INITIAL COMMENTS 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 and is equipped with a partial automatic sprinkler system. NOTE: The resident room closets are not sprinklered. CFR#: 42 CFR 483.70 (a)	K 000	*Sanford Health and Rehabilitation requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is May 10, 2013. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law.*	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 3/26/2013 the door releases for the freezer and cooler in the dietary department did not have door release mechanisms inside the door that could be located in all levels of light in case of an emergency. CFR#: 42 CFR 483.70 (a)	K 038	A glow-in- the dark door release mechanism has been placed on the inside of the freezer and cooler doors in the dietary department so the door can be located in all levels of light in case of an emergency. There are no other similar doors in the facility. The administrator is responsible for oversight of the safety committee. All safety system check logs and reports will be reviewed monthly in Safety Meeting. The Quality Assurance Committee monitors all sub-committee functions and implements actions to correct any deficiencies when reported.	4/5/13

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

Richard C. Lovenser — Administrator — 4/10/13

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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
	345534	A. BUILDING 03 - (200 HALLWAY) B. WING _____	03/26/2013

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K 000	INITIAL COMMENTS 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 and is equipped with a partial automatic sprinkler system. NOTE: The resident room closets are not sprinklered. CFR#: 42 CFR 483.70 (a)	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 2/27/2012 the following item was observed as noncompliant, specific findings include: The findings include the rated ceiling in the laundry room was penetrated by PVC piping just behind the washers. There was no fire rated collar installed on the PVC piping grater than an inch in diameter. CFR#: 42 CFR 483.70 (a)	K 012	Fire rated collars have been installed on the PVC piping greater than one inch in diameter penetrating the ceiling in the laundry room. All rated ceilings in the facility that have potential to be penetrated by piping have been inspected by the Director of Maintenance. There were no other findings of this standard not being met. All future installation of PVC that would penetrate a rated ceiling will be inspected by the Director of Maintenance to ensure this standard is met.	4/9/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Richard C. Stevenson | TITLE: Administrator | (X6) DATE: 4/10/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING 05 - (NEW 100 HALLWAY) B. WING _____	03/26/2013

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K 000	INITIAL COMMENTS 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 and is equipped with an automatic sprinkler system. CFR#: 42 CFR 483.70 (a)	K 000	The administrator is responsible for oversight of the safety committee. All safety system check logs and reports will be reviewed monthly in Safety Meeting. The Quality Assurance Committee monitors all sub-committee functions and implements actions to correct any deficiencies when reported.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 3/26/2013 the following Life Safety item was observed as noncompliant, specific findings include: The facility had 200 degree sprinklers in the (1) file room and (2) sprinkler riser room.	K 062	The 200 degree sprinklers in the (1) file room and (2) sprinkler riser room have been replaced with 155 degree sprinklers. All other sprinklers have been inspected by the Director of maintenance and are in proper compliance. Any future installation of sprinklers will be inspected by the Director of Maintenance to ensure they are in compliance.	4/1/13
K 072 SS=E	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant 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		The administrator is responsible for oversight of the preventative maintenance program. All safety system check logs and reports will be reviewed monthly in Safety Meeting. The Quality Assurance Committee monitors all sub-committee functions and implements actions to correct any deficiencies when reported.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Richard C. Sherman	Administrator	4/10/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING 05 - (NEW 100 HALLWAY) B. WING _____	03/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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K 072	Continued From page 1 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 3/26/2013 the following Life Safety item was observed as noncompliant, specific findings include: The facility had items stored and blocking hand rails in the following areas in the 100 hallway. 1. egress corridor near room numbers 101/102 2. egress corridor near room numbers 119/120 3. egress corridor near room numbers 129/130 CFR#: 42 CFR 483.70 (a)	K 072	All items stored and blocking hand rails in the following areas in the 100 hallway have been removed: Egress corridor near rm 101/102 Egress corridor near rm 119/120 Egress corridor near rm 129/130 All areas in the facility where hand rails are present have been inspected by the Director of Maintenance and any items blocking rails have been removed. The Director of Maintenance will monitor hand rail access in the facility weekly and correct any violations immediately. He will report finding of his inspections monthly in safety committee and quarterly per facility policy. The administrator is responsible for oversight of the safety committee. All safety system check logs and reports will be reviewed monthly in Safety Meeting. The Quality Assurance Committee monitors all sub-committee functions and implements actions to correct any deficiencies when reported.	4/1/13