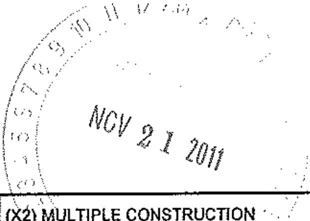

PRINTED: 11/09/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345284	A. BUILDING ______ B. WING ______	C 11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA RD WINSTON SALEM, NC 27103

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. 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. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide privacy while administering personal care to 1 of 4 sampled residents (Resident #4) whose care was observed. Findings include:	F 164	**The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies.** **To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.** **483.10 (e), 483.75(I)(4) Personal Privacy/Confidentiality of Records** **F Tag # 164** **This requirement will be met as follows:** **The facility has taken corrective action for the residents affected by this practice by:** • Interview with Resident #4 on 11/16/11 has revealed that her privacy has been maintained with care. • NA #7 was counseled and educated by DON. • Observations of care on 11/14/11 by SDC indicated privacy was provided. **The facility will take corrective action for those residents having the potential to affected by the same deficient practice:** • Alert and oriented residents were interviewed on 11/16/11 for any issues with privacy concerns during care. Any concerns were shared with nursing staff.	11/16/11 11/14/11 11/16/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan C. Hollett
TITLE: Administrator
(X6) DATE: 11/17/11

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 164	Continued From page 1 Resident #4 was admitted to the facility on 05/03/11. Cumulative diagnoses included congestive heart failure, atrial fibrillation, diabetes mellitus, anemia, hypertension and depression. The most recent Quarterly Minimum Data Set (MDS) assessment of 09/20/11 indicated she had a cognition score of 14 out of 15. She needed extensive assistance with toileting and bathing. During an observation of personal care, on 11/01/11 at 8:45 AM, Nurse Aide #7 (NA#7) was providing a bath to Resident #4. She indicated she needed to go to the bathroom. NA#7 with the help of another aide assisted her from the bed to the wheelchair and rolled her to the bathroom. He assisted her to sit on the toilet. He left the bathroom door open. Resident #4's roommate (Resident #5) was awake and in her bed. The bathroom was on Resident #5's side of the room and the bathroom was fully visible to Resident #5. The privacy curtain was not pulled. After Resident #4 finished, NA#7 went into the bathroom and asked her to stand up and hold onto the grab bar. While she was holding onto the grab bar, he used wipes and soap to wash her buttocks and provide perineal care. The door remained open. Once he completed care, he assisted her to pull up her slacks and assisted her to sit in the wheelchair. During an interview with Resident #5 (Resident #4's roommate), on 11/01/11 at 12:15 PM, she stated sometimes staff would pull her privacy curtain when they took Resident #4 to the bathroom and sometimes they would not. Resident #5 reported that she could see Resident	F 164	**The following measures/systemic changes will be put in place to ensure that the deficient practice does not occur:** • All nursing staff to include C N As and staff nurses were in-serviced by SDC by 11/28/11 on providing privacy while administering personal care. • Any in-house staff who did not receive in-service training will not be allowed to work until training is completed. • This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:** • Facility will monitor compliance regarding privacy by observing care on 2 residents per day Monday- Friday for 2 weeks and then weekly for 2 months. • Any immediate concerns will be brought to the DON or Administrator for appropriate action. • Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting.	11/28/11

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F 164	Continued From page 2 #4's bottom and "that won't right". She stated staff should have pulled her curtain so she would not have been able to visualize what was being done to Resident #4. During an interview with the Staff Development Coordinator (SDC) on 11/02/11 at 9:16 AM, she stated staff were taught to always provide privacy for the residents any time care was being provided. She stated the blinds should be closed for the resident on the window side of the room and the privacy curtain should be pulled all the way around the resident's bed. The SDC stated if the resident was in the bed at the door and needed to use the bathroom, the aide should pull the privacy curtain around the other bed since the bathroom was on that side of the room. She added that sometimes it was not possible to close the bathroom door due to wheelchairs being left nearby but staff were expected to pull the privacy curtains. Resident #4 was interviewed on 11/02/11 at 11:45 AM. She stated she did not like Resident #5 being able to see her naked bottom when care was being provided. NA#7 was interviewed on 11/02/11 at 12:40 PM. He stated he had been instructed to pull privacy curtains when providing care. He also stated he should have pulled Resident #5's privacy curtain before he provided personal care to Resident #4 in the bathroom. During an interview with the Director of Nurses (DON), on 11/02/11 at 4:45 PM, she stated staff should always provide privacy during personal care. She stated they should close the blinds,	F 164		

