| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345533 | A. BUILDING _____ B. WING _____ | 03/20/2014 |

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| THE CEDARS OF CHAPEL HILL | 101 GREEN CEDAR LANE CHAPEL HILL, NC 27517 |

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| F 176 SS=D | 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE<br><br>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, staff and resident interviews, the facility failed to ensure a self administration of medications assessment was conducted/completed for 1 of 11 residents (#5), observed during tour to have medications kept at the bedside and was self administering medications. The findings include:<br><br>A review of the facility's undated policies and procedures entitled - Self Administration of Medications read in part on page 33:<br>Item 1 - A resident may not be permitted to administer or retain any medications in his/her room unless so ordered, in writing by the attending physician, after the resident successfully demonstrates that he/she is capable for self administration.<br>Item 2 - The Inter-Disciplinary Team (IDT) will review the "Assessment for Self Administration of Medications" form; then determine ability of resident to administer own medications.<br>Item 4f - The licensed nurse will observe ability and/or train the resident in self administration of medications.<br><br>Resident #5 was admitted to the facility on 11/12/2013. The resident's diagnoses included Chronic Obstructive Pulmonary Disease (COPD). The resident's medications included continuous | F 176 | This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited. This is not to be construed as an admission against interest by the community, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission of agreement of any kind by the community of the truth of any conclusions set forth in this allegation by the survey agency. This plan of correction is submitted to meet requirements established by State and Federal Law.<br><br>It is the policy of this facility to ensure that an individual resident, who may desire to self-administer medications, has received a Self-Administration of Medications Assessment approved by the IDT members along with an MD order. | 4/9/14 |

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

Electronically Signed | 04/09/2014

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| F 176 | Continued From page 1<br>oxygen at 2 liters/minute via a nasal cannula. The resident's quarterly MDS dated 2/19/2014 indicated the resident to be cognitively intact and needing extensive assistance of 1 staff for activities of daily living. The resident's care plan dated 11/12/2013 with updates indicated the resident was to receive continuous oxygen for the diagnosis of COPD.<br><br>On 03/17/2014 a tour of the facility was conducted. During the tour resident # 5's room was observed. During the observation it was noted that there were 2 medications (AYR nasal gel and ARY nasal spray) on the bedside table. An interview with the resident revealed the resident was using the medications for her nose which hurt due to the nasal cannula she was wearing. Resident #5 indicated the nurse talked to the doctor and told her she could use the medications and keep them in her room. Resident #5 could not state when she started self administering the medications or how long she had been keeping the medications in her room but did indicate she felt it was possibly several weeks.<br><br>On 03/19/2014 at 9:20 a.m. a medication pass observation was observed. During the medication pass to resident #5 the same 2 medications (AYR nasal jelly and AYR nasal spray) were observed still on the resident's bedside table.<br><br>On 03/19/2014 at 9:25 a.m., an interview with the nurse #2 was conducted. The nurse was asked how long resident #5 had been self administering and keeping the medications observed on the bedside table. Nurse #2 indicated the resident had been self keeping and administering the | F 176 | Upon notification of noncompliance, medications for Resident #5 were removed from the bedside on 03/19/2014 by ADON. A Self-Administration of Medication Assessment for Resident #5 and a meeting with the IDT members was completed. The Resident was deemed capable of medication self-administration. Proper assessment and documentation was added to Resident #5□s record and Care Plan on 03/19/2014 by ADON.<br><br>Any resident of the facility who self-administers medications has the potential to be affected.<br><br>By 04/10/2014 DON completed an audit of all resident rooms to confirm proper documentation/orders were present for residents with bed side medications. On 04/11/2014 Associate Administrator will complete a second audit to ensure compliance. Any areas found to be non-compliant will be corrected by 4/17/14.<br><br>An in-service on Self-Administration of Medication policy and procedure will be held for all nursing staff and the interdisciplinary team by 04/14/2014. All resident records will be audited 24 hours after admission to assure completion of the Self Administration of Medication Assessments. Completed audits will be turned into designated licensed nurse for review.<br><br>Compliance of F176 will be monitored weekly x4 weeks, monthly x3 months, and | |

