STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING ______ B. WING ______	C 08/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR HEIGHTS CENTER	**804 SOUTH POPLAR STREET** **ELIZABETHTOWN, NC 28337**

(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 000	INITIAL COMMENTS There were no deficiencies cited as a result of this complaint investigation survey of 08/23/17. Event ID #XPOR11.	F 000		
F 441 SS=D	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); (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;	F 441		9/8/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/01/2017

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 441	Continued From page 1 (iv) When and how isolation should be used for a resident; including but not limited to: (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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (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 and staff interviews the facility failed to wash or sanitize their hands prior to exiting an isolation room (Room 235) for 1 of 1 rooms posted for contact isolation precautions (Methicillin Resistant Staph Aureus pneumonia). Findings included:	F 441	1. Nurse #1 received one-on-one training by the Director of Nursing on facility hand washing policy for residents on isolation. Nurse #1 also received training by the Director of Nursing on types of isolation and importance of hand washing to	

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F 441	Continued From page 2 In an observation on 08/22/17 at 11:50 AM an isolation cart with Personal Protective Equipment (PPE) was seen outside the door of room 235. A Contact Precautions card was posted on the door of the room with a checkmark next to the statement "Perform hand hygiene before entering and before leaving room." A staff member was seen in room 235 wearing a mask and gloves. The staff member removed the PPE and left the room without washing her hands or using hand sanitizer. She walked down the hallway to a locked room, unlocked the door, and went inside. On exit from the room it was verified by visualization that there were no sinks in the room for hand washing. In an interview on 8/22/17 at 11:55 AM Nurse #1 stated the resident in Room 235 was on contact isolation precautions for Methicillin Resistant Staph Aureus pneumonia. She stated she should have washed her hands prior to exiting the isolation room and that she had not. Nurse #1 stated she had not cleansed her hands as directed by policy because she was in a hurry and that it was an oversight. In an interview on 08/23/17 at 2:50 PM the Director of Nursing (DON) stated it was her expectation that staff wash their hands or use hand sanitizer before exiting an isolation room.	F 441	prevent the spread of infection. 2. Contact isolation for resident in Room 235 was discontinued on 8/22/17 and no other residents were identified with isolation precautions. Facility staff will be in-serviced on types of isolation and the importance of hand washing to prevent the spread of infection by the Director of Nursing or designee by 9/8/17. 3. The Director of Nursing or designee will maintain a list of residents with isolation precautions. The Director of Nursing or designee will randomly monitor staff hand washing upon exit of isolation rooms to ensure staff wash their hands or use hand sanitizer before exiting the room. Random monitoring will begin once resident is placed on isolation and will be conducted daily x 3 days and then weekly until isolation is discontinued. 4. The Director of Nursing or designee will provide a list of residents with isolation precautions to the facility's Performance Improvement Committee along with any hand washing audits completed to validate staff compliance with hand washing monthly x 3 months.	