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F 164	Continued From page 3 pull the privacy curtains and close the door. She stated if the resident was in the bathroom, the privacy curtain should be pulled around the other resident's bed as sometimes the door to the bathroom could not be closed.	F 164		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide grooming services for 1 of 1 sampled residents (Resident #4) who needed shaving. Findings include: According to the facility's policy for shaving a resident, dated 10/01/01, it was the basic responsibility of the licensed nurse and the nursing assistant. The purpose of the policy was to "remove facial hair and improve the resident's appearance and morale." Resident #4 was admitted to the facility on 05/03/11. Cumulative diagnoses included congestive heart failure, atrial fibrillation, diabetes mellitus, anemia, hypertension and depression. The most recent Quarterly Minimum Data Set (MDS) assessment of 09/20/11 indicated she had a cognition score of 14 out of 15. She needed extensive assistance with toileting and bathing.	F 312	**483.25 (a)(3) ADL Care Provided for Dependent Residents** **F Tag # 312** **This requirement will be met as follows:** **The facility has taken corrective action for the residents affected by this practice by:** • Resident #4 was shaved on 11/02/11. **The facility will take corrective action for those residents having the potential to affected by the same deficient practice:** • All female residents were interviewed and assessed for facial hair. • No other resident was identified with facial hair nor was there any resident who wished to be shaved. **The following measures/systemic changes will be put in place to ensure that the deficient practice does not occur:** • The C N A staff in-serviced by 11/28/11 by SDC on the shaving policy. • Any in-house C N A staff who did not receive in-service training will not be allowed to work until training is completed. • This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	11/02/11 11/19/11 11/28/11

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F 312	Continued From page 4 During initial tour on 10/31/11 at 5:20 PM, Resident #4 was eating dinner in her room. It was noted that she had several long white hairs on her chin and neck as well as clearly visible white hair on her upper lip. An observation of personal care was conducted on 11/01/11 at 8:45 AM. Resident #4 was sitting on the side of her bed and was observed to have the same long chin hairs and hair to her upper lip. Nurse Aide #7 (NA#7) was providing a bath for Resident #4. Once the bath was completed, he brushed her hair. He did not offer to shave her. Resident #4 was observed sitting in her wheelchair in her room on 11/02/11 at 8:35 AM. She had long white hairs on her chin and neck as well as white hair on her upper lip. During an interview with the Staff Development Coordinator (SDC), on 11/02/11 at 9:16 AM, she stated female residents should be shaved when the hair was visible as "fuzz". She stated some female residents did not want to be shaved but staff should still offer to shave them. On 11/02/11 at 10:30 AM, NA#8 reported that Resident #4 had received her bath. It was noted that she continued to have the facial hair. NA#8 was interviewed on 11/02/11 at 10:45 AM about grooming. She stated female residents were shaved depending upon how quickly their facial hair grew. NA#8 added that some female residents would refuse to be shaved or the family would request that they not be shaved. When questioned if Resident #4 refused, she stated she	F 312	**The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:** • Facility will monitor compliance by observing 5 female residents weekly for facial hair. • This will be done weekly for 4 weeks then monthly for 3 months. • Any immediate concerns will be brought to the DON or Administrator for appropriate action. • Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting.	