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| F 176 | Continued From page 2<br>medications for a while (no specific time frame).<br><br>On 03/19/2014 a review of the resident's medical record was conducted. The physician's orders indicated the original order on the February Physician's Order Sheet (POS) was dated 02/13/2014 and indicated - AYR Gel, apply to nostrils as needed for irritation from O2 cannula. A clarification telephone order dated 03/12/2014 indicated - Clarification: AYR saline nasal gel, Apply to nostrils three times daily (TID) as needed (PRN) complaint of (c/o) nasal dryness. May keep at bedside and self administer. An order for AYR gel nasal spray was dated 03/17/2014. A 2nd clarification telephone order dated 03/18/2014 indicated - Clarification: AYR gel, may apply to nostrils four times daily (QID) PRN, irritation from O2 cannula, may keep at bedside and self administer. During the review of the resident's chart there was no documentation or other evidence to indicate resident #5 had been assessed for self administration of medications. Further review of the chart also revealed there was no documentation or evidence to indicate the facility's Inter-Disciplinary Team had reviewed an Assessment for Self Administration of Medications for resident #5 at any time.<br><br>On 03/19/2014 at 10:16 a.m., an interview was conducted with the ADON. The ADON indicated the facility was supposed to conduct and complete an assessment for self administration of medications and fill out the associated form before letting any resident self administer and keep medications in their rooms. The DON indicated she had talked to resident #5 on 03/17/2014 about the physician's order for AYR nasal saline gel. The DON indicated she did not document anything in the resident's chart or any | F 176 | then quarterly via QAPI. Further monitoring will be determined via QAPI. | |

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| F 176 | Continued From page 3<br>other records except the physician's order. The ADON indicated she was supposed to fill out an assessment for self administration of medications check sheet and the IDT team was supposed to meet and discuss the findings prior to letting the resident keep and self administer medications.<br><br>On 03/19/2014 at 11:10 a.m. an interview was conducted with the facility's DON concerning self administration of medications. The DON indicated it was her expectation that an assessment for self administration of medications be conducted and the assessment be reviewed by the IDT team prior to letting any resident keep medications in their room and/or self administer medications. | F 176 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews the facility failed to act on the consultant pharmacist's monthly Medication Regimen Review recommendations for 2 of 5 residents (# 6 and # 12) reviewed for unnecessary medications. The | F 428 | Upon notification of noncompliance, the Director of Nursing obtained the unsigned Pharmacy Recommendations for Resident #6 and Resident #12 and notified corresponding physician and | 4/9/14 |

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| F 428 | Continued From page 4<br>findings included:<br><br>1) Resident # 6 was admitted to the facility on 01/14/2014. The resident's diagnoses included a history of Inguinal hernia, a history of nausea and vomiting, a history of constipation, and a history of bowel obstruction. The resident's medications included an order dated 01/15/2014 for Zofran ODT (Ondansetron ODT) 4 milligram tablet 1 PO (by mouth) TID (3 times daily) as needed for nausea and vomiting. The resident's Minimum Data Set (MDS) dated 01/14/2014 indicated the resident to be severely cognitively impaired. The MDS also indicated resident #6 needed extensive to total assistance for all Activities of Daily Living (ADLs) except eating and had an active diagnosis of Hernia w/obstruction. The physician's progress notes dated 02/20/2014 indicated resident # 6 having two episodes of Hernial Incarceration in the past three months along with constipation, Acid reflux (GERD), and microscopic colitis.<br><br>A review of the facility's contracted pharmacist's monthly Medication Regimen Reviews (MRRs) indicated there was a MRR conducted for each month since the resident's admission. The consultant pharmacist's monthly MRR dated 02/16/2014 indicated the consultant pharmacist documented a recommendation to the Physician/Director of Nursing to discontinue the resident's Zofran or change it to an alternate therapy. The consultant pharmacist also indicated that if the medication (Zofran) was to continue, further testing (via an EKG) was needed to be done on the next convenient lab day and every 6 months there after as there was a risk of resident # 6 getting "Torsade de Pointes," a prolonged electrical QTc wave interval | F 428 | Medical Director on 3/19/2014. Response to recommendation was obtained.<br><br>Any resident of the facility has the potential to be affected.<br><br>On 03/19/2014 the Director of Nursing along with Pharmacy Consultant audited all resident records to ensure pharmacy recommendations had been addressed by the resident□s physician. On 03/19/2014 the Director of Nursing was educated by the Administrator and Pharmacy Consultant regarding timeliness of Pharmacy Recommendations. Director of Nursing will also receive education from RN Nurse Consultant on pharmacy recommendation reporting standards during the Nurse Consultants scheduled visit of 4/22/14-4/23/14. On 03/25/2014 the Administrator spoke with Medical Director regarding expectations for physicians regarding pharmacy review.<br><br>Pharmacy Consultant will give a verbal report to the DON or RN designee regarding recommendations prior to her exit from monthly site visit. Director of Nursing or designated RN, will review recommendations, and based on nursing judgment, assess recommendations for need of immediate notification to physician. If immediate review is deemed necessary, physician will be notified within 1 business day or sooner. If immediate review is deemed unnecessary, physician will have 1 week to review and sign pharmacy recommendations. | |

