STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK RD ARDEN, NC 28704

(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) COMPLETIO DATE
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review the facility failed to obtain a laboratory value as ordered by the Physician for two (2) of ten (10) sampled residents (Resident #s 73 and 91). The findings are: 1. Resident #73 was admitted to the facility on 2/22/11 with diagnoses that included Chronic Obstructive Pulmonary Disease, coronary artery disease, congestive heart failure, hypertension, stage IV kidney disease, bilateral lower extremity edema, and others. Resident #73's medical record revealed a nurse practitioner's progress note dated 3/25/11 that specified the resident required "very close monitoring" of specific laboratory values that included BUN (blood urea nitrogen), creatinine, potassium and renal function due to her chronic kidney disease and hypokalemia. The nurse practitioner specified her plan was to recheck the resident's laboratory values and wrote a Physician's order on 3/25/11 for "BMP (Basic Metabolic Panel) in 1 week." Further review of the resident's medical record revealed no BMP labs for that time period were found. On 5/12/11 at 8:45 a.m. the Director of Nursing (DON) reviewed the Resident's medical record and reported she was unable to locate the BMP diagnostic results. At 9:05 a.m. the DON	F 281	**This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law** RECEIVED JUN 3 2011 BY: DPH RECEIVED MAY 31 2011 BY:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: ✓ Verna McEntire — TITLE: Administrator — (X6) DATE: 5-27-11

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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review the facility failed to obtain a laboratory value as ordered by the Physician for two (2) of ten (10) sampled residents (Resident #s 73 and 91). The findings are: 1. Resident #73 was admitted to the facility on 2/22/11 with diagnoses that included Chronic Obstructive Pulmonary Disease, coronary artery disease, congestive heart failure, hypertension, stage IV kidney disease, bilateral lower extremity edema, and others. Resident #73's medical record revealed a nurse practitioner's progress note dated 3/25/11 that specified the resident required "very close monitoring" of specific laboratory values that included BUN (blood urea nitrogen), creatinine, potassium and renal function due to her chronic kidney disease and hypokalemia. The nurse practitioner specified her plan was to recheck the resident's laboratory values and wrote a Physician's order on 3/25/11 for "BMP (Basic Metabolic Panel) in 1 week." Further review of the resident's medical record revealed no BMP labs for that time period were found. On 5/12/11 at 8:45 a.m. the Director of Nursing (DON) reviewed the Resident's medical record and reported she was unable to locate the BMP diagnostic results. At 9:05 a.m. the DON	F 281	**F281** **1) For resident #73 affected by this alleged deficient practice, the attending physician was notified immediately of error when facility was informed during survey. All subsequent lab orders were carried out and there was no harm to resident.** **For resident #91 affected by this alleged deficient practice, the attending physician was notified immediately of error when facility informed during survey. Order obtained at that time for TSH to be drawn that day. TSH drawn and results back same morning and noted to be within normal limits.** **2) All residents have the potential to be affected by this alleged deficient practice. A complete chart audit of all routinely scheduled labs as well as all labs ordered within the past 30 days will be completed.**	06/07/11