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F 312	Continued From page 5 did not. NA#8 stated she had provided Resident #4's personal care earlier but did not notice she had facial hair. NA#8 commented that she usually would ask the female residents if they wanted to be shaved but she did not ask Resident #4. Resident #4 was interviewed on 11/02/11 at 11:40 AM. She stated she was aware that she had the long hairs on her neck and chin. She stated she had been pulling at them trying to remove them but was never successful. Resident #4 stated she did not like having facial hair and would like for staff to shave her. NA#7 was interviewed on 11/02/11 at 12:45 PM. He stated female residents should be shaved whenever needed. He added that he did not shave Resident #4 nor did he offer to shave her during the bath yesterday. NA#7 stated he would shave her before he left today. During an interview with the Director of Nurses (DON), on 11/02/11 at 4:45 PM, she stated female residents should be shaved as needed. She commented that she had not noticed the long chin hairs on Resident #4.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	**483.25 (h) Free of Accident Hazards/Supervision/Devices** **F Tag # 323** **This requirement will be met as follows:** **The facility has taken corrective action for the residents affected by this practice by:** • Resident #1 fall interventions and the use of the mechanical lift for transfers were reviewed for effectiveness and confirmed to be implemented through communication to the C N A via smart charting. • Care plan was updated by MDS staff to reflect all interventions in place. • Resident #3 was discharged on 7/15/11; no further action taken. • Nurse #2 was in-serviced and counseled regarding procedures of reporting a fall and completion of all Quality Assurance paperwork on 11/15/11 by DON. **The facility will take corrective action for those residents having the potential to affected by the same deficient practice:** • All residents who have had a fall in the past 30 days (10/14/11 -11/14/11) were reviewed to ensure all prior interventions were in place and appropriate. • Care plans were updated, interventions communicated via smart charting computer system provided by AHT.	11/16/11 11/15

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F 323	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to transfer the resident as recommended to prevent a fall for 1 of 2 sampled residents reviewed for falls (Resident # 1) and failed to follow the facility policy for reporting and investigating a fall for 1 of 2 sampled residents reviewed for falls (Resident # 3). Findings include: 1. Resident # 1 was admitted to the facility on 11/20/07 with cumulative diagnoses of transient ischemic attacks, peripheral vascular disease, dementia and multiple strokes. Physician Progress Notes, dated 05/08/11, indicated the resident had a decreased ability to stand and right ankle pain. Review of the most current care plan, dated 07/14/11 with a target date of 10/14/11 did not indicate falls for Resident # 1 had been identified as a problem. Nurse's notes, dated 07/23/11, written by Nurse # 3, indicated Resident # 1 had fallen while being transferred to the commode from the wheelchair. The nurse documented the resident had been lowered to the floor and no injury was noted. The nurse completed an incident report on 07/23/11. Immediate action included assessment of Resident # 1 for injury. Handwritten on the form was an entry , "make sure use Hoyer (mechanical lift)/stand + (plus) 2 CNAs (certified nursing assistants)". Resident # 1's fall was not added to the care plan. Interventions were not	F 323	**The following measures/systemic changes will be put in place to ensure that the deficient practice does not occur:** • All residents will be assessed for risk of falls on admission and quarterly. The care plan team interdisciplinary team will review and assess for appropriate interventions. • All residents with falls will be reviewed each morning by the Clinical Team and assessed weekly at the Quality of Life Meeting to ensure interventions are appropriate and in place. • Interventions will be included in the care plan,and smart charting used as a communication tool for the C N A staff. • The nursing staff including C N As and staff nurses were in-serviced by SDC by 11/28/11 regarding falls, transfers, documentation. • Any in-house C N A staff who did not receive in-service training will not be allowed to work until training is completed. • This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:** • Facility will monitor compliance by reviewing 5 residents with incident of fall to ensure fall was investigated, interventions in place, communicated, and documented. • This will be done weekly for 4 weeks then monthly for 3 months. • Any immediate concerns will be brought to the DON or Administrator for appropriate action. • Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting.	11/28/11

