STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345449	A. BUILDING _____ B. WING _____	C 03/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/KING	**115 WHITE ROAD KING, NC 27021**

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 3/20/14. Event ID# 42MV11.	F 000		
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:	F 164		4/17/14

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

Electronically Signed | 04/16/2014

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F 164	Continued From page 1 Based on observation and staff interviews the facility failed to provide full visual privacy for 1 of 2 residents (Resident #114) during pressure ulcer dressing change. Findings included: Resident #114 had cumulative diagnoses that included protein calorie malnutrition, anemia, CHF (congestive heart failure) and vitamin D deficiency. The most recent MDS dated 1/8/14 indicated resident was cognitively intact and had no pressure ulcers noted. Observation of Resident #114 pressure ulcer dressing change to the her right heel on 3/19/14 at 2:45pm revealed Nurse #1 closed the outside door leading to the hallway but did not pull the privacy curtain to provide full visual privacy. Resident #114 pant leg was rolled up midway of her right calf, exposing her lower leg and foot. Resident #114 roommate was lying in her bed during the pressure ulcer dressing change. During an interview on 3/19/14 at 4:52pm Nurse #1 stated " Pull the curtain, and I apologize I did not pull the curtain for [Resident #114]. If they have a roommate I pull the curtain and make sure the blind is pulled down. If they (resident) are in a private room, pull the curtain and make sure blind is closed. Make resident as comfortable as possible and provide as much dignity as possible. " During an interview on 3/19/14 at 3:08pm the DON (Director of Nursing) indicated her expectation would be for the nurse to pull the	F 164	1. Following interview with surveyor on 3/19/14, Nurse #1 was in-serviced by the Director of Nursing on 03/19/2014 for Resident privacy during wound treatments including: pulling privacy curtain(s) and/or window curtain(s) and positioning Residents where they will not be observed by other individuals during wound care. 2. All Residents with wounds have the potential to be affected, but no other Residents were identified. The Wound report was audited by the Director of Nursing on 03/19/2014 to identify all Residents with wound treatments. On 3/19/14 education was initiated by Director of Nursing for all nurses regarding Resident Privacy during wound care treatments: pulling privacy curtain(s) and/or window curtain(s) and positioning Residents where they will not be observed by others when provided wound care. Competencies will be observed by the Director of Nursing for all staff beginning on 03/19/2014 and nurses will provide a return demonstration to ensure Resident privacy before the treatment is provided by the assigned nurse. 3. The Director of Nursing will audit 4 Residents wound treatment for privacy weekly during wound rounds for 1 month and then twice a month for 3 months to ensure the Resident s privacy. The observations will be recorded on the Privacy/Infection Control/Wound Care Audit form. All new nurse hires will be educated and competencies evaluated during new hire orientation by the Director of Nursing or Nursing Supervisor. 4. The audits will be reviewed monthly by	

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F 164	Continued From page 2 privacy curtain to provide full privacy.	F 164	the Director of Nursing and findings will be reported to Quality Assessment & Assurance Committee monthly for 3 months to ensure proper compliance and determine if further action is warranted. The Administrator will be responsible to ensure compliance of all audits.	
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 record review and staff interviews, the facility failed to assess and monitor the dialysis access site/shunt daily each shift according to the facility guidelines for 1 of 2 residents (Res. #13) receiving dialysis. Findings include: Record review indicated Res. #13 was admitted to the facility on 1/15/13 with current diagnoses of End Stage Renal Disease (ESRD) with Renal Dialysis status. Review of the Dialysis Communication Sheet revealed guidelines for communication to enhance the coordination of care between the dialysis center and the nursing facility. Guideline number 4 read: Additional documentation of residents with dialysis shunts will be documented	F 309	1. On 3/19/14 a physician order was received for Res. #13 by the Nurse Supervisor to monitor right arm AV fistula for Bruitt and Thrill every shift. Also an order to monitor right arm AV fistula for swelling, bruising, bleeding and infection. Both orders were placed on this Residents Medication Administration Record by the Nurse Supervisor, to ensure monitoring and documenting daily. 2. All Dialysis Residents have the potential to be effected. The facility□s only other dialysis Residents□ Medication Administration Record was audited by the Director of Nursing on 03/19/2014 for physician orders to provide dialysis site monitoring on each shift and no other	4/17/14