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

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F 281	Continued From page 1 confirmed the laboratory values were not performed as ordered. She explained the lab was not drawn because the nurse who transcribed the Physician's order failed to record the laboratory requisition on the calendar to notify the lab technician. 2. Resident #91 was admitted to the facility 12/3/10 with diagnosis that included hypothyroidism with admission medications that included 50 mcg every day of Levothyroxine (a medication to treat hypothyroidism). On 12/8/10 the Levothyroxine was changed to 75 mcg due to a TSH (thyroid stimulating hormone) test done on 12/7/10 with a result of 6.31 with a normal range of .35-5.5. On 1/20/11 a TSH level on Resident #91 was done with a result of .08. On 1/20/11 the resident's physician changed the Levothyroxine to 50 mcg every day and wrote orders to recheck the TSH level in six weeks. Since admission, Resident #91 had lost 17 pounds. A progress note by the resident's Nurse Practitioner on 2/16/11 read, Staff requested I visit resident due to weight loss. Patient has had weight loss over past couple months. Last TSH low and dose adjusted in January with planned recheck in six weeks. Another TSH level was not checked until brought to the attention of staff on 5/11/11. On 5/12/11 a TSH level was done with a result of .32. On 5/12/11 the resident's Nurse Practitioner wrote orders to decrease Synthyroid to 25 mcg QD. On 5/11/11 at 10:50 AM the Director of Nursing (DON) stated an outside contract service was utilized by the facility to draw labs twice a week. The DON stated after an order was written for labwork it would be recorded on the facility calendar lab book. The DON reviewed the calendar lab book and could not locate the need	F 281	**3) Measures put in place to ensure this deficient practice does not occur include Licensed nursing staff present at time of discovery of error were immediately inserviced on order transcription procedures. All other current licensed nursing staff were inserviced regarding transcribing orders. Copies of all Physician's Telephone Orders are to be given to RCC (Resident Care Coordinator) and DON (Director of Nursing) daily. All lab orders will be checked against the lab calendar by RCC/DON Monday through Friday, to include weekend orders, to verify labs have been placed on calendar as ordered.** **4)The trending of this plan of correction is presented to the RM/QI (Risk Management/ Quality Improvement) committee by the DON.**	

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F 281	Continued From page 2 for the TSH level six weeks after it was ordered on 1/20/11 for Resident #91. On 5/11/11 at 10:55 AM the licensed nurse that took the 1/20/11 order for the TSH level stated she forgot to include it in the facility lab book calendar which was why it was not done as ordered.	F 281	**The Administrator will continue to monitor and evaluate this action plan for its effectiveness during the RM/QI Meetings monthly for 12 months. Any revision to this plan will be implemented when indicated.**	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, family, resident, and staff interviews, and documentation review the facility failed to implement Physician ordered measures for the treatment of a medical condition for one (1) of one (1) sampled residents with edema (Resident #73). The findings are: Resident #73 was admitted to the facility on 2/22/11 with diagnoses that included end stage cardiomyopathy, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, hypertension, stage IV kidney disease, bilateral lower extremity edema, and others. The most recent Minimum Data Set (MDS) dated 3/1/11 specified the resident had no cognitive impairment and required extensive assistance with Activities of Daily Living (ADLs) that included personal hygiene, transfers and bed mobility. The Care Area Assessment (CAA) summary dated 3/4/11 specified the resident had "bilateral lower extremity edema 2+ which made it hard for	F 309	**F309** **1) For resident #73 affected by this alleged deficient practice, the attending physician was notified immediately of error when facility was informed during the survey. Licensed Nursing staff present at time of discovery were immediately inserviced on proper documentation on the MAR of the resident's offer and/or refusal of treatment. Licensed nurse #1 also counseled regarding the requirement to provide all treatments as ordered. Resident #73's order to elevate legs was discontinued by the Physician on 05/25/11.**	06/07/11

