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

PRINTED: 7/26/2011
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
	345233	A. BUILDING _____ B. WING _____	C 07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE REHABILITATION & CARE	308 DEER PARK ROAD NEBO, NC 28761

(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	**Without admitting or denying the validity or existence of the alleged deficiencies, Sunrise Rehabilitation & Care provides the following plan of correction.** 1. Individual counseling with staff member #1 has been done by ADON. 2. All residents have the potential to be affected. Infection control nurse monitored observed staff in regards to infection control practices and provided immediate in-services as needed. 3. Direct care staff will be in-serviced by ADON/Designee on infection control policy and procedure for hand washing. Non-direct care staff (dietary & Housekeeping) will be in-serviced by directors of the departments on department specific infection control. 4. The ADON/Designee will audit/monitor 10% of direct care staff. Dietary Manager/designee and Environmental Director/ designee will audit/monitor 10% of their staff. Audits will be done weekly x 4 weeks, monthly x 3 months and then quarterly. Findings will be reported to the QA committee monthly. 7/30/11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: William J. Allman | TITLE: Administrator | (X6) DATE: 8/02/11

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, staff interview and record review, facility staff failed to remove gloves and/or wash hands following care for one (1) of four (4) sampled residents. (Resident #4) The findings are: Review of the facility policy dated June 2010 for hand washing/hand hygiene revealed the following: "The facility considers hand hygiene the primary means to prevent the spread of infections." Implementation of this policy statement included that employees must wash hands under the following conditions: Before and after coming in contact with a resident's intact skin, after handling soiled linens, and after removing gloves. Resident #4 was readmitted to the facility with diagnoses including spinal cord injury, quadriplegia, pressure ulcers, neurogenic bladder with indwelling urinary catheter and history of urinary tract infections. Review of the current Minimum Data Set (MDS) dated 6/13/11 revealed the resident was assessed as being totally dependent on staff assistance for all activities of daily living. Observation on 7/20/11 at 10:05 a.m. revealed Nursing Assistant (NA) #1 completing the repositioning of Resident #4 on his left side. The NA removed her gloves, positioned the resident's head on the pillow and touched the top sheet covering the resident. NA #1 walked out of the resident's room without cleaning her hands,	F 441		

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F 441	Continued From page 2 accessed the linen cart and proceeded to walk into the resident activity/dining room. She touched the handle on a geri chair in the room, and then walked into the utility and washed her hands. Observation on 7/20/11 at 10:45 a.m. revealed NA #1 and #2 preparing to transfer Resident #4 from the bed to the chair. Both NAs put on gloves, changed the resident's clothes and provided incontinence care prior to transferring the resident. NA #1 left the room without removing the gloves or washing her hands. She pulled a mechanical lift from the hall into the room while she continued to wear the gloves. The two staff members transferred the resident to a geri chair using the lift. NA #1 manouvered the lift into position and lowered the resident into the geri chair. Staff removed the sling from the lift. NA #1 then walked out of the room to a linen cart positioned in the hall where she collected a roll of plastic bags. She continued to wear the same gloves. She reentered the resident's room and proceeded to remove the resident's soiled linens and brief from the bed, and placed the items in the plastic bags torn from the roll. At this time, NA #1 placed the roll of plastic bags on the mattress. She then, removed her gloves and washed her hands. She picked up the roll of plastic bags and returned them to the linen cart in the hall. During an interview on 7/20/11 at 11:10 a.m., NA #1 stated she knew she was supposed to wash her hands "before and after care," but stated wasn't told anything more specific than that. Interview on 7/20/11 at 2:50 p.m. with the Infection Control Nurse confirmed the actions of the direct care staff would need to be corrected.	F 441		

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