

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

PRINTED: 04/12/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/15/2017
NAME OF PROVIDER OR SUPPLIER WILMINGTON HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 820 WELLINGTON AVENUE WILMINGTON, NC 28401		
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F 164 SS=D	<p>483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>(h)(3)The resident has a right to secure and confidential personal and medical records.</p> <p>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.</p> <p>§483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation</p>	F 164		4/12/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/03/2017

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 164	<p>Continued From page 1</p> <p>purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interviews, the facility failed to maintain the privacy of 1 of 1 residents, (Resident # 8), on the 600 Hall during incontinence care. Findings included:</p> <p>Resident # 8 was admitted to the facility on 11/14/14. The most recent Minimum Data Set (MDS) for Resident # 8, dated 02/03/17, revealed the resident was moderately cognitively impaired, was totally dependent on staff with toileting and bathing, and was always incontinent of bladder and bowel.</p> <p>During a round of the facility at 1:35 PM on 03/15/17, Nursing Assistant (NA) #4 was observed giving incontinence care to the resident in the B bed in room 603. The door to the resident's room was open and the curtain was pulled half way. The resident's body from the mid torso to the feet was visible from the hallway and NA # 4 could be seen wiping the resident's buttocks.</p> <p>At 1:37 PM on 03/15/17, NA # 3, who was in the bathroom of room 603 assisting the resident in bed A with toileting, responded to knocking on the room door and pulled the curtain around bed B and closed the door to room 603 upon being made aware of the resident's exposure.</p> <p>In an interview with NA # 3 and NA # 4 at 2:45 PM on 03/15/17, NA # 3 stated that she had wheeled the resident in bed A into the bathroom and</p>	F 164	<p>Resident #8 suffered no ill effects regarding providing personal privacy during patient care.</p> <p>Nursing Assistant #3 and Nursing Assistant #4 were provided education on 3/15/17 by the Director of Nursing, regarding providing privacy during all Activities of Daily living care. Both nursing assistants verbalized understanding and demonstrated skills to the Director of Nursing.</p> <p>Facility Staff have been in serviced regarding maintaining privacy during patient Activities of Daily living care at all times.</p> <p>Random audits will be completed three times a week, for four weeks by Director of Nursing or Designee, to check for proper privacy provided during care and personal patient care.</p> <p>Results of monitoring will reviewed by the Quality Assurance Committee monthly for three months.</p>		

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F 164	Continued From page 2 pushed the main door to the room with her foot as she was entering the bathroom and thought it had closed all the way. She stated that she was aware that NA # 4 was providing care to the resident in bed B. NA # 4 stated that she thought the curtain around bed B was drawn far enough to provide privacy. Both NA # 3 and #4 stated that the resident in bed B was a total care resident and was not able to use the call bell. NA # 4 stated that she was providing incontinence care to the resident in bed B as a part of her normal rounding routine before her shift was over. In an interview with the Director of Nursing (DON) at 4:31 PM on 03/15/17, she reported that it was her expectation that resident care be provided in privacy.	F 164			
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--	F 431		4/12/17	

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F 431	<p>Continued From page 3</p> <p>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>(h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to store medications out of the reach of residents for 1 of 4 hallways observed during the survey. Findings included:</p>	F 431	<p>No resident suffered any ill effects related to labeling and administering drugs and biologicals.</p> <p>Nurse #2 was counseled and re educated</p>		

