DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	05/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PO BOX 5309 PINEHURST, NC 28374

(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 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; (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.	F 441	**STANDARD DISCLAIMER:** **This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).** Resident #108 currently has wound treatments administered in accordance with facility policy and the physician's orders. For those residents having the potential to be affected by the same alleged deficient practice, the wound treatment nurse was counseled and re-trained related to on ensuring the bedside table is disinfected before placing treatment supplies on it, as well as being in-serviced on the disinfecting of re-usable equipment on May 26, 2011. The treatment nurse has also been evaluated by the Director of Nursing for competency of accepted professional standards and has been found to meet those standards. All licensed nurses have been provided in-service education on infection control and disinfecting of re-usable equipment, as indicated by accepted professional practice and facility policy. The Director of Nursing and Clinical Supervisor shall monitor for compliance by completing infection control wound rounds weekly for 4 weeks, monthly for 3 months, and quarterly thereafter.	6/15/11 6/15/11 6/15/11 6/15/11

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

Dakena Nichols — Administrator

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 This REQUIREMENT is not met as evidenced by: Based on observation, records review and staff interviews the facility, failed to provide wound treatment in a manner to prevent cross contamination for 1 of 2 observed wound treatments. (Resident #108) Findings include: A review of a memo dated 5/12/11 to the treatment nurse from the Director of Nursing (DON) identified the following items. Do not keep supplies in your pocket and provide care from room to room. This memo was provided by the DON when the policy and procedure for wound treatments was requested. The DON also provided a copy of an in-service provided on 2/25/11 on infection control which included a section on environmental cleaning. The environmental cleaning section included wiping down surfaces with a disinfectant, and clean between patient contacts any equipment used from patient to patient should be wiped down - use alcohol wipes or disinfecting wipes - even soap and water is effective. The sign in sheet included the treatment nurses name. Resident #108 was admitted to the facility on 3/14/11 and re-admitted on 4/18/11. Diagnosis included Chronic blood Loss Anemia, Protein-calorie Malnutrition, failure to Thrive-Child, gross Hematuria and Sepsis. Observed outside of Resident #108 ' s room during initial dour on 5/23/11 was an isolation precautions sign, which indicated the use of	F 441	The plan of correction for this alleged deficient practice shall be incorporated into the minutes of the facility's most recent Quality Assurance Committee meeting minutes. Any infection control deficient practice will be reviewed in the Continuing Quality Improvement Committee.	6/15/11

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F 441	Continued From page 2 gloves and gowns when providing care to the resident. A review of the clinical record for Resident #108 revealed a laboratory test result identifying that a culture of hip drainage taken on 5/6/11 tested positive for Methicillin Resistant Staphylococcus Aureus. A laboratory test result of a stool specimen collected on 5/9/11 was positive for Clostridium difficile. On 5/25/11 at 8:45am wound treatments were observed for Resident #108. The treatment nurse was observed placing packages of dressings, a cup filled with normal saline, a cup with Betadine and 4 X 4 gauze in it, scissors and a package of Betadine swabs on top of the over-the-bed-table. The table was not wiped down nor was any type of barrier placed on the table before placing the supplies for the dressing changes on it. After the wounds had been provided treatment per the physician orders' the treatment nurse removed all the equipment from the over-the-bed-table and discarded them. The scissors were observed being wiped by the treatment nurse with a dry paper towel gotten from the paper towel dispenser located above the sink in the resident ' s room. The scissors were then observed being placed in the pocket of the treatment nurses ' scrub top. The treatment nurse then left the room. The over-the-bed-table was not cleansed after the dressing supplies had been removed from it. As the nurse was walking down the hallway preparing to provide another wound treatment an interview was conducted at 9:20am .The treatment nurse confirmed the observations of not cleaning the over-the-bed-table before and	F 441		