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F 309	Continued From page 3 her to be mobile." Resident #73's care plan dated 2/22/11 specified the resident had the potential for altered nutrition related to edema and diagnosis of congestive heart failure. Interventions to decrease edema included: 1. Monitor lab/diagnostic work as ordered. 2. Report all concerns to medical doctor Resident #73's medical record was reviewed and revealed a Family Nurse Practitioner's (FNP) encounter note dated 3/25/11specified, "She is having a lot of edema. She is consistently gaining weight every day." The FNP's physical examination revealed the resident had +2 edema of extremities. The FNP's assessment specified she asked nursing staff to put the leg rests on Resident #73's wheelchair and elevate her legs one hour three times daily after meals for the resident's congestive heart failure. Resident #73's Physician's orders revealed an order written on 3/25/11 to elevate her legs one hour three times daily after meals. The Medication Administration Record (MAR) dated 5/11 was reviewed and specified the resident's legs were to be elevated for one hour three times daily at 10:00 a.m., 2:00 p.m. and 6:00 p.m. Observations made of Resident #73 revealed: 1. On 5/9/11 at 1:45 p.m. and at 3:00 p.m. she was in her wheelchair with her legs down. Her wheelchair leg rests were on the floor underneath her bed. Her ankles appeared swollen and tight. 2. On 5/10/11 at 9:15 a.m., 10:30 a.m., 1:00 p.m., and at 2:30 p.m. she was in her wheelchair with her legs down. Her wheelchair leg rests were on the floor underneath her bed. Her ankles appeared large and swollen. 3. On 5/11/11 at 10:00 a.m. and 2:00 p.m. she	F 309	**2) An audit was completed for all resident's specific to positioning as a treatment for medical conditions and no other resident's were identified with the potential to be affected by the deficient practice.** **3) Measures put in place to ensure this deficient practice does not occur include re-education of nursing staff for need to provide positioning as ordered and the necessity to document and report noncompliance of resident. The DON/ designee will review all new Physician's Orders daily Monday – Friday in the Daily Clinical Review meeting for any resident's found with new orders regarding positioning specific to the treatment of a medical condition.** **4)If any resident is found with an order for positioning specific to the treatment of a medical condition, the resident will be monitored three times per week for the first four**	

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F 309	Continued From page 4 was in her wheelchair with her legs down. Her wheelchair leg rests were on the floor underneath her bed. Her ankles appeared swollen and bulged over the sides of her shoe. 4. On 5/12/11 at 9:00 a.m., 10:00 a.m. and 11:00 a.m. she was in her wheelchair with her legs down. Her wheelchair leg rests were on the floor underneath her bed. Her ankles were observed to be swollen and puffy in appearance. On 5/9/11 at 3:30 p.m. Resident #73's family member was interviewed and reported Resident #73 had medical conditions that resulted lower extremity edema. The family member specified nursing staff were supposed to elevate the resident's legs after meals to help with the edema but confirmed they had not observed this to happen during frequent visits to the facility. During the interview, the resident's legs were observed at rest on the floor while she sat in her wheelchair. The wheelchair leg rests were observed on the floor under the resident's bed. The family member stated that Resident #73's legs were not elevated after meals during visits and added nursing staff had not been observed to offer to elevate Resident #73's legs. On 5/12/11 at 11:00 a.m. licensed nurse #1 (LN) was interviewed and reported Resident #73's legs were to be elevated after meals for one hour. He reported that he or the nurse aide assigned to care for the resident was responsible for doing this. He added that Resident #73 would at times refuse initially but would comply when he explained the importance of elevating her legs. He confirmed that he had not offered to elevate the resident's legs that morning and explained he didn't always do it at 10:00 a.m. as specified on the MAR. Resident #73's MAR was reviewed with LN #1 on 5/12/11. The MAR specified the resident's legs had been elevated for one hour on at the following times:	F 309	**weeks then monthly times three months to ensure compliance of the order. The trending of this plan of correction is presented to the RM/QI (Risk Management/ Quality Improvement) committee by the DON. The Administrator will continue to monitor and evaluate this action plan for its effectiveness during the RM/QI Meetings monthly for 12 months. Any revision to this plan will be implemented when indicated.** **F329** **1) For resident #46 affected by this alleged deficient practice, the attending physician was notified immediately of error when facility was informed during survey. There is a current AIMS Assessment (03/22/11) in the resident's chart. Resident show no signs or symptoms of involuntary movement disorders related to his anti-psychotic medication.**	**06/07/11**

