STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345429	A. BUILDING _____ B. WING _____	C 05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - PINELAKE	**801 PINEHURST AVENUE CARTHAGE, NC 28327**

(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 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(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; §483.80(a)(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:	F 880		6/7/18

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

Electronically Signed | 06/07/2018

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F 880	Continued From page 1 (A) The type and duration of the isolation, depending upon the infectious agent or organism 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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, observation, staff interviews, and physician interview the facility failed to implement contact precautions for a methicillin resistant staphylococcus aureus infection for one of three residents reviewed for infection (Resident #1). Resident #1 was admitted on 12/19/17. Resident ' s quarterly MDS dated 5/5/18 revealed the resident was cognitively intact. The resident	F 880	F483.80 Root cause. There was a missed communication between Peak Resources Pinelake and Moore Regional hospital (MRH). The resident was admitted on 5/19/18. The information that confirmed that the resident had a wound that was positive for MRSA infection was included on the discharge summary that the facility received on 5/21/18. There was a delay in	

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F 880	Continued From page 2 required extensive assistance of two staff members for transfers and one staff member for all other activities of daily living. The resident ' s diagnoses were quadriplegia, malnutrition, and pressure ulcer. The resident had two pressure ulcers; one stage 2, one stage 4 and one unstageable. The resident required respiratory therapy, four physician evaluations, and five new orders in the 14-day look back period. The resident had a care plan dated 4/25/18 with goals and interventions for activities of daily living deficit, to report resident deterioration, pain management, pressure ulcers, quadriplegia, non-compliance for wound care, nutritional deficit, and diabetes mellitus. The hospital discharge summary dated 5/20/18 revealed Resident #1 was admitted and treated for aspiration pneumonia, the urinary catheter was positive for bacteria (the catheter was changed and the urinalysis was negative), and sepsis from several etiologies. The resident saw an infectious disease physician on 5/11/18 for his elevated white blood cell count. During hospitalization the left great toe pressure ulcer developed redness and drainage which resulted in a positive methicillin resistant staphylococcus aureus (MRSA) culture. The resident received the antibiotic Vancomycin and was discharged to the facility with antibiotic Vibramycin for the left toe MRSA infection. A review of Resident #1 ' s nurses ' notes for admission through 5/23/18 revealed there was no mention of an infection to the left great toe or the need for contact precautions. On 5/23/18 at 10:00 am an observation was done	F 880	receiving the Discharge Summary from MRH and there was no mention of a positive MRSA culture in any documentation the facility received from the hospital when the resident was admitted. In addition, the nurse who gave report to our admitting nurse did not communicate the positive MRSA wound culture. The facility only became aware of the positive wound culture when the discharge summary was received on 5-21-18, however this information was not reviewed by the Infection Control Nurse/Staff Development Coordinator timely. How we corrected the issue for Resident #1 Resident #1 was placed on contact precautions immediately when the facility became aware that the resident had an active MRSA diagnosis. Resident #1 was admitted on antibiotics to treat the wound infection. Resident #1 will be seen weekly by the wound doctor to assess active infection. Resident #1 has a follow up meeting with infectious disease on 6-19-18. Resident #1 did not suffer any adverse effect from not being on contact precautions. Standard precautions were utilized with any direct care administered to Resident #1. Other residents potentially affected. All residents on the same assignment as Resident #1 were assessed for signs and symptoms of active infection on 5/25/18. No other residents were identified with having new signs and symptoms of	

