STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE DREXEL, NC 28619

(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 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to date a container of pimento cheese that was opened and available for use. The findings are: During a tour of the kitchen on 08/27/12 at 9:15 AM an opened container of pimento cheese was observed in a reach in cooler available for resident use. The pimento cheese container was approximately one-third full and had no date to indicate when the container was first opened. An interview was conducted with the Dietary Manager (DM) on 08/27/12 at 9:20 AM. She stated the pimento cheese was good for seven days after opening but was unable to say when the container had been opened. The DM discarded the container of pimento cheese immediately. On 08/30/12 at 9:00 AM a sign was observed on the door of the dining room which listed food	F 371	This written plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal Law. No resident was named in this deficiency. No residents experienced negative outcomes. The open container of pimento cheese was discarded immediately on 8/27/12. All items in refrigeration storage units were checked that all items were labeled with date opened as well as manufactures best if used by date checked. All items were in compliance. Dietary staff were in-serviced by Food Service Director 8/27-8/30/12 on storage/ serving food under sanitary conditions. A tracking tool was developed to monitor for open items and labeling of items. Audits are conducted by Food Service Director/Designee twice daily for four weeks, then daily for four weeks then random as needed. Results of the audits are reviewed quarterly to the Quality Assurance Committee. Food Service Director/Assistant are responsible for monitoring compliance.	8/27/12 8/30/12 8/30/12 9/27/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Murray — TITLE: LNHA — (X6) DATE: 9/18/2012

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.

RECEIVED
SEP 25 2012
BY: MH

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F 371	Continued From page 1 items that were available upon request at any time and included pimento cheese sandwiches. During an interview on 08/30/12 at 10:27 AM with the DM she stated the pimento cheese should have been dated when opened and discarded after seven days. She further reported the pimento cheese had been used the evening of 08/26/12 for residents requesting pimento cheese sandwiches.	F 371		
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.	F 441		

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F 441	Continued From page 2 (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 observations, staff interviews, and medical record review, the facility failed to prevent potential contamination of a treatment cart by intending to return items touched during a dressing change for one (1) of one (1) resident observed under contact precautions. The findings are: Resident #24 was admitted to the facility with peripheral vascular disease and bone and cartilage disorder. A review of Resident #24's medical record revealed laboratory results dated 08/27/12. The report specified a light growth of Methicillin Resistant Staphylococcus Aureus (MRSA) had been cultured from an ankle wound. An observation of a dressing change to Resident #24's ankle wound was conducted on 08/29/12 at 1:49 PM. Upon entering the resident's room a sign was observed that contained instructions regarding Contact Precautions. Licensed Nurse	F 441	Resident #24 has not experienced any negative outcomes related to potential contamination. No other residents have experienced a negative outcome. Licensed Nurse #1 was re-educated on proper policy and procedure to prevent potential contamination. 8/29/12 All Nursing staff in-serviced on Infection Control policies and procedures to help prevent the development and transmission of disease and infection including standard precautions and transmission based precautions. This in-service includes preventing potential contamination by direct or indirect transmission. 9/27/12 The Assistant Director of Nursing/Infection Control nurse conducts infection control rounds daily for one week, three times weekly for one week, then weekly ongoing. Results of the audits are reviewed quarterly to the Quality Assurance committee to ensure compliance. Director of Nursing responsible for monitoring compliance. 9/17/12	

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F 441	Continued From page 3 (LN) #1 was observed donning gown and gloves. During the dressing change, LN #1 was observed touching a spray container of cleaning solution and irrigated the wound. She picked up a paper container of cotton tipped applicators (cotton-tipped wooden stick) and pulled out an applicator with her gloved hand. She used the applicator to clean the inside of the wound. LN #1 held a bottle of iodoform gauze in her gloved hand and cut a piece of gauze which she used to pack the wound. LN #1 was also observed squeezing medication from a plastic tube onto gauze and applying it to a wound. Using the same gloved hands, she tore two (2) pieces of tape from a roll of tape and placed the tape on the outside of the dressing. The remainder of the tape roll was placed with the medication tube and applicator container. After the dressing change was completed, LN #1 removed her gown and gloves and washed her hands. She picked up the items mentioned and attempted to place them on top of the treatment cart located outside of Resident #24's room. She was stopped by the surveyor. When questioned at this time, LN #1 stated she did not think about replacing the items to the treatment cart. She acknowledged this act would cause potential contamination of other supplies on the cart. An interview was conducted with the Assistant Director of Nursing (ADON) on 08/29/12 at 2:40 PM. The ADON stated it was her expectation supplies utilized during a dressing change were not placed back onto the wound cart. She acknowledged this was especially important when the items were utilized for a resident with known MRSA.	F 441		