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F 323	Continued From page 7 developed to protect the resident from future falls. An entry was made in the resident's chart, written by the Rehabilitation Manager that indicated Resident # 1 was not appropriate for skilled physical therapy due to a lack of change in functional status. The manager added Resident # 1 needed continued use of a mechanical lift for transfers due to weakness and impaired coordination. He added the Nurse Practitioner had verbalized agreement. On 07/26/11, the physician's progress notes indicated rehabilitation attempts for Resident # 1 were futile. The Minimum Data Set (MDS), dated 10/13/11, indicated Resident # 1 had severe cognitive impairment. The MDS indicated the resident required extensive assistance for transfer. The MDS did not indicate any falls since the last assessment. An observation was made on 11/01/11 at 10:30 AM. Resident # 1 was sitting in her wheelchair. A chair alarm was not seen. Nursing Assistant (NA) # 4 was interviewed on 11/02/11 at 12:30 PM. NA # 4 was assigned to care for Resident # 1 on 07/23/11 and was in attendance when the resident fell. The NA stated she had not worked with Resident # 1 prior to that day. She stated at the time, she did not know the resident's capabilities and assumed she could stand and pivot. The NA stated she took the resident to the bathroom. Resident # 1 held onto the hand rail, but then started sliding. The NA added she slide the resident to the floor. NA # 1	F 323		

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F 323	Continued From page 8 stated she had not been sure where to find information about a resident's ability to transfer. She added she did not find out until after Resident # 1's fall that she was unable to transfer. This information was given to her by Nurse # 3. NA # 4 stated after the fall she did not receive any disciplinary action or training from the Director of Nursing or the Staff Development Coordinator. On 11/02/11 at 3:10 PM, the Rehabilitation Manager was interviewed. He stated the physical therapist that had completed the 07/26/11 screen of Resident # 1 was not available for interview. The manager added Resident # 1 was able to bear weight, but was too weak to stand, had cognitive issues, was unable to follow directions and coordination problems that made pivot/stand transfers unsafe for both the resident and the facility staff. Nurse # 3 was interviewed on 11/02/11 at 3:20 PM. Nurse # 3 cared for Resident # 1 on 07/23/11. He stated the NA had called him to the room. Resident # 1 was found sitting in front of the toilet with her legs straight out in front of her. He assessed the resident, found no injury, and with the assistance of the NA, transferred the resident back to the wheelchair. The nurse stated Resident # 1 was supposed to be transferred by mechanical lift. Information regarding transfers was found in the daily plan book available to NA's. Nurse # 3 stated on the day of Resident # 1's fall, it was the first day NA # 4 had worked with the resident. The nurse stated he was unsure if the NA knew how to transfer the resident. Nurse # 3 added he was not sure why the NA had transferred the resident to the toilet,	F 323		

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F 323	Continued From page 9 since Resident # 1 was totally incontinent. The nurse added he was not sure if the NA had known the resident's continence status. Nurse # 3 stated he reported the incident to the Responsible Party and the nurse manager on duty. He stated after the fall, he informed the NA she should have asked for help before transferring Resident # 1. The Director of Nursing (DON) was interviewed on 11/02/11 at 3:35 PM. She stated NA # 3 was new when the fall with Resident # 1 occurred. At the time Resident # 1 fell, transfer information had been found on a sheet that was placed inside the resident's closet. The DON stated NA # 3 should not have tried to transfer the resident alone. The DON added she had told the NA after the fall not to move another resident without knowing the resident. She added NA # 3 had not received disciplinary action and in-services were not held with the nursing staff. The DON stated it was not a preventable fall, only human error on the part of NA # 3. On 11/02/11 at 4:40 PM, the Administrator stated the accident for Resident # 1 was preventable. If NA # 3 had used the lift, Resident # 1 probably would not have fallen. 2. The facility's Falls Plan, which had an effective date of 02/01/02, indicated that an incidnet report was to be completed in detail and all spaces were to be completed. The incident report was then forwarded to the Director of Nurses (DON) or designee. The DON or designee was to make sure that the resident had been thoroughly assessed. The DON or designee would also ensure that the physician and family were notified of the falls and that the incident report was fully	F 323		

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F 323	Continued From page 10	F 323		

completed. The incident report was to be investigated. It further indicated that all residents who have fallen should be referred to the Falls Management meeting.