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| F 428 | Continued From page 5<br>as seen on an EKG. A second entry by the consultant pharmacist was made on the 03/12/2014 during resident # 6's monthly MRR. The note indicated there had been 0 (zero) action on 02/16/2014 recommendation to discontinue resident #6's Zofran medication or change it to another medication. Further review of resident #6's medical record revealed there was no documentation to indicate the consultant pharmacist's recommendation had been reviewed or acted on by the physician or the DON during the 4+ weeks since the consultant pharmacist's initial recommendation.<br><br>On 03/19/2014 at 2:45 p.m. an interview was conducted with the DON. The DON indicated the facility had changed the way it was receiving the facility's consultant pharmacist's consultation reports (pharmacist's recommendations). The DON indicated the reports were no longer being sent with the medications being delivered to the facility but now being transmitted on line and had to be downloaded and printed off. The DON indicated she was unaware if there were any pharmacist ' s recommendations for the past two months but would access the site and see if there were any.<br><br>On 03/19/2014 at 3:20 p.m. the DON indicated she had found several consultation reports documenting recommendations for facility residents dated 02/16/2014 and printed them off for the survey team's review.<br><br>An interview was conducted withj the DON on 03/19/2014 at 3:30 p.m. The DON was asked if the recommendations had been acted on by the physician or herself. The DON indicated the physician had not yet seen the recommendations | F 428 | Compliance of F428 will be monitored monthly via Quality Assurance Performance Improvement process. | |

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| F 428 | Continued From page 6 | F 428 | | |

as she had only just now accessed the web site and printed off the recommendations. The DON indicated since printing the reports/recommendations she knew the recommendations were over a month old and there had been no action taken by her (DON) or the physician. The DON could not explain why the reports were not accessed in a timely manor and presented to the physician for review/action. The DON indicated she was unaware the consultant pharmacist had recommended further testing (doing an EKG) if the drug (Zofran) was to be continued. The DON indicated it was her fault that the reports/recommendations had not been acted on by the physician as she had not accessed/printed the consultant pharmacist's recommendations from the computer in a while.

2) Resident #12 was admitted to the facility on 2/9/2014 and had diagnoses which included Atrial Fibrillation, Cardiomyopathy, Chronic Heart Failure, Chronic Kidney Disease Stage III, Dementia, Depression, Hyperlipidemia, Hypertension, Hypothyroidism, and Osteopenia. Resident #12 ' s Physician Order Sheet (POS) dated 3/1/2014 through 3/31/2014 included the medications Celexa daily for Depression, Trazadone at night for Depression, and Tramadol (an opiate (narcotic) analgesic) for chronic headaches. Resident #12 ' s Medication Administration Record (MAR) also revealed Resident #12 ' s daily medications included Tramadol and the antidepressants Celexa and Trazadone. The Minimum Data Set (MDS) dated 2/15/14 revealed Resident #12 was cognitively impaired and required limited to extensive assist for her Activities of Daily Living. She was assessed for the use of antidepressants daily. A review of the Care Plan revealed Resident #12

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| F 428 | Continued From page 7 | F 428 | | |

received antidepressant medications Celexa and Trazadone on a regular basis. The interventions included to plan for a trial period of dose reduction with Resident #12 and the Physician.

A review of Resident #12 ' s medical chart revealed a Psychoactive Medication Informed Consent dated 2/10/2014 for Celexa and Trazadone that included drug classifications, benefits and adverse reactions signed by Resident #12 ' s responsible party. Pharmacy Progress Notes dated 2/16/2014 revealed a notation for Trazadone plus Celexa.

On 03/19/2014 at 2:45 p.m. an interview was conducted with the DON. The DON indicated the facility had changed the way it was receiving the facility ' s consultant pharmacist ' s consultation reports (pharmacist ' s recommendations). The DON indicated the reports were no longer being sent with the medications being delivered to the facility but now being transmitted online and had to be downloaded and printed off. The DON indicated she was unaware if there were any pharmacist ' s recommendations for the past two months but would access the site and see if there were any.