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F 441	Continued From page 3 after using it for supplies during the dressing changes. The treatment nurse stated that she knew the over-the-bed-table should have been cleansed or a barrier should have been placed on the table before placing her treatment supplies and equipment on it. When asked about how she was trained to handle the scissors she removed them from her pocket and stated "I wiped them with a clean paper towel." Further discussion revealed that she " should have used a disinfectant before placing the scissors in her pocket. " On 5/25/11 at 12:10pm an interview with the DON revealed that the treatment nurse had spoken with her regarding the observed dressing change. The DON stated this was unacceptable and that training had just recently been completed regarding infection control and treatments. The DON indicated the treatment nurse had attended that in-service. The DON stated "the table should have been cleaned before and after. The scissors should not have been wiped with a dry paper towel and never should be placed in a pocket. The scissors should have been disinfected before she left the room and then replaced on the treatment cart."	F 441		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 469		

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F 469	Continued From page 4 Based on observations, record reviews, and staff interview the facility failed to provide an effective pest control program for the kitchen, activity director ' s office and 4 of 7 common areas. Findings include: An observation on 5/23/2011 at 12:30pm in the restorative dining room revealed 9 residents were present during lunch. Three flies were observed on Resident #3's pureed lunch. No staff member attempted to swat the flies off the food. After the flies had landed on the food the staff member asked the resident again if he wanted to eat. The resident refused to eat the food. Observations on 5/25/2011 at 11am in the resident library revealed four flies were observed flying around in the room landed on table, chairs and books. Observation on 5/25/2011 at 4:45pm in the kitchen during tour, 10 flies were observed flying around in the kitchen by oven, tray line and landed on staff. Staff in the kitchen were observed fanning the flies to keep them off the food and themselves. Observation on 5/26/2011 at 9am in the resident ' s library, two flies observed flying around in the room landed on resident ' s head and marri-walker. An interview on 5/26/2011 at 9:30am with the dietary manager revealed that the maintenance manager handles the pest control for the kitchen. An interview on 5/26/2011 at 10:30am with the	F 469	**STANDARD DISCLAIMER:** **This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).** **No residents were identified to have been affected by this deficiency.** **For those residents having the potential to be affected by the same alleged deficient practice, employees were in-serviced by their department managers to replace any resident meal if a pest is observed or reported as having landed on the resident's food. Employees will continue to be encouraged to report any evidence of pests to the Maintenance Director and/or their Department Manager.** **The dumpsters located at the rear of the facility were replaced with sanitized, clean dumpsters on Wednesday, May 20, 2011. The area surrounding the dumpsters and the rear loading dock were thoroughly cleaned on June 13, 2011 with (1) a pressure wash, and (2) a special grease-eating enzyme chemical.** **The broken air blower identified during the survey has been repaired and is now in working order.**	6/15/11 6/15/11 5/25/11

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F 469	Continued From page 5 Maintenance Manager revealed that the facility does not have a contract with an outside pest control company. MM revealed that he used fly base granules outside and also indicated that the air blower in the kitchen does not work. He also indicated that no staff had reported any concerns with flies in the facility. During an interview with the activity director on 5/26/11 at 11:39am 2 flies were observed flying around the room landing on the activity director and her desk. The activity director stated " there have been a lot of flies the last couple of days. I do not know what the problem is, they are pesky things. " An interview on 5/26/2011 at 3pm with the Administrator revealed that someone from corporate office came out to the facility monthly, and provided pest control services. Administrator revealed that the maintenance manager provided weekly monitoring of this facility. Administrator also indicated that this was North Carolina and you are going to see a few flies.	F 469	**The monthly routine pest control program provided by the Corporate sponsor and the facility shall continue. The pest report monitoring system will be reviewed in the monthly Quality Assurance (QA) Committee Meeting monthly for three months, and then quarterly thereafter.** **The area surrounding the dumpsters located at the rear of the facility will continue to be thoroughly cleaned monthly with (1) a pressure wash, and (2) a special grease-eating enzyme chemical.** **The Plan of Correction for this alleged deficient practice will be included in the facility's most recent Quality Assurance Committee meeting minutes.**	6/15/11 6/15/11 6/15/11