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F 309	Continued From page 5 · 5/9/11 at 2:00 p.m. · 5/10/11 at 10:00 a.m. · 5/10/11 at 2:00 p.m. · 5/11/11 at 10:00 a.m. · 5/11/11 at 2:00 p.m. On 5/12/11 at 11:15 p.m. LN #1 was interviewed and was unable to explain why observations of Resident #73 revealed her legs were not elevated as indicated by the MAR. On 5/12/11 at 1:30 p.m. Resident #73 was observed in her room with the leg rests attached to her wheelchair and her legs elevated. Resident #73 was interviewed and reported that this was the first time staff had offered to elevate her legs. She stated her legs felt better elevated. On 5/12/11 at 2:45 p.m. the medical doctor was interviewed and reported several measures were implemented to treat Resident #73's edema that included elevating her legs. He added that the resident's edema was difficult to treat due to her overall condition. He confirmed he would expect nursing to elevate the resident's legs as ordered. On 5/12/11 at 3:35 p.m. the Director of Nursing (DON) was interviewed and confirmed the license nurse should have elevated the resident's legs as ordered by the physician. She added the MAR should have accurately reflected whether or not the Resident's legs were elevated each day.	F 309	**2) All residents on antipsychotic medication and/or Reglan have the potential to be effected by this alleged deficient practice. A chart audit of all residents on antipsychotics and/or Reglan was performed for AIMS status and any found out of date were completed and brought into compliance.** **3) Licensed nurse responsible for quarterly Clinical Review will at same time complete AIMS if required. IDT (Interdisciplinary Team) members will review charts quarterly for completion of AIMS.**	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329	**4) The DON/designee will monitor 5 charts per week for 4 weeks, then 5 charts per month for 3 months and then will review quarterly for compliance. The trending of this plan of correction is presented to the RM/QI (Risk Management/ Quality Improvement)**	

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F 329	Continued From page 6 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to monitor one (1) of four (4) sampled residents for the development of side effects of antipsychotic medications. (Resident #46). The findings are: A facility clinical Programs Manual, revised date 8/10, contained the following directions for completion of Abnormal Involuntary Movement Scale (AIMS): The purpose is to monitor residents for the development of involuntary movement disorders related to medications. The form should be completed with the initiation of antipsychotic medications and quarterly. Resident #46 was admitted to the facility 04/14/09. Current diagnoses included end stage chronic obstructive pulmonary disease and congestive heart failure. A review of Resident #46's medical record	F 329	**committee by the DON. The Administrator will continue to monitor and evaluate this action plan for its effectiveness during the RM/QI Meetings monthly for 12 months. Any revision to this plan will be implemented when indicated.** **F441** **1) For resident #144 affected by this alleged deficient practice, the attending physician was notified immediately of error when facility was informed during survey. A bedside commode was put in place for their use, as well as a cart with all PPE supplies placed outside the resident's door.** **2) For those residents with the potential for the alleged deficient practice:**	**06/07/11**

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F 329	Continued From page 7 revealed Haldol (an antipsychotic medication) 1 milligram (mg) was initiated 11/24/10. Further medical record review revealed a recommendation dated 12/10/10 from the consulting Pharmacist for an AIMS assessment. Continued medical record review revealed a documentation of an AIMS assessment dated 03/22/11. An interview with the Director of Nurses (DON) on 05/12/11 at 3:44 p.m. revealed an AIMS assessment was not performed until 03/22/11. She stated the system utilized to implement recommendations from the consulting Pharmacist had failed. The DON continued an AIMS assessment should have been completed upon initiation of Haldol and quarterly thereafter.	F 329	**A)There were no other residents in the facility with any infectious disease process.** **B) Resident #144's bathroom cohorts showed no signs of any infectious disease process.** **3) Systemic changes made to address the alleged deficient practice include inservices completed for the housekeeping department regarding cleaning principles for C-Diff per company policy as well as inservices for all Licensed Nurses and C.N.A.'s regarding contact isolation and PPE use. All Licensed Nurses and C.N.A.'s inserviced as well on dedicating the use of non-critical items to single resident or cohort of residents infected with C-Diff and that items must be cleaned with a 1:10 bleach solution between residents use if items are not dedicated to one resident or resident cohort.**	
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	F 441		