On 03/19/2014 at 3:20 p.m. the DON indicated she had found several consultation reports documenting recommendations for facility residents dated 02/16/2014 and printed them off for the survey team ' s review.

On 3/19/2014 at 3:30 PM an interview with the Director of Nursing revealed she had not presented the Consultant Reports dated 2/16/14 for Resident #12 to the Physician nor had she acted upon the recommendations.

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| F 428 | Continued From page 8<br><br>A review of the contracted consultant pharmacist ' s Consultation Reports (two) dated 2/16/2014 with an electronic signature from the Consultant Pharmacist was conducted. The first report revealed Resident #12 was taking two antidepressant medications (Trazadone and Celexa) concomitantly. The consulting pharmacist ' s recommendation was to re-evaluate the continued use of this combination with the rationale; the combined use of two or more antidepressant medications not only increase cost, but also complicate the drug regimen and may increase the potential for adverse events. The second report also dated 02/16/2014, indicated the medications Trazadone, Celexa, and Tramadol when taken together increased the risk for serotonin syndrome. The consulting pharmacist ' s recommendation was to re-evaluate the continued use of these medications concurrently, to discontinue the use of Tramadol and/or Trazadone with the rationale; drug interactions exist between these medications with the potential for serotonin syndrome. Serotonin syndrome presents with mental, autonomic and neuromuscular changes, included but not limited to, confusion, myoclonus (twitching of a muscle), tremor, agitation, ataxia (lack of voluntary coordination of muscle movements), restlessness, diarrhea, nausea, diaphoresis (profuse perspiration) and tachycardia (a faster than normal heart rate). There was no documentation in resident ' s chart or that the facility could provide to indicate the Director of Nursing (DON) or Physician had acted on the consultant pharmacist ' s recommendations. | F 428 | | |

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| F 431 | Continued From page 9 | F 431 | | |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by: | F 431 | | 4/9/14 |

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| F 431 | Continued From page 10<br>Based on observations and interviews the facility failed to remove from service expired medications and sterile supplies comingled with non-expired medications and supplies in 2 of 3 medication storage areas (medication room and wound care treatment cart). The findings include:<br><br>On 03/18/2014 at 3:40 p.m., an observation was made of the facility's medication room and wound care treatment cart with nurse #1. The following items were found to be expired and comingled and ready for use with non-expired medications, wound care dressings, and treatment supplies:<br><br>Medication room -<br>In the wall cabinets the following were observed to be expired:<br>Sterile ABD pads 8x10 (2 boxes - 24 ea) lot # CAC06-12, expiration date 06/14/2013<br>Sterile ABD pads 8x10 (3 ea) lot # CAC05-01, expiration date 05/07/2013<br>Sterile ABD pads 5x9 (1 box - 18 ea) lot # CAC05-07, expiration date 05/06/2013<br>Adaptic impregnated wound dressing 3x16 (1 box - 32 ea/packages) lot # 0843/5/1/2 expiration date 10/2013<br>Collagen Dressing 1 package Lot # A0908254 Expiration date 09/02/2011<br>Sodium Chloride 0.45% IV solution (1000 ml bag) Lot # C894477 Expiration date 08/2014 (Note - The Rx label on the IV bag was dated 03/06/2013 and was observed to be half torn off so resident's name was missing and the mixed with other medication information was not visible. Nurse #1 could not state who the IV was for or what other medications was possibly mixed with the IV medication solution, or why the IV solution was being kept. | F 431 | Upon notification of noncompliance, 03/18/2014, all expired medications and sterile supplies comingled with non-expired medications and supplies were immediately and appropriately disposed.<br><br>Any resident of the facility has the potential to be affected<br><br>On 03/19/2014, the Destruction of Medications policy was updated to reflect the inclusion of treatment supplies.<br><br>By 04/14/2014, all nursing staff will be re-educated regarding the updated policy and procedure.<br><br>Compliance of F431 will be monitored nightly on the 11p-7a shift. Random weekly audits will be completed x 4weeks, monthly x3 months, and then quarterly. Further monitoring will be determined via QAPI. | |

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| | 345533 | A. BUILDING _____ B. WING _____ | 03/20/2014 |

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| THE CEDARS OF CHAPEL HILL | 101 GREEN CEDAR LANE CHAPEL HILL, NC 27517 |