Resident #3 was re-admitted to the facility on 06/01/11 and discharged 07/15/11. Cumulative diagnoses included diabetes mellitus, hypertension, atrial fibrillation, and congestive heart failure. Her admission Minimum Data Set (MDS) of 06/10/11 indicated she had a cognition score of 15 out of 15. She needed extensive assistance with bed mobility and dressing. She needed total assistance with transfer, toilet use and bathing.

Upon review of Resident #3's electronic record, it was noted that there was no discharge nurse's note nor was there any mention of a fall. There was no care plan found for Resident #3.

A therapy note of 07/06/11 indicated Resident #3 ambulated 8 feet and was extremely short of breath. The note indicated she required standby assist from staff for all mobility.

A nurse's note of 07/14/11 at 1:32 PM indicated the nurse had met with Resident #3's family on 07/05/11 and 07/12/11 to finalize discharge plans for discharge home 07/15/11.

A therapy note of 07/14/11 indicated she had ambulated 10 feet with a rolling walker with minimal assistance due to poor gait quality.

During an interview with the Nurse #2, on 11/02/11 at 8:35 AM, he stated he was responsible for obtaining resident weights and 2

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F 323	Continued From page 11 nurse aides obtained the weights every Wednesday. Nurse #2 stated the facility had 2 types of scales to include a scale residents could stand on and a mechanical lift scale for those who could not stand. When questioned if anyone had ever fallen while being weighed he responded there had been an incident where a resident fell while standing on the scales but it had been a while back. Nurse #2 stated he would look for the incident report. He stated the nurse should have documented the fall in the nurse note section of Resident #3's electronic chart. During an interview with the Staff Development Coordinator (SDC), on 11/02/11 at 9:16 AM, she stated when a resident fell, whoever discovered the fall should report it to the nurse. She stated the nurse should then asssess the resident for injury. The SDC stated all falls were documented and investigated. At 9:47AM on 11/02/11, Nurse #2 stated he had been thinking about the fall incident and remembered he had received a telephone call from Resident #3's family the day after the resident was discharged home asking him about the fall. He stated he had reviewed Resident #3's chart today and found no documentation in regards to the fall. The Nurse #2 stated he knew a note had been written because he remembered speaking with the nurse about it. He reported looking in the electronic records and found a note that had been written in the wrong resident's record detailing Resident #3's fall of 07/15/11. According to a late entry nurse's note of 11/02/11 at 12:04 PM for the date of 07/15/11, staff had	F 323		

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F 323	Continued From page 12 obtained Resident #3's weight. While she was standing on the scales, Resident #3 reported to staff that her leg was getting weak and she was assisted by staff to the floor. The note indicated family had been notified when they arrived at the facility to take Resident #3 home. According to the late entry note, there had been no injury. There was no mention that the physician had been notified. During an interview with the DON, on 11/02/11 at 4:45 PM, she stated if a resident fell on the day of discharge, staff were still responsible for following the facility's fall policy. She stated the resident should be assessed, the physician as well as the family should be notified and an incident report should be completed. The DON commented she was not aware of Resident #3's fall of 07/15/11 until Nurse #8 had reported it to her today. During an interview with Nurse #8 on 11/02/11 at 5:45 PM, she stated she remembered Resident #3 after she had spoken with the Nurse #2 earlier today. She stated she also remembered writing a nurse's note in regards to Resident #3's fall on the day she was to be discharged home (07/15/11). Nurse #8 reported informing the family of her fall while she was going over Resident #3's discharge instructions. She stated she did not think about completing an incident report because she knew the resident was being discharged home that day. Nurse #8 stated an incident report should have been completed even though the resident was being discharged as she had fallen at the facility. She also commented Nurse #3 had informed her that she had written the note in the wrong resident's record.	F 323		