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F 431	<p>Continued From page 4</p> <p>During observations of call bell response times on the 200 Hall at 11:20 AM on 03/15/17, Nurse # 2 was observed in resident room 214 assisting the resident in bed near the window. There were medications in a medication cup sitting on the bedside table beside the bed near the door. The resident in the bed near the door was lying in the bed with open eyes staring towards the window. Nurse # 2 finished assisting the resident in the bed near the window and exited the room, leaving the medications in the cup on the bedside table beside the bed near the door. Nurse # 2 returned to her medication cart, located in the middle of the hall, approximately 3 resident rooms away from room 214 and began to prepare to administer medications to another resident on the hall.</p> <p>During an interview with Nurse # 2 on 03/15/17 at 11:23 AM in resident room 214, the nurse stated that she had meant to take the medications with her out of the room, but became distracted with the resident near the window and forgot to take them with her on the way out. She reported that she had to return to the medication cart to retrieve a spoon because the resident in the bed near the door needed to have the medications mixed in her protein liquid to swallow the medications. Nurse # 2 reported that the resident in the bed near the window was not capable of self-administration of the medications relied on staff for administration. She stated that she should not have left the medications on the bedside table in the resident's room unattended and that she was thankful that it was brought to her attention.</p> <p>In a follow up interview with Nurse # 2 on 03/15/17 at 2:55 PM, she reiterated that she had</p>	F 431	<p>regarding this incident by the Director of Nursing on 3/15/17. All medication must be administered to the patient in the presence of the nurse, and not to be left at the bedside.</p> <p>Facility staff will be in serviced concerning proper medication administration to the residents.</p> <p>Director of Nursing or designee will audit 3 separate nurses, three times a week for four weeks on their medication pass, to ensure proper medication is being administered.</p> <p>Results of monitoring will reviewed by the Quality Assurance monthly for 3 months.</p>		

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F 431	Continued From page 5 gotten distracted with the resident at the window in room 214 and had sat the medications for the resident in the bed near the door down on the bedside table to assist the other resident and forgot to retrieve them before leaving the room. She reported that the resident was not capable of medication self-administration and that she required her medications to be mixed in a medium to be administered with a spoon because she was unable to swallow them. In an interview with the Director of Nursing (DON) at 4:31 PM on 03/15/17, she stated that pills should be supervised and given to the resident and not left in the room. She reported that Nurse # 2 was a seasoned nurse and was aware of this and she was not sure why she would have made that error other than she must have gotten distracted.	F 431			
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);	F 441		4/12/17	

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F 441	<p>Continued From page 6</p> <p>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p>	F 441			

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F 441	Continued From page 7 (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 observation, record review and staff interviews the facility failed to prevent cross contamination of a urinary catheter drainage tube by placing it uncapped in a bag of dirty linen for 1 of 1 sampled residents (Resident #3), failed to handle dirty linen in a sanitary manner by placing it on the floor for 1 of 1 residents (Resident #7), failed to administer medications in a manner to prevent cross contamination and to dispose of a used syringe in an approved biohazard container for 1 of 1 residents (Resident # 2), and failed to post an isolation precautions sign on the door of 1of 1 resident rooms (Resident # 6) who was on isolation. Findings included: 1. Review of the Quarterly Minimum Data Set (MDS) dated 01/19/17 revealed Resident #3 was admitted to the facility on 05/20/15 and had an external urinary catheter. Review of the Physicians Orders dated 02/08/17 revealed a (name brand) external catheter be used for Resident #3 as needed to manage urinary incontinence. Catheter care was to be performed with each application. In an observation on 03/15/17 at 3:55 PM Resident #3 was lying in bed with the head of the bed elevated. The sheet was pulled back by the	F 441	1. Resident #3 has suffered no ill effects related to this incident. The Unit manager was educated on 3/15/17 regarding proper infection control by the Director of Nursing. To prevent cross contamination of a urinary catheter drainage tube. Director of Nursing reviewed the policies and procedures directly with the Unit Manager. Facility staff were educated on 3/31/17 regarding proper foley catheter care and maintenance to ensure infection control and prevent cross contamination during foley catheter care. Director of Nursing or designee will audit foley catheter care three times a week, for four weeks, to ensure proper technique to keep patient free of cross contamination. Results of monitoring to be reviewed by Quality Assurance monthly for three months 2. Resident #7 suffered no ill effects related to this incident. Nursing assistant #1 and Nursing Assistant #2 were		

