STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING ______ B. WING ______	08/17/2017

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NORTHAMPTON NURSING AND REHABILITATION CENTER	**HWY 305 NORTH** **JACKSON, NC 27845**

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F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 441		9/5/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 08/30/2017

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 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and review of the facility ' s infection control policy the facility failed to complete and document surveillance and data to track and trend infections in the facility during two (June, July 2017) of eleven months. This had the potential to affect all residents in the facility. The findings included: Review of the facility ' s policy titled Infection Control Preventionist dated 9/2014 noted the responsibilities of the infection control nurse and included the following: "Performs surveillance for	F 441	Northampton Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.	

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Continued From page 2

the identification, investigation and documentation of facility acquired infections, community acquired infections and communicable disease outbreaks as necessary. Compiles surveillance data monthly for review."

During an interview with the Director of Nursing (DON) on 8/17/17 at 9:20 AM the DON was unable to provide the documentation for tracking and trending infections in the facility for June and July 2017. The DON stated the Staff Development Coordinator (SDC) was the designated Infection Control Nurse and resigned her position early May 2017. The DON further stated she had tried to cover the position until another SDC could be hired. The DON stated she had not completed the log for tracking and trending of infections within the facility for June and July 2017.

On 8/17/17 at 10:04 AM the Administrator stated in an interview that during their monthly Quality Assessment and Assurance Meeting in July 2017 they recognized the information had not been compiled for June and the DON was going to get to it but had not done it. The Administrator stated the QAA Committee had not met this month to review data for July 2017.

F 441

Northampton Nursing and Rehabilitation Center
response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission
that any deficiency is accurate. Further, Northampton Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

The Facility's Infection Control Surveillance Policy was implemented to include surveillance and data analysis beginning 8/18/17 by the Director of Nursing. The month of June and July infection control surveillance and data will be completed and documented to track and trend infections in the facility by 8/31/17 by the
Director of Nursing.

A 100% audit will be completed for current Residents by 8/31/17 by the Director of Nursing
for presence of infections with required documentation completed on the surveillance and data analysis.

The Director of Nursing and the Staff Facilitator responsible for Infection Control, will be in-serviced by the Nurse

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F 441	Continued From page 3	F 441	Consultant related to the responsibility of the facility to ensure an Infection Control Program is maintained that includes surveillance and data analysis of monthly infections by 8/30/17. The Director of Nursing or the Staff Facilitator will review all new orders for antibiotics and all residents progress notes to identify residents with infections and document on the infection control surveillance individual resident log for all identified residents to include resident name, date, name of infection, date of onset of infection, and signs and symptoms of infection 5 times per week for 4 weeks, then weekly times 4 weeks then monthly times one month. Upon analysis by the Director of Nursing or Staff Facilitator, the data collected from the infection control surveillance individual resident log will be entered on the monthly infection log by the Director of Nursing or the Staff Facilitator to track and trend infections in the facility monthly times 3 months utilizing the Infection Control Monitoring QI audit tool. The Administrator will review and initial the Infection Control Monitoring QI Tools for completion, ensure all areas of concern were addressed per the infection control surveillance protocol, and retrain the Director of Nursing or Staff Facilitator for all identified areas of concern during the audit monthly times 3 months. The Administrator will forward the results	

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F 441	Continued From page 4	F 441	of the Infection Control Monitoring QI Audit Tools to the Executive QI Committee monthly times 3 months. The Executive QI committee will meet monthly and review the Infection Control Monitoring QI Audit tools and address any issues, concerns, and/or trends as well as make changes as needed to include continued frequency of monitoring monthly times 3 months.	
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and	F 520		9/5/17

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F 520	Continued From page 5 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility ' s Quality Assessment and Assurance (QAA) Program failed to maintain implemented procedure put into place following the recertification survey of September 2016. This was for one deficiency originally cited 09/22/2016 and was recited on the current recertification survey in the area of infection control. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility ' s inability to sustain an effective QAA program. The findings included: Cross refer F441: Based on record review, staff interview and review of the facility ' s infection control policy the facility failed to complete and document surveillance and data to track and trend infections in the facility during two (June, July 2017) of eleven months. This had the potential to affect all residents in the facility. Based on record review,	F 520	The Administrator, Director of Nursing and the Staff Facilitator will be educated by the Corporate Nurse Consultant on the QI process, to include implementation of Action Plans, Monitoring Tools and the Evaluation of the QI process, and modification and correction if needed by 8/30/17. The Administrator, Director of Nursing and the Staff Facilitator will be educated by the corporate nurse consultant by 8/30/17 regarding the QI process to include identifying issues that warrant development and establish a system to monitor the corrections and implement changes when the expected outcome is not achieved. The Corporate Nurse Consultant and the Administrator will complete 100% audit of previous citation action plans within the past year to include completing and documenting surveillance and data to	

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F 520	Continued From page 6 staff interview and review of the facility ' s infection control policy the facility failed to complete and document surveillance and data to track and trend infections in the facility during two (June, July 2017) of eleven months. This had the potential to affect all residents in the facility. On 8/17/17 at 9:49 AM the Administrator stated they had monthly QAA meetings and when the committee met in July 2017 they recognized the infection control surveillance and data analysis for tracking infections for June and July 2017 had not been compiled and the Director of Nursing was going to get to it but had not done it. The Administrator stated they had yet to have a QAA meeting in August 2017.	F 520	track and trend infections in the facility to ensure that the QI committee has maintained and monitored interventions that were put into place by 8/30/17. Action plans will be revised and updated and presented by the Director of Nursing by 9/5/17 for any concerns identified. All data collected for identified areas of concerns to include completing and documenting surveillance and data to track and trend infections in the facility and current citations will be taken to the QI committee for review monthly times 4 months by the Director of Nursing or the Staff Facilitator.The QI committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the QI committee will be documented monthly by the Staff Facilitator. The Executive committee Quarterly meeting minutes will be reviewed and initialed by the Corporate Nurse Consultant to ensure implemented procedures and monitoring practices to address interventions, to include, completing and documenting surveillance and data to track and trend infections in the facility and current citations are followed and maintained Quarterly times 2. The results of the monthly QI meeting	

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F 520	Continued From page 7	F 520	minutes will be presented by the Administrator and/or Director of Nursing to the Executive Committee Quarterly times 2 for review and the identification of trends, development of action plans, as indicated to determine the need and/or frequency of continued monitoring.	