STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G268	A. BUILDING _____ B. WING _____	C 07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORE COUNTY HOME FOR AUTISTIC ADULTS	1112 DEVONSHIRE TRAIL ABERDEEN, NC 28315

(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
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure an active program for the prevention, control and investigation of infection was maintained. This affected all clients residing in the home. The finding is: The potential for the spread of infection was not prevented. During observations in the home on 7/19/18 at 6:48am, client #1's left eye was red and slightly puffy. Client #6's right eye appeared slightly puffy; however, not redness was noted. Staff interview on 7/19/18 revealed three of the six clients in the home, including client #1 and client #6, have conjunctivitis or "pink eye". The staff indicated all three clients were receiving eye drops for the condition. Review on 7/19/18 of client #6's record revealed he had been to an urgent care facility (Fast Med) on 7/8/18 with redness and swelling of his right eye. The urgent care report noted "acute conjunctivitis, right eye". The client was prescribed three different eye drops. Additional review of the record indicated client #6 was taken to his primary physician on 7/12/18 after his symptoms worsened. A physician's note dated 7/12/18 revealed, "Due to severity of symptoms	W 455		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 455	Continued From page 1	W 455		

and exam, will refer to ophthalmologist for appt ASAP." Another physician's note dated 7/13/18 indicated the client had been seen at Family Eye Care of the Carolina's where two of his eye drops were discontinued and another one ordered. Another physician's note dated 7/13/18 revealed, "If no improvement in 5 days pt to call for appt."

Review on 7/19/18 of client #1's record noted she had been seen at an urgent care facility (Fast Med) on 5/3/18 and was diagnosed with "conjunctivitis". The medical report noted, "Chief complaint of constant (but worse at times) eye discharge of the left eye and rt eye since approximately Weds 5/2/18." The report also indicated the client had been prescribed an eye drop medication to treat the condition. Further review of the physician's notes dated 7/17/18 indicated the client had been seen by her primary physician and again diagnosed with conjunctivitis for which Cipro eye drops were prescribed.

Further review of client #1 and client #6's urgent care medical reports for conjunctivitis noted, "This condition is caused by several common bacteria. You may get the infection if you come into contact with another person who is infected. You may also come into contact with items that are contaminated with the bacteria..." The report indicated under Home Care Instruction, "...Change or wash your pillowcase every day...Do not share towels or washcloths. This may spread the infection...Wash your hands often with soap and water. Use paper towels to dry your hands...Avoid touching or rubbing your eyes..."

During additional observations in the home on 7/19/18 at 8:05am, a staff entered the living room where client #1 was sitting and began prompting

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W 455	Continued From page 2	W 455		

the client to hold her head back so eye drops could be applied to her eyes. During this time, another client was seated on the couch next to client #1. After much difficulty, the staff prompted client #1 to a nearby table where the eye drops were applied. At 8:15am, client #1 and another client sat in very close proximity on the couch. The client put her head on client #1's shoulder and both clients briefly held hands. At 8:27am, a client entered the bathroom briefly and then returned to the living room. A staff asked the client if she had washed her hands, although no water was heard running while inside the bathroom, the client stated, "Yes." Throughout these observations, no clients were prompted, assisted or encouraged to wash or sanitize their hands except just before breakfast. With the exception of wiping two tables, staff did not disinfect any areas of the home or items utilized/touched by client #1 and client #6.

Review on 7/19/18 of a third shift cleaning checklist for 7/9/18 - 7/15/18 revealed only two days in which cleaning tasks were completed. No cleaning checklist had been completed for 7/16/18 - 7/18/18.

Staff interview on 7/19/18 revealed they know pink eye is "very contagious" and they try to wear gloves to prevent the spread of it.

Another staff was asked if they had been trained regarding universal precaution procedures, the staff stated, "I don't know what that is...What is it? The staff indicated they had a lot of training when they were hired a couple of years ago; however, they could not remember all of it.

Interview on 7/19/18 with facility's nurse

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W 455	Continued From page 3 confirmed three clients in the home have contracted conjunctivitis and they were "working on...trying to eradicate it" and getting to the bottom of it. The nurse stated, "When one gets better, another one gets it." Additional interview indicated staff are trained annually on using universal precautions and they should be following those procedures, cleaning thoroughly and washing specific items used by infected clients. Interview on 7/19/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed staff should be washing their hands, ensure client's are washing their hands thoroughly (30 seconds per physician) with soap and water, using and changing gloves as needed, and using hand sanitizer in order to prevent the spread of infection. Additional interview with the QIDP noted third shift staff should be completing most thorough cleaning and sanitation tasks overnight and documenting on a checklist. The QIDP also indicated second shift staff should be cleaning toys and other items on their shift; however, there is no way of documenting cleaning tasks completed on second shift. The QIDP indicated staff receive annual training on universal precautions; however, she acknowledged additional training would be necessary after a contagious infection like conjunctivitis has been diagnosed.	W 455		