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F 441	Continued From page 8 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. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff, and physician interviews, medical record review, and review of facility policy, the facility failed to implement interventions to prevent the spread of infection for one (1) of one (1) sampled resident. (Resident # 144) The findings are: Review of the facility policy dated 2/09 titled "Clostridium Difficile: Preventing Spread" revealed Clostridium Difficile (C- Diff) was a spore-forming gram-positive anaerobic bacillus producing toxins that cause mucosal inflammation and damage. An active or symptomatic infection is characterized by mild to moderate diarrhea. The policy stated the procedure for preventing the spread of C-Diff included utilization of standard precautions plus the following modified Contact Precautions. * Dedicate the use of non-critical items to a single resident or cohort of residents infected with C-Diff. Items must be cleaned with a 1:10 bleach solution between residents use if items are not dedicated to one resident or resident cohort.	F 441	**4) The DON/designee will monitor 5 charts per week for 4 weeks, then 5 charts per month for 3 months and then will review quarterly for compliance. The trending of this plan of correction is presented to the RM/QI (Risk Management/ Quality Improvement) committee by the DON. The Administrator will continue to monitor and evaluate this action plan for its effectiveness during the RM/QI Meetings monthly for 12 months. Any revision to this plan will be implemented when indicated.**	

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F 441	Continued From page 9 * Use appropriate hand hygiene or handwashing, personal protective equipment, and isolation precautions during cleaning and disinfecting procedures. Resident #144 was admitted to the facility on 02/18/2011 with diagnoses which included shortness of breath, hypertension, and difficulty in walking. The admission Minimum Data Set (MDS) dated 02/25/2011 revealed the resident was cognitively intact, able to understand others, and able to make herself understood. The MDS revealed Resident #144 was assessed to require the limited assistance of one person for bed mobility, transferring, walking in her room and corridor, dressing, toilet use, and personal hygiene. The MDS indicated that Resident #144 was continent of bowel and bladder. Review of the Care Area Assessments (CAAs) dated 03/02/2011 revealed Resident #144 was alert and oriented to name, place, and date but did have some episodes of confusion which were easily redirected. The CAAs indicated she was recently hospitalized with weakness, poor endurance, and had a decline in her activities of daily living (ADLs). The CAAs revealed the resident required assistance with her activities of daily living, was continent of bowel and bladder, and was able to verbalize all her needs. Review of the Self Care Deficit Care Plan dated 02/18/2011 revealed Resident #144 was unable to complete self care tasks independently due to shortness of breath, poor endurance, and needed assistance making decisions. Review of the medical record revealed that an order was received on 04/03/2011 for a stool specimen to be sent for C-Diff testing after Resident #144 had had several days of loose stools which was first thought to be a gastrointestinal virus. The stool culture was	F 441		

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	345477	A. BUILDING _____ B. WING _____	05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 10 positive for C-Diff. Resident #144 was started on a ten day course of Flagyl (an antibiotic) for the positive result on 04/03/2011. Review of the nursing notes revealed the loose stools resolved over the next 48-72 hours and no diarrhea was documented through 04/23/2011. Review of the nursing notes from 04/03/2011 through 04/12/2011 revealed Resident #144 was incontinent of bowel and bladder at times. Resident #144 was discharged to the hospital on 04/23/2011 due to a reaction to Levaquin which was initiated on 04/19/2011 due to pneumonia. Resident #144 was readmitted to the facility on 04/27/2011. An order was received on 05/03/2011 for another stool specimen to be sent for C-Diff testing. The culture was again positive. Resident #144 was started on Vancomycin (a stronger antibiotic) for ten days. The last dose was due on 05/14/2011. Review of the nursing notes revealed that Resident #144 continued to have loose stools up until 05/11/2011. It was documented that she had three loose stools on 2nd shift on 05/11/2011. On 05/09/2011 at 2:35 p.m. observations revealed a green laminated sign posted on Resident #144's door which stated "STOP PLEASE SEE NURSE BEFORE ENTERING ROOM." An interview on 05/09/2011 at 2:35 p.m. with the Resident Care Coordinator revealed that Resident #144 was on contact precautions for C-Diff. Continued observations at 2:35 p.m. revealed Resident #144 had a roommate present in the room and the bathroom was shared with an adjoining room where two (2) other residents resided. There was no isolation cart or personal protective equipment outside the room at this observation. On 05/10/2011 at 9:30 a.m. observations were made inside the bathroom between Resident #144's room and the adjoining room. The	F 441		