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F 323	Continued From page 13 Nurse #2 was interviewed again on 11/02/11 at 5:50 PM. He reported that he had received a telephone call from Resident #3's family after she had been discharged. He stated he had spoken with Nurse #8 at that time concerning the fall. He stated that he should have intervened to make sure the incident report was completed by Nurse #8 but he had spoken with her and she had reported to him that she wrote a nurse's note regarding the fall. Nurse #2 stated in hindsight he should have been more proactive to ensure the facility's fall policy was followed even though Resident #3 was being discharged the same day she fell.	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of facility policies, the facility failed to label and date opened food/beverage items in 3 out of 3 resident nourishment refrigerators and failed to keep medications separate from resident food items in 1 of 3 nourishment refrigerators. Findings include:	F 371	**483.35 (i) Food Procedure, Store/Prepare/Serve-Sanitary** **F Tag # 371** **This requirement will be met as follows:** **The facility has taken corrective action for the residents affected by this practice by:** • All nourishment room refrigerators at the nursing station were inspected and all medications, open, outdated or unlabeled food were disposed of on 11/02/11. **The facility will take corrective action for those residents having the potential to affected by the same deficient practice:** • All nourishment refrigerators checked for opened, outdated, or unlabeled food and medications; items removed if not labeled or dated, non-perishable items checked for expiration dates, perishable items removed after 72 hours. Medications removed. **The following measures/systemic changes will be put in place to ensure that the deficient practice does not occur:** • In-service for dietary, housekeeping, and nursing staff by SDC by 11/28/11 regarding labeling & dating open food items; discarding perishable items within 72 hours, and disposing of expired items; items removed immediately if not dated/labeled. No medications to be kept in nourishment refrigerators. • Any in-house staff, nursing and housekeeping staff, who did not receive in-service training will not be allowed to work until training is completed. • This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	11/02/11 11/28/11

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F 371	Continued From page 14 An observation was made of the Nursing Station I nourishment refrigerator on 11/01/11 at 5:05 PM. Inside the refrigerator was found one pint of ice cream dated as opened on 07/22/11. The container had no label identifying the owner. One opened container of a liquid supplement was dated as opened on 10/20/11. Also seen were 1 container of opened cranberry juice cocktail with no opened date, 1 container of opened prune juice with no date, a styrofoam container of food with no date, and one container of coffee creamer with no name and no opened date. At 5:25 PM on 11/1/11, the resident nourishment refrigerator for Nursing Station III was observed. Found inside was a tin pie plate of food with no name of the owner and no date, an opened container of cottage cheese with no name or date of when it was opened, 1/2 bottle of mustard and 1/2 bottle of ketchup with no open date, an opened container of orange juice with no opened date, 2 opened containers of prune juice with no opened date. Inside the nourishment refrigerator was also seen 1/2 bottle of Magnesium Citrate. The resident nourishment refrigerator for Station II was observed on 11/01/11 at 5:35 PM. Inside the refrigerated section was found 1 opened container of cranberry juice cocktail, 1 opened container of a nutritional supplement with no opened date listed. Also observed was 1/2 pint of milk with an expiration date of 10/15/11. In the door of the refrigerator were found 1/2 bottle of ranch dressing with no opened date or name, 1/4 bottle of ranch dressing with no opened date or name, 1/2 bottle of french dressing with no opened date or label to identify the owner, another 1/2 bottle of ranch with a resident's	F 371	**The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:** • Facility will monitor compliance by monitoring 3 refrigerators per week for compliance. • This will be done weekly for 4 weeks then monthly for 3 months. • Any immediate concerns will be brought to the DON or Administrator for appropriate action. • Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting.	

