F 441 483.65 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

PLAN OF CORRECTION

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with this statement of deficiency. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulation.

1. a. Resident #1 suffered no harm.
   b. Resident #7 suffered no harm.
   c. Nurse was immediately re-educated on 3-19-13, by the Director of Clinical Services.

2. All current facility residents with physician’s orders for wound care treatments were reviewed to ensure that they are stable per their vital signs and their wounds are without signs and symptoms of infection by the facility’s Director of Clinical Services on 4/16/13.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting if it can demonstrate to the agency that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosed to the public within 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and those of the survey conducted 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.

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

EXECUTIVE DIRECTOR 4/12/13

FORM CMS-2587(02-99) Previous Versions Obsolete
Event ID: 40K911
Facility ID: 923161
If continuation sheet Page 1 of 6
3. The Director of Clinical Services/Assistant Director of Clinical Services/Nurse Unit Manager have re-educated all current facility staff on the facility's policies and procedures for infection control and hand washing. The Director of Clinical Services/Assistant Director of Clinical Services/Nurse Unit Manager have re-educated current facility Licensed Nurses on the facility's policy and procedure for wound care to include infection control and hand washing during the provision of wound care along with validation of education via return demonstration.
and cleaned the wound. Without changing gloves or washing her hands, she packed the tunneling wound with a calcium alginate 2 x 2 dressing then covered the wound with a 2 x 2 bordered, self-adhesive gauze. She then removed her gloves and put them in the bag with the soiled dressings. She placed the bottle of wound cleanser back in the basin with other unused supplies. Without washing her hands, she opened the door to the resident’s room and carried the bag down the hall to the nurse’s station and discarded it. Without washing her hands, she placed the wash basin on top of the treatment cart and removed additional supplies from the treatment cart needed to complete wound care for Resident #1. She placed the additional supplies in the wash basin and left the same bottle of wound cleanser in the wash basin. She went directly from the nurse’s station to Resident #1’s room.

During an interview on C3/19/13 at 2:15 PM the WCN stated she should have changed gloves and washed her hands after removing the soiled dressing and before cleaning the wound, then again after cleaning the wound before applying the clean dressing. She also stated she should have washed her hands when she finished the dressing change. When asked what she usually did, she stated she usually washed her hands in the resident’s bathroom before starting the dressing change then went to the bathroom in the nurse’s lounge and washed her hands after she finished.

During an interview on 03/19/13 at 2:39 PM the WCN stated she usually used the same bottle of wound cleanser for all the treatments on the
Continued From page 3

Alzheimer's unit. She stated she usually washed her hands after removing the soiled dressing and before cleaning the wound but just got nervous and forgot. She stated she could see how she might have contaminated the bottle of wound cleanser by not changing her gloves after removing the soiled bandage and before cleaning the wound.

During an interview on 03/19/13 at 4:58 PM the Director of Nursing (DON) stated her expectation was for the nurse to wash her hands before assembling the supplies then again when entering the resident's room. She stated the nurse should then put on gloves, remove the soiled dressing, packing or anything covering the wound. The DON stated the nurse should then remove the gloves, wash her hands and put on clean gloves. After clearing the wound, the nurse should remove the gloves, wash her hands and put on clean gloves. After applying the new dressing, the nurse should remove the gloves and wash her hands before leaving the resident's room. The DON stated the bottle of wound cleanser should not have been put back in the treatment cart. When asked about any training provided to the WCN, the DON stated the Assistant Director of Nursing had reviewed the Wound Care protocol with the WCN when she started about 2 weeks ago.

2. During an observation on 03/19/13 at 2:00 PM the facility's Wound Care Nurse (WCN) was observed entering Resident #1's room to do wound care. She placed a wash basin with supplies on Resident #1's overbed table. Without washing her hands, the WCN started to put on gloves to do the dressing change. When asked
Continued From page 4

about her usual practice for washing hands
between residents, she stated she forgot and
then went in Resident #1's bathroom and washed
her hands. She put on gloves and picked up the
same bottle of wound cleanser she had handled
with soiled gloves when doing Resident #7's
treatment. She sprayed cleanser on a 4 X 4
gauze and cleaned a 3 cm X 6 cm area of black
eschar on Resident #1's left heel. Without
changing gloves or washing her hands, the WCN
removed a hydrogel gauze from the pack and
placed it on Resident #1's left heel. She then
covered the area with a bordered, self-adhesive 4
X 4 gauze. The WCN removed her gloves,
ashed her hands and put on clean gloves then
plied skin prep to Resident #1's right heel. She
removed her gloves, opened the door to Resident
#1's room and walked down the hall to the
urse's station on the Alzheimer's Unit without
ashing her hands. She placed the bottle of
wound cleanser back in the treatment cart
and put the cart in a closet at the nurse's station. She
left the Alzheimer's Unit with a bag of soiled
plies and discarded them; then, went to the
employee lounge and washed her hands.

During an interview on C3/19/13 at 2:15 PM the
WCN stated she should have changed gloves
and washed her hands after cleaning the wound,
then again after applying the clean dressing.
When asked what she usually did, she stated she
usually washed her hands in the resident's
bathroom before starting the dressing change
then went to the bathroom in the nurse's lounge
and washed her hands after she finished.

During an interview on C3/19/13 at 2:39 PM the
WCN stated she usually used the same bottle of
**Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
</tr>
</thead>
</table>
| F 441 |        |     | Continued From page 5 wound cleanser for all the treatments on the Alzheimer's unit.  
During an interview on C3/19/13 at 4:58 PM the Director of Nursing (DON) stated her expectation was for the nurse to wash her hands before assembling the supplies, then, again when entering the resident's room. She stated the nurse should then put on gloves, remove the soiled dressing, packing or anything covering the wound. The DON stated the nurse should then remove the gloves, wash her hands and put on clean gloves to clean the wound. After cleaning the wound, the nurse should remove the gloves, wash her hands and put on clean gloves. After applying the new dressing, the nurse should remove the gloves and wash her hands before leaving the resident's room. The DON stated the bottle of wound cleanser should not have been put back in the treatment cart. When asked about any training provided to the WCN, the DON stated the Assistant Director of Nursing had reviewed the Wound Care protocol with the WCN when she started about 2 weeks ago. |

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*DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES  
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  
(x1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:  
348447  
(x2) MULTIPLE CONSTRUCTION  
A. BUILDING  
B. WING  
(x3) DATE SURVEY COMPLETED  
C  
03/20/2013  
NAME OF PROVIDER OR SUPPLIER  
EMERALD RIDGE REHAB AND CARE C  
STREET ADDRESS, CITY, STATE, ZIP CODE  
25 REYNOLDS MOUNTAIN BOULEVARD  
ASHEVILLE, NC 28804  
(x4) ID PREFIX TAG  
F 441  