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F 441	Continued From page 11 bathroom was used for a total of four (4) residents and included a toilet and a sink. The bathroom was clean and no obvious stool was observed on any surface. No sinks were present inside the rooms on either side of the bathroom. On 05/10/2011 at 9:36 a.m., Resident #144's roommate was observed rolling out of the bathroom in her wheelchair and requested to go back to bed. On 05/10/2011 at 9:46 a.m. an interview with NA #1 revealed Resident #144 was on contact precautions for C-Diff in her stool. NA #1 stated the resident was usually continent however since she has been sick she has had incontinent episodes. On 05/10/2011 at 10:09 a.m. an interview with Resident #144 revealed that she was capable of using the bathroom and does use the bathroom in their room. She stated that she rings her call bell when she needs to go to the bathroom and staff come assist her. On 05/11/2011 at 11:53 a.m., Resident #144's roommate was observed to be taken into the bathroom by an NA and a wound treatment aide, to perform a treatment on the resident's bottom. After the treatment was completed, the roommate was removed from the bathroom in a wheelchair and taken to the dining room by another NA. On 5/11/2011 at 11:54 a.m. an interview with NA #1 revealed she was getting ready to provide care to Resident #144 but she wanted to get some assistance in case incontinence care was needed because the resident had been having some diarrhea. On 05/11/2011 at 12:04 p.m. observations were made of Resident #144 during incontinence care. Resident #144 had been incontinent of a soft,	F 441		

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F 441	Continued From page 12 small stool and care was provided direct care staff. NA #1 and NA #2, as well as the Resident Care Coordinator, participated in the care utilizing gloves, periwash, disposable cloths, and a disposable brief. No gowns were worn during the personal care. No contamination of the surrounding environment was identified. On 05/11/2011 after the incontinence care was completed, an interview was conducted with NA #1. She stated that Resident #144 had not gotten up to use the bathroom on 05/11/2011 but did use the bathroom on 05/10/2011. NA #1 stated that they do assist Resident #144 to the bathroom and do pericare after she has completed going to the bathroom. NA #1 stated that they called housekeeping to come clean the bathroom after Resident #144 had finished using it on 05/10/2011. On 05/12/2011 at 2:50 p.m. in an interview with NA #3, he was asked about the green laminated sign on Resident #144's door. NA #3 stated that Resident#144 had been having a lot of diarrhea and that they were to wash their hands real good after providing care to her. He stated that Resident #144 was assisted to the bathroom unless she had had an incontinent episode and then incontinence care was provided. NA #3 also stated that Resident #144's roommate was toileted every two hours in the same bathroom which Resident #144 used. He revealed that one of the residents who resided in the room adjoining the bathroom of Resident #144 was also toileted every two hours. NA #3 confirmed that two other residents shared a bathroom with Resident #144. When asked if he took any special precautions due to Resident #144's infection, NA #3 stated no that they just washed their hands really well. On 05/12/2011 at 2:34 p.m. an interview with the Medical Director revealed that it would be his expectation for any resident diagnosed with C-Diff	F 441		

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F 441	Continued From page 13 to be on contact precautions which would include gloves, a gown, and no sharing of items between residents. He stated he would continue the contact precautions until the loose stools ceased for one to two days. The Medical Director stated that a bathroom should not be shared with a resident with C-Diff while they are having loose stools. He stated that if contact precautions were followed, he would not have the expectation of a private room. On 05/12/2011 at 3:17 p.m. an interview with the Director of Nursing (DON) revealed that she was not aware that Resident #144 had been having incontinent episodes and thought she remained continent. She stated that if a resident was positive for C-Diff and able to use the bathroom, it would be her expectation that the staff use bleach wipes to wipe down the toilet after resident use and wash their hands very good. The DON stated that it was her expectation for the licensed nurse to report the diagnosis of C-Diff to the nursing assistants caring for the residents. The DON stated the staff (licensed and unlicensed) had been educated on the proper techniques of caring for a resident who was diagnosed with C-Difficile including continent and incontinent residents.	F 441		