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F 880	Continued From page 3 of Resident #1. The spouse was present providing a bed bath. The resident had a tracheostomy with an intact dressing, a colostomy with soft brown stool present, a gastrostomy tube, and a dressing to the left foot (heel and great toe with scant serosanguineous drainage). The resident was alert and oriented to self and situation and able to verbalize needs. On 5/23/18 at 10:10 am an interview was conducted with Resident #1. The resident stated that he was recently in the hospital and had pressure ulcers, diabetes, a tracheostomy, and did not require oxygen. The resident used humidified room air. The resident did not have pain in his pressure ulcers because he was quadriplegic and could not feel pain. The resident was not aware his toe was infected. On 5/23/18 at 10:40 am an interview was conducted with the wound care physician. The physician stated he was familiar with Resident #1 who had long standing pressure ulcers. The resident had a deep tissue injury to the left great toe. The physician last saw the toe on 5/9/18 and the toe had eschar tissue and was unstageable. The toe did not have an infection. The resident was admitted to the hospital on 5/9/18 which was not wound related and returned recently on 5/19/18. Today 5/23/18 would be the resident ' s first physician wound care visit since his hospitalization. On 5/23/18 at 11:30 am an observation was done of the wound care physician ' s evaluation of Resident #1 ' s left great toe. The toe now had a small amount of purulent, yellow drainage when depressed and would require debridement to address the infection and promote healing. The	F 880	infection. The Staff Development Coordinator (SDC), Director of Nursing (DON), Clinical Supervisor and the MDS coordinators examined all current residents with active infections and any residents that had orders for antibiotics on 5/24/18. They reviewed the Discharge (DC) summaries, cultures and lab results to ensure that no other resident with an active infection required contact precautions. There were no other residents identified in the facility requiring contact precautions. Admission coordinator at MRH was contacted by the Administrator on 6/4/18 to request that all patients requiring contact precautions or any type of isolation have that information included on the After Visit Summary to ensure that any new admission requiring contact precautions is identified immediately upon admission to the facility. In addition, the Admission Coordinator at MRH was instructed to send the discharge summary with the resident upon or prior to admission to the facility. In addition, nurse to nurse report will advise the facility of any resident requiring contact precautions. The DON educated the Infection Control Nurse/SDC on 5-24-18. The infection control policy and the antibiotic stewardship program was reviewed with the Infection Control Nurse/SDC by the DON. Additional education included to have proper diagnosis for antibiotic use, ensure that all admissions are screened	

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F 880	Continued From page 4 physician explained the debridement to the resident and his spouse and obtained permission to debride the toe. Physician order 5/19/18 cleanse left great toe with normal saline apply medi-honey and dry sterile dressing each day. Vibramycin 100 mg twice a day with an end date of 6/10/18. On 5/23/18 at 1:45 pm an interview was conducted with Nurse #1 who stated that she very familiar with Resident #1 and was not aware that the resident had a positive culture for MRSA of the left great toe at the hospital. Residents that had MRSA were placed on contact precaution. Resident #1 was not placed on contact precautions since readmission. On 5/23/18 at 1:50 pm an interview was conducted with the treatment nurse who stated that she was not aware that resident #1 had a positive MRSA culture while in the hospital of his left great toe pressure ulcer. Resident ' s with MRSA are required to be on contact precautions to protect other residents and staff. On 5/23/18 at 3:23 pm an interview was conducted with the Infection Control Nurse (ICN). The ICN stated that she was not aware until today that Resident #1 had a positive MRSA culture of his left great toe while in the hospital. The resident was readmitted to the facility on Saturday 5/19/18 and the ICN was not present on the weekend and yesterday. The ICN had not read the resident ' s discharge summary and assumed the Vibramycin was for the aspiration pneumonia. The ICN stated that the resident was placed on contact precautions today, 5/23/18. The ICN provided the facility policy for MRSA and would	F 880	to ensure they don't have an infection requiring contact precautions and if the resident does require precautions that the resident is on those precautions. The Infection Control Nurse/SDC/DON will review all new admissions Monday through Friday to ensure that any resident admitted with an active infection or on antibiotics has the correct diagnosis, if the resident requires any precautions, and if so, is the resident on the precautions. The weekend supervisor was also educated regarding this process by the DON on 5/24/18. The weekend supervisor will review all admissions to the facility on Saturday and Sunday to ensure compliance with the above. The SDC educated all licensed staff by 6-1-18. The education included to have proper diagnosis for antibiotic use, ensure that all admissions to the facility are screened to ensure they don't have an infectious disease requiring contact precautions. Any resident identified as requiring contact precautions will be immediately placed on such precautions. To monitor this deficiency The DON, Clinical Supervisor and weekend supervisor will review every new admission weekly for 4 weeks, then monthly for 3 months. This audit will include the following questions: Does this resident have an active infection, is this resident on antibiotic for this infection, does this infection require any isolation precautions and is the resident on appropriate precautions?	

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F 880	Continued From page 5 expect staff to place the resident on contact precautions for an active MRSA infection. On 5/23/18 at 3:30 pm an interview was conducted with the wound care physician. The physician stated that if Resident #1 had a positive MRSA in the hospital of his great left toe, upon return to the facility he recommended the resident be placed on contact precautions. The physician was not aware that the resident had a positive MRSA culture. The resident had not had a previous wound to the great left toe so the MRSA could be an active infection, not colonized. The physician stated that the facility should follow their infection control policy. A review of the facility ' s infection control practice termed Methicillin Resistant Staphylococcus Aureus (MRSA) dated December 2004 revealed that general guidelines No. 8 "At the first indication that a resident may be infected, Contact Precautions will be instituted."	F 880	QAPI The DON will bring all audit results to QAPI monthly. The QAPI team will determine if more auditing is needed from results.	