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F 371	Continued From page 15 name, but no opened date and an opened bottle of Caesar dressing with no name or opened date. Inside the freezer section was found an opened plastic bag with grapes. The grapes had no name and no date. Additionally, 3 opened containers of ice cream were found with no opened date. Nurse # 4, who was the Staff Development Coordinator (SDC) was interviewed on 11/02/11 at 9:25 AM. She stated staff were taught to label and date all food items placed in the nourishment refrigerators. She added staff were taught not to store medications in the nourishment refrigerator. The SDC added nurses were responsible for checking the refrigerators to make sure the foods were labeled and dated. The Director of Nursing (DON) was interviewed on 11/02/11 at 3:35 PM. She stated the night shift nurses were responsible for making sure all food items had opened dates and were tabled with names. She added she was not sure how the ball got dropped. The DON stated food items and medications should not be stored together.	F 371		
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	F 441	**483.65 Infection Control, prevent Spread, Linens** **F Tag # 441** **This requirement will be met as follows:** **<u>The facility has taken corrective action for the residents affected by this practice by:</u>** • Resident # 5 experienced no ill effects. • NA #1 & #2 were counseled and in-serviced by the DON on 11/19/11. **<u>The facility will take corrective action for those residents having the potential to affected by the same deficient practice</u>:** • All residents have the potential to be effected. **<u>The following measures/systemic changes will be put in place to ensure that the deficient practice does not occur:</u>** • All C N As will be in-serviced regarding glove usage, when to change gloves ,and hand washing by SDC by 11/28/11. • Any in-house C N A staff who did not receive in-service training will not be allowed to work until training is completed. • This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **<u>The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:</u>** • Facility will monitor compliance by observing care for 5 residents. • This will be done weekly for 4 weeks then monthly for 3 months. • Any immediate concerns will be brought to the DON or Administrator for appropriate action. • Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting.	11/19/11 11/28/11

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F 441	Continued From page 16 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to change gloves between soiled and clean tasks and failed to follow standard infection control guidelines in handling a soiled brief for 1 of 4 sampled residents (Resident # 5) whose care was observed. Findings include: Resident # 5 was admitted to the facility on	F 441		

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F 441	Continued From page 17	F 441		

11/27/10.

An observation was made on 11/01/11 at 4:30 PM of Nursing Assistant (NA) # 1 and NA # 2 providing incontinent care to Resident # 5. NA # 1 and NA # 2 used hand sanitizer prior to donning gloves. NA # 1 unfastened both sides of the resident's brief and rolled the resident to her left side. While Resident # 1 was lying on her left side, NA # 1 cleansed the bowel movement from the resident using disposable wipes. NA # 1 then rolled the soiled brief, containing the stool in the center of the brief. The NA then placed the clean brief under the soiled brief. Resident # 5 was then assisted to her right side. NA # 2 used disposable wipes and cleansed the resident's buttocks. After completion, she removed the soiled brief that had been sitting in the middle of the clean brief. Without changing gloves, NA # 1 completed dressing the resident and restarted the feeding pump. NA # 2 placed the soiled brief in the trash can and removed the brief from the resident's room. On interview, NA # 1 stated she had been taught to change her gloves between dirty and clean tasks. She acknowledged she had not changed her gloves after cleansing Resident # 5 and used the same gloves to secure the resident's clean brief and don her clothes. NA # 1 stated not changing gloves was "just a habit". The NA stated not changing gloves and placing the soiled brief in the middle of the clean brief could cause transfer of bacteria.

Nurse # 4 was interviewed on 11/02/11 at 9:25 AM. Nurse # 4 was the facility's Staff Development Coordinator (SDC). She stated NA's were taught to change gloves and wash

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F 441	Continued From page 18 hands after removing gloves. Gloves should be changed when visibly soiled, between residents and between dirty and clean tasks. The nurse added soiled briefs should not be placed on clean briefs. Nurse # 4 added placing soiled briefs on clean briefs had the potential to transfer stool to the clean brief and causing skin breakdown or infections. An interview was held with the facility's Medical Director on 11/02/11 at 11:30 AM. The physician stated if gloves were not changed between dirty and clean tasks and dirty briefs were placed on clean briefs, contamination of the clean items could occur and possibly cause infections. At 3:35 PM on 11/02/11, the Director of Nursing (DON) was interviewed. The DON stated she expected staff to change gloves after completion of dirty tasks and prior to starting a clean task. She added soiled briefs should not be placed on top of a clean brief.	F 441		