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F 441	<p>Continued From page 8</p> <p>Unit Manager (UM) and the urinary catheter was exposed. A wet washcloth and towel were placed on the bed. The catheter attachment was removed from Resident #3 by the UM. The UM then disconnected the attachment from the catheter collection bag tubing leaving the end open and uncapped. The open tubing was placed over a folded towel and rested against the top sheet of the bed. The UM cleansed Resident #3's penis with a washcloth and placed the soiled washcloth into a plastic bag at the foot of the bed. She then pulled the towel out from under the tubing and patted the area dry and placed the towel in the soiled linen bag at the bottom of the bed. When the towel was pulled out the open end of the tubing fell onto the bottom sheet of the bed. The tubing continued to slide down the sheet and the UM picked it up and placed the open end into the plastic bag containing the soiled linens. The UM removed the tubing from the soiled linen bag and proceeded to connect the urinary attachment to the drainage bag.</p> <p>In an interview on 03/15/17 at 4:15 PM the UM stated she should have capped the urinary catheter tubing and not placed it into the dirty linen bag. She indicated by placing the tubing into the dirty linen bag it could have contaminated the tubing and could cause an infection.</p> <p>In an interview on 03/15/17 at 4:35 PM the Director of Nursing (DON) stated it was her expectation that when catheter tubing was disconnected a cap should be placed on the end of the tube if the tubing was to be reused. Uncapped tubing should not be placed in a bag with soiled linens and should not be used if that happened.</p>	F 441	<p>educated on 3/14/17 regarding proper handling of soiled linen by the Director of Nursing. All soiled linen must be properly bagged and placed in the soiled utility room. Soiled linen must not be un bagged, on the floor, or on another resident's bed.</p> <p>Facility staff have been educated on proper disposal of soiled linen on 3/31/17. Director of Nursing or designee will audit resident rooms three times a week for four weeks, to ensure proper lined handling and disposal of soiled linen. Results of monitoring to be reviewed by the Quality Assurance Committee monthly for three months.</p> <p>3. Resident #2 suffered no ill effects related to this incident.</p> <p>Nurse #1 was counseled by the Director of Nursing on 3/13/17, regarding proper disposal of syringes after administration and disposal of medications that accidentally dropped on floor.</p> <p>Facility staff were educated on 3/31/17 regarding proper syringe disposal and medication waste if accidentally dropped on the floor. Despite a patient "insisting" it is ok to give. Nursing must follow proper medication administration guidelines.</p> <p>Director of Nursing or designee will audit patients requiring injections and oral medication administration three times a week, for four weeks, to ensure proper</p>		

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F 441	<p>Continued From page 9</p> <p>2. In an observation on 03/14/17 at 12:33 PM Nursing Assistant (NA) #1 opened the door to Resident #7's room from the inside and came out of the room. A used rolled up hospital gown and used rolled up towels were seen on the floor between the door jamb and the trash can next to "A" bed. The linens were not in a bag. Resident #7 was assigned to "B" bed which was across the room next to the window. NA #2 was in the room assisting Resident #7.</p> <p>In an observation on 03/14/17 at 12:39 PM the linens that had been on the floor next to the door jamb had been placed on top of the blue mattress of "A" bed next to the clean linen.</p> <p>In an interview on 03/14/17 at 2:35 PM NA #2 stated she was the NA assigned to Resident #7 that day. She indicated there was no resident currently assigned to "A" bed. NA #2 stated used linens should be placed in a plastic bag and taken from the room. She indicated she had placed the dirty linen on top of the trash can without bagging it and the linen must have fallen to the floor. She stated she had not picked up the linen from the floor and placed it on the mattress of "A" bed. NA #2 stated NA #1 should have picked the dirty linen up off the floor and put it in a bag before she left the room.</p> <p>In an interview on 03/14/17 at 2:55 PM NA #1 stated she had not touched the dirty linen and did not pick it up or place it on "A" bed. She indicated she did not know how the linen got on the floor or back up on the mattress of "A" bed.</p> <p>In an interview on 03/14/17 at 3:05 PM the Billing Office Representative, who had been helping serve trays on the hall at the time of the incident,</p>	F 441	<p>technique and procedures are followed. Results of monitoring will be reviewed by the Quality Assurance committee monthly for three months.</p> <p>4. Resident #6 has suffered no ill effects related to this incident. A contact isolation sign was placed on the patient's door per policy and procedure on 3/14/17.</p> <p>Facility staff were educated on 3/16/17 regarding Personal protective equipment and all specific isolation precautions. Isolation signs have been placed and are accessible on the units. All education provided by Director of Nursing on 3/14/17.</p> <p>Nursing assistant assignments have been updated, as well as patient care plans, with specific isolation information by the Unit Manager on 3/14/17</p> <p>Director of nursing or designee will audit all residents placed on isolation, three times a week for four weeks, to ensure proper signage specific to infection and staff awareness of Personal protective equipment needs.</p> <p>An Infection control Registered Nurse was hired at Wilmington Health and Rehabilitation on 3/23/17. She will attend the SPICE program in September 2017 to continue to educate and enforce infection control systems, policies and procedures.</p> <p>Results of monitoring will be reviewed by the Quality Assurance committee monthly</p>		