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K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: residents bedroom doors 101, 102(gap at top) and Medical Records door had gap at bottom of door that does not allow the door to seal against the passage of smoke. Also, bedroom #115 had trash can blocking door from closing. 42 CFR 483.(a)	K 018	STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). The gaps at the top of doors # 101 and 102 will be closed. The gap at the bottom of the Medical Records door will be closed as well. The resident in room #115, as well as staff were in-serviced not to prop door open with trash can. There are no other areas affected by this same alleged deficient practice(s). To ensure that this alleged deficient practice does not recur, the Director of Maintenance or his designee will complete a monthly assessment within the facility to determine if other doors need to be adjusted. The Director of Maintenance or his designee will monitor to ensure a sustained solution and report any system failures quarterly to the Quality Assurance Committee for further evaluation. RECEIVED JUL 05 2011 CONSTRUCTION SECTION	7/22/11 7/22/11 7/22/11 7/22/11

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

Sabrina Nesbitt — Administrator — 7/1/11

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K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: a single bulb fixture at the 200 and 600 wing exit. Lighting must be arranged to provide light from the exit discharge to the public way (parking lot). 42 CFR 483.70(a)	K 045	The single bulb light fixtures at the 200 and 600 wing exits will be replaced with double bulb light fixtures. There are no other areas affected by this same alleged deficient practice(s). To ensure that this alleged deficient practice does not recur, the Director of Maintenance or his designee will replace the single bulb fixtures with two bulb light fixtures. The Director of Maintenance or his designee will report any system failures quarterly to the Quality Assurance Committee for further evaluation.	7/22/11 7/22/11 7/22/11 7/22/11
K 047 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: exit and directional signs on 300 hall were not continuous illumination.	K 047	The light bulbs for the exit and directional signs on 300 hall were changed out and now illuminate continuously. There are no other areas affected by this same alleged deficient practice(s). To ensure that this alleged deficient practice does not recur, the Director of Maintenance or his designee will complete a monthly assessment within the facility to determine if any exit or directional signs need new light bulbs. The Director of Maintenance or his designee will report any system failures quarterly to the Quality Assurance Committee for further evaluation.	6/29/11 7/22/11 Ongoing 7/22/11 Ongoing 7/22/11 Ongoing

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K 047	Continued From page 2 42 CFR 483.70(a)	K 047		
K 072 SS=F	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 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: facility had excess storage of items through out the facility. 1) beverage cart by TV on 100 hall, also lift by room 102. 2) linen cart blocking exit access(cart did not move during survey). 3) lift stored by room 301. 4) storage at exit discharge on short hall 500(chairs, linen carts and lifts).	K 072	With regards to the excess storage of items throughout the facility, all items were removed from the hallways immediately. All staff is being in-serviced on excess storage of items in the hallways, and the importance of keeping the means of egress free of obstructions or impediments. To ensure that this alleged deficient practice does not recur, in-service training will occur quarterly for all staff by the Maintenance Director or his designee. The Director of Maintenance or his designee will report any system failures monthly to the Quality Assurance Committee for further evaluation.	6/17/11 7/22/11 7/22/11 7/22/11 Ongoing
K 076 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour	K 076		

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K 076	Continued From page 3 separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: in both oxygen storage rooms empty and fulls were mix in racks. Oxygen storage room on 500 hall had tanks that were not support in racks or stands. 42 CFR 483.780(a)	K 076	With regards to the oxygen storage, the tanks were separated by empty and full and placed in the appropriate holders. All oxygen tanks located on the floor were immediately placed in the proper storage rack. All other areas have been inspected to ensure compliance and oxygen tanks are properly stored and labeled. To ensure that this alleged deficient practice does not recur, inservice training has been provided by the Director of Nursing to staff on proper storage and signage of oxygen tanks. D) The Central Supply Clerk will routinely inspect for compliant storage in designated storage areas. Discrepancies will be reviewed in the Quality Assurance Committee and the Administrator will monitor for compliance.	6/17/11 6/17/11 7/22/11 7/22/11 Ongoing