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| F 431 | Continued From page 11<br>Zeroflo Sterile Guaze Dressing (1 box - 12 ea) Lot # 731026, expiration date 11/2010<br>Zeroflo Sterile Guaze Dressing (6 ea/packages) Lot # 800210, expiration date 01/2011<br>DuoDerm 4x4 wound dressing 3.7 x 3.8 (1 box - 2 ea/packages) Lot #8L39446, expiration date 11/2013 (other non-expired packages in same box)<br>Solosite Conformable wound gel dressing (1 box - 9 ea/packages) lot # 31366, expiration date 10/2012<br>Allevyn AG Silicone gel (Silver Alginate) wound dressing (1 box - 10 ea/packages) lot # 1123, expiration date 06/2013<br><br>Also in the Medication Room -<br>In a blue plastic container on a wire shelf next to room door (used for resident #15):<br>Hydrogen Peroxide, 1 opened 8 fl/oz bottle 3/4 full, lot # 9EP0604, with an expiration date of 05/2011<br>Extra Strength Benadryl cream, 1 opened and ½ used tube, Lot # 1161LZ, expiration date 03/2013<br>Aquacel Hydrofiber impregnated antimicrobial wound dressing 2 x 2 (1 open box - 10 ea/packages) lot # 2A02014, expired 01/2014<br>Aquacel Hydrofiber impregnated antimicrobial wound dressing 2 x 2 (1 open package) lot # 2A02014, expired 01/2014<br><br>In the Wound Care treatment cart located in the medication room:<br>Isopropal 70% alcohol 16 fl/oz bottle - opened/1/4 used, Lot # 32379 expiration date 02/2014<br>Lubricating jelly packs (1 opened box - 14 ea/packs) lot # 050021, expiration date 02/2013<br>Aquacel Hydrofiber 2 x 2 impregnated antimicrobial wound dressing (1 box - 10 ea/packages) lot # 2A02984, expired 01/2014 | F 431 | | |

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| F 431 | Continued From page 12<br>On 03/18/2014 at 4:15 p.m., an interview was conducted with nurse #1. The nurse indicated all of the above medications were expired. The nurse indicated all nurses were responsible for ensuring expired medications, wound care dressings, and sterile supplies were removed from service as to not be used on any resident. Nurse #1 indicated resident #15 was being administered all of the expired medications, wound care dressings, and sterile supplies on a daily basis per the request of the resident as to what she wanted on a given day. Nurse #1 indicated the wound care treatment cart and all items within were used on a daily basis to treat the resident ' s wound care needs.<br><br>On 03/18/2014 at 5:05 p.m., an interview was conducted with the facility's ADON. The ADON indicated all of the above medications were expired and should have been removed from the medication room and wound care treatment cart.<br><br>On 03/18/2014 and interview was conducted with the facility's DON. The DON indicated the night shift nurse was responsible for doing audits of the medication room, supplies, medications, as well as the wound care treatment cart. The DON indicated the night shift nurse was supposed to ensure expired medications, wound care dressings, and other supplies were removed from service as to not be used on any resident. The DON indicated it was her and the facility's expectation that all expired medications, creams, dressings, IVs, and/or other supplies be removed from service and not comingled - ready use, by the nursing staff. | F 431 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS | F 441 | | 4/9/14 |

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| F 441 | Continued From page 13<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | F 441 | | |

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| F 441 | Continued From page 14<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure staff followed infection control procedures when providing care for 1 of 1 (#7) residents on contact isolation. The findings included:<br><br>A review of the facility's policies and procedures entitled - Methicillin and Oxacillin Resistant Staph MRSA/ORSA dated 01/24/2014 read in part on page 47 in items 1 - 4:<br>1a. wash your hands thoroughly with soap and water before the procedure.<br>1f. wash your hands thoroughly with soap and water upon completion of your task or procedure.<br>2. Wear appropriate personal protective equipment/PPE (e.g., gloves, gown, mask, eyewear, etc. as necessary) to prevent exposure. Don gloves prior to entering the room and gown if risk of clothes coming into contact with objects in the room.<br>4. Remove PPE and leave in appropriate containers just before exiting the room.<br><br>Resident # 7 was admitted to the facility on 12/18/2013. The resident's diagnoses (Dx) included: a history of MRSA (Methicillin Resistant Staph Aureus), a current wound infection from ORSA (Oxacillin Resistant Staph Aureus) to the right calf ulcer, a skin tear, three venous ulcers and Cellulitis of the lower right leg. The resident's Medication Administration Record (MAR) for the months of January - March 2014 and Physician's Monthly Order Sheet (POS) for the months of January - March 2014 indicated the resident was receiving two types of antibiotics daily for the diagnosis of ORSA to the right posterior calf wound infection. The resident's Minimum Data | F 441 | It is the policy of this facility to provide an adequate Infection Control Program in order to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. Resident #7□s room contained a special container for the disposal of Personal Protective Equipment before during and after the survey team was present.<br><br>Upon notification of noncompliance, staff was re-educated on the facility infection control protocol as related to Resident #7.<br><br>Any resident of the facility on isolation precautions has the potential to be affected.<br><br>By 04/16/2014 all staff will be re-educated/in-serviced on infection control protocol related to isolation policies and procedures.<br><br>All direct care staff to include dietary and environmental services, will complete a skills competency related to Isolation precautions by 4/30/14.<br><br>Compliance monitoring of F441 will include additional skills competency observation by RN designee as residents are placed on Isolation precautions. RN designee will complete random competency observations daily x 5 days, 2 observations per week x2 weeks. | |