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F 441	<p>Continued From page 10</p> <p>stated she did not know who picked the dirty linen up off the floor and placed it on the "A" bed. She indicated she had informed Nurse Manager #1 when the placement of the dirty linen had been brought to her attention but did not know who had actually gone and disposed of the linen.</p> <p>In an interview on 03/14/17 at 3:10 PM Nurse Manager #1 stated she took the dirty linen off of "A" bed and placed it in a plastic bag. She indicated she did not know who had placed the dirty linen on the bed. She stated it was protocol to bag dirty linen and then remove it from the room. She indicated the dirty linen should not have been placed on the mattress of "A" bed. The Nurse Manager stated she told Housekeeper #1 to wash the mattress on "A" bed because dirty linen had been placed on it.</p> <p>In an interview on 03/15/17 at 8:12 AM Housekeeper #1 stated she had not been asked to clean the "A" bed mattress the previous day. However, as part of her normal cleaning routine she had wiped down the mattress after lunch since the bed was not made. She was not aware that dirty linen had been placed on the bed.</p> <p>In an interview on 03/16/17 at 4:35 PM the Director of Nursing (DON) indicated she was filling the role of the Infection Control Nurse at this time until the new Infection Control Nurse that had been hired was able to start. She indicated it was her expectation that dirty linen not be placed on the floor or on another bed. Used linens should be placed in plastic bags and taken out of the room.</p> <p>3. In an interview with Resident # 2 and his family on 03/15/17 at 1:20 PM, he stated that the nurse who had administered his medications on</p>	F 441	for three months.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/15/2017
NAME OF PROVIDER OR SUPPLIER WILMINGTON HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 820 WELLINGTON AVENUE WILMINGTON, NC 28401		
(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	<p>Continued From page 11</p> <p>03/13/17 had left the syringe that was used to inject his Lovenox in the room on the window sill and his wife had to take it to the Director of Nursing (DON) to inform her that it was left in the room and to have it disposed of properly. Resident #2's wife stated that she was not in the room when the medication was administered, but when she arrived at the facility in the afternoon, the syringe was still sitting in the window when she removed it from the room and gave it to the DON. She reported that she was not sure how long the used syringe had been there. Both Resident # 2 and his wife stated that the needle was not exposed as it had retracted back into the syringe after the injection had been given. Resident #2 also stated that the same nurse had given him medications that were to be taken by mouth (po) after they had been dropped on the floor. The resident reported that the nurse had done this several times and the most recent time was the morning of 03/15/17.</p> <p>A review of Resident # 2's medication administration record (MAR) for March 2017 revealed that Nurse # 1 was the nurse who administered the Lovenox to the resident on 03/13/17 and was the nurse who had administered the by mouth medications on the morning of 03/15/17.</p> <p>In an interview with Nurse # 1 on 03/15/17 at 2:05 PM, she stated that she had left the syringe on the window sill on 03/13/17 because she sat it down after giving the injection to assist the resident to move up in the bed, per his request. She reported that she had just forgotten about it and left the room after helping him move up in the bed. Nurse # 1 stated that the needle was not exposed because it was one that retracted after</p>	F 441			

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F 441	<p>Continued From page 12</p> <p>injection, but she understood that it could have still been a hazard because it had been used. She reported that she was made aware that she had left the syringe on the window by the DON who told her that the family member had taken the syringe to her office. Nurse #1 stated that she had dropped by mouth medications at times, but Resident #2 stated that he did not want her to get replacement medications and he was not opposed to taking the medications after being dropped on the floor. When asked if she thought she should have still thrown the by mouth medications away, Nurse #1 stated that she gave the resident the medications after being dropped on the floor because he insisted.</p> <p>In an interview with the DON at 4:31 PM on 03/15/17, she stated that Resident #2's family member had taken the used syringe to her immediately and brought it to her attention. She then took it to Nurse #1 and had her dispose of it properly. The DON stated that her expectation was that the syringe should have been disposed of properly after it was used. She also stated that it was never ok to administer medication that was to be taken by mouth once it had been dropped on the floor and it was her expectation that a nurse would dispose of the medication and administer new medication.</p> <p>4. During a tour of the facility on 03/14/17 at 11:55 AM, an isolation box was observed on the door for resident room 203 with personal protective equipment (PPE) in the box, but there was no sign regarding the type of isolation the resident in the room required or the type of PPE that would be needed to be donned before entering the room.</p>	F 441			

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F 441	<p>Continued From page 13</p> <p>A review of the record for Resident # 6 revealed that she had been admitted to the facility on the morning of 03/14/17, but there was no information readily available regarding the resident's diagnosis for isolation.</p> <p>In an interview with the Nursing Assistant (NA) # 2 assigned to room 203 at 2:47 PM on 03/14/17, she stated that she was not sure why Resident # 6 was on isolation, but whenever she saw that box on the door with the PPE, she would just put on the gown and gloves anyway. NA # 2 reported that she would normally ask the nurse if she had a question about a resident's isolation status.</p> <p>In an interview with NA # 5 at 2:55 PM on 03/14/17, she stated that she did not know why Resident # 6 was on isolation, but she would just put on everything that was in the box, including a mask. She reported that there should be a sign on the box or the door because visitors would not know what the box on the door meant.</p> <p>At 3:05 PM on 03/14/17, NA # 6 stated that she did not know why the resident was on isolation, but she would just put on the gown and gloves. She reported that she was new to the facility, but was used to seeing a sign on the box or the door letting staff and visitors know what type of isolation precautions to observe and what PPE to use.</p> <p>Additional observations of the isolation box hanging on the door for room 203 were made throughout the afternoon of 03/14/17 at 2:43 PM, 3:51 PM, 4:20 PM and 5:17 PM and the morning of 03/15/17 at 8:20 AM, 10:15 AM, and 11:45 AM and a sign was never placed on the door.</p>	F 441			

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F 441	<p>Continued From page 14</p> <p>In an interview with Nurse # 1 at 2:05 PM on 03/15/17, she stated that Resident # 6 had Methicillin-resistant Staphylococcus Aureus (MRSA) in her foot. Nurse # 1 reported that there should have been a sign placed on the door along with the PPE box, but she was not sure who was responsible for that.</p> <p>In an interview with Nurse # 2 at 2:55 PM on 03/15/17, she reported that she was not sure why Resident # 6 was on isolation because she had not seen a sign on the door or on the PPE box. She stated that she was not working the day the resident was admitted, but she would have expected to see a sign on the door or PPE box in addition to the PPE being available.</p> <p>In an interview with the DON at 4:31 PM on 03/15/17, she stated that she was not sure exactly how isolation was handled in nursing homes in North Carolina because she was new to the state, but she would have at least expected there to be a sign to see the nurse on the door in addition to the PPE.</p>	F 441			