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| F 441 | Continued From page 15<br>Set (MDS) dated 12/26/2013 indicated the resident was moderately impaired and needed extensive assistance of 1 staff member for all Activities of Daily Living (ADLs) except eating. The physician's progress notes dated 01/14/2014 indicated the resident was treated for MRSA and was clinically resolved however the follow-up cultures indicated the presence of ORSA and follow up-treatment/Contact Isolation was ongoing.<br><br>On 03/18/2014 at 5:55 p.m., an observation of a medication pass was conducted. Nurse #1 was observed to pull up resident # 7's medication, put on gloves at the nurse's station then go to the resident's room. The nurse then entered the resident's posted "Contact Isolation" room to administer the medication. The nurse was observed to enter the room without gowning (nurse only had gloves on). Per the signage on the resident's door the resident was on contact isolation and gloves, gown and/or mask were required. The nurse was observed to move the resident's bedside table with her body/left side of her leg, to get in front of the resident to administer the medication. After administering the resident's medication the nurse was then observed to exit the room without removing her gloves or washing her hands. There was no special container observed in the room to dispose of the Personal Protective Equipment (PPE) The nurse walked back to the nurse's station then removed her gloves and put them into the garbage can next to the medication cart and then washed her hands.<br><br>On 03/19/2014 at 8:15 a.m., an observation was made of the Dietary Aide carrying a breakfast tray into the contact isolation room of resident # 7. The Dietary Aide was not wearing gloves or gown | F 441 | Further monitoring will be determined via QAPI. | |

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| F 441 | Continued From page 16 | F 441 | | |

(duty uniform and hair net only). The Dietary Aide moved the resident's bedside table with her bare hands and set up the resident's breakfast tray while touching against the resident's bed. The Dietary Aide was then observed to exit the resident's room without washing her hands and push an open air 3 shelf meal tray service cart down the hall towards the facility's kitchen.

On 03/19/2014 at 8:22 a.m. an interview was conducted with the Dietary Aide. The Dietary Aide indicated she knew the resident was on isolation precautions per the sign on the resident's door and she should have been wearing gloves and a gown prior to entering the resident's room. The Dietary Aide indicated she had training during her orientation and annual training concerning infection control and isolation precautions.

A review of each staff member's education files was conducted. The review revealed Nurse # 1 took the Infection Control (edition 3) online course (facility required) on 07/15/2013. The review revealed the Dietary Aide took the Infection Control (edition 3) online course (facility required) on 07/09/2013.

On 03/19/2014 at 3:10 p.m., an interview with the facility's DON was conducted concerning the facility's isolation precautions and procedures while providing care. The DON indicated all facility staff were required per the facility's policies and procedures to gown and glove when entering a room where a contact isolation resident lives. The DON indicated that if there is possible contact with any object in the room including the resident the staff were to gown as well as glove. The DON indicated the staff were supposed to

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remove the gown and gloves and wash their hands prior to exiting the contact isolated resident's room. The DON indicated resident # 7 was treated for MRSA but was still ORSA positive per the latest tests and had not been cleared to come off isolation. The DON indicated it was her expectation that all staff followed the facility's isolation precaution procedures and gown and glove when entering a contact isolation resident's room.

On 03/19/2014 at 3:32 p.m., an interview with Nurse # 1 was conducted concerning the facility's isolation precautions and procedures while administering medications to resident #7. The nurse indicated she did not wear a gown when going into resident #7's room on 03/18/2014 to administer the resident's medication (only wearing gloves). The nurse indicated she did not think she touched the resident's bedside table while administering the resident's medication. The nurse indicated she was unaware of the need to remove her gloves and wash her hands prior to exiting the resident's room.