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F 309	Continued From page 3 daily on the MAR (Medication Administration Record). This is to include checking the dialysis access site/shunt daily each shift and checking for bleeding, swelling, redness, signs of infection daily each shift. Review of the current Physician's orders, the Treatment Administration Record (TAR), and the Medication Administration Record (MAR) for Res. #13 for January 2014 - March 19, 2014, indicated there were no orders to assess the dialysis access site/ shunt. The Treatment Administration Record and the Medication Administration Record did not have documentation related to assessment of the access site/shunt. The Annual MDS of 1/2/14 indicated the resident had no cognition impairment. Active Diagnoses included Renal Failure, and receiving Special Treatments: Dialysis. The Care Plan of 1/13/14 indicated the Problem: Diagnosis ESRD, Hemodialysis three times per week. The resident is at risk for complications. The Approaches included: Monitor the dialysis access site upon return to the facility and daily per protocol. Check access site per orders. A staff interview conducted on 3/19/14 at 11:30 AM with Registered Nurse (RN # 2) indicated the facility and Dialysis center communicate via the Dialysis Resident Communication Report. Nurse # 2 indicated the dialysis access site/shunt was assessed before and after dialysis and the results documented on the Dialysis Resident Communication Report form. Nurse #2 also indicated she had not documented the assessment of the dialysis access site/shunt for Res. #13 on the Medication Administration	F 309	Residents were identified as being affected by alleged deficient practice. All nurses were educated by the Director of Nursing on 03/19/2014 for the examination and Medication Administration Record documentation for a Bruitt and Thrill daily on each shift for all dialysis Residents. The education also included how the Dialysis Communication Form is to be initiated and completed and the new guidelines were placed in the front of each Resident□s Medication Administration Record who receives dialysis. The current physicians Standing Orders were revised by the Director of Nursing and Medical Director on 03/27/2014 to include daily documentation and monitoring of a dialysis access. The approved, revised Standing Orders were placed in the Residents charts by the Director of Nursing on 03/27/2014. 3. Audits for the monitoring and documentation of Dialysis access sites and completion of Dialysis Communication will be conducted by supervisors and Director of Nursing; daily for 1 month, three times per week for 2 weeks and weekly x 3 months. Results will be documented on the Dialysis Audit form. All new nurse hires will be educated and competencies evaluated during new hire orientation for monitoring and documenting of Bruitt and Thrill for dialysis Residents, by the Director of Nursing or Nursing Supervisor. 4. The audits will be reviewed monthly by the Director of Nursing and findings will be reported to Quality Assessment & Assurance Committee monthly for 3	

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F 309	Continued From page 4 Record and the Treatment record according to the facility guidelines,because she did not have doctor 's orders. Interview with the Director of Nurses (DON) on 3/19/14 at 1:58 PM indicated. "I did not receive a Doctor's order to assess the dialysis access site/shunt and we have no Policy stating to assess the dialysis site /shunt. We have guidelines. I expect the dialysis sites to be assessed on a daily basis. There is nothing on the TAR and Mar where I would expect it to be. The DON said the access site/shunt is assessed when the resident goes to dialysis three times a week, but is not assessed the other 4 days of the week. The DON stated, " We have two dialysis residents. The other resident who receives dialysis has MD orders to assess the dialysis access site/shunt, and it's documented on the MAR and the Dialysis Resident Communication Report Form, but this resident (referring to Res. # 13) does not have MD orders, and the assessment of the dialysis access site/shunt has not been documented on the MAR or the TAR." An additional interview with the DON on 3/19/14 at 2:45 PM indicated there was no documentation on the 24 hour Report related to any assessment of the dialysis access site /shunt for Res. #13. The DON also indicated she expected the nurses to assess the site/shunt daily every shift according to the facility ' s guidelines/protocol, to have documented on the Medication Administration Record and the Treatment Record, and to have called the doctor for orders related to assessing/checking the dialysis access site/shunt.	F 309	months to ensure proper compliance and determine if further action is warranted. The Administrator will be responsible to ensure compliance of all audits.	

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F 314	Continued From page 5	F 314		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on resident observations, medical record review, and staff interviews the facility failed to clean 2 of 2 (Resident #74 and #114) pressure ulcers in a circular motion, starting inside the wound and moving outward to surrounding tissue. Findings included: 1. Resident #74 was admitted to the facility on 8/28/13 with a stage 2 pressure ulcer to his sacrum. Resident current cumulative diagnoses included Stage 4 pressure ulcer to sacrum. The most recent MDS (Minimum Data Set) was coded as a quarterly assessment with an ARD (Assessment Reference Date) of 3/7/14. The resident had been assessed as having severely impaired cognition. His functional status was assessed as needing extensive assistance with two persons to provide physical assistance for bed mobility, transfers and dressing, but required total dependence with two person assist for toilet use and bathing. He was independent with set up	F 314	1. On 3/19/14, following an interview with the Surveyor, the Director of Nursing in-serviced Nurse #1 on a step-by-step procedure using Aseptic technique with dressing changes. Education included: a) cleansing wound in a circular motion, starting in the center of the wound moving outwards to surrounding tissue, b) wounds near sacral area should be cleaned from wound towards sacral area, c) treatments with creams and ointments should be applied to wound bed with an applicator, d) infection control practices regarding the cleaning of scissors prior to and after each use with a germicidal disposable wipe and allowed to dry, e) establishing a clean area, using a nonporous barrier, to place supplies and scissors upon. On 03/19/2014, Resident#74 and #114 Treatments were redone by Nurse #1 and observed for correct technique by the Director of Nursing, using aseptic technique and	4/17/14

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F 314	Continued From page 6 help only for eating. Additionally, the resident was identified as having a stage 4 pressure ulcer to his sacrum. The most recent care plan identified the resident as having a potential in alteration in skin integrity related to his limited mobility and incontinence and a goal to maintain clean and intact skin. The interventions were listed as: pressure reduction mattress, keep skin clean and dry, reposition as needed, and maintain adequate nutrition and hydration. Resident care plan was updated to include a stage 4 pressure ulcer to the sacrum. Record review of the wound notes from January 2014 through March 2014 indicated the dressing was changed as ordered. Monthly MD orders dated March 2014 indicated the wound vac was to be changed every Monday, Wednesday and Friday. If wound vac comes off or malfunctions, remove dressing from sacrum, clean wound with NS, pack wound with moist to dry dressing prn (as needed). Observation of Resident #74 wound on 3/19/14 at 9:54am revealed the following: - Resident #74 had a stage 4 pressure ulcer to his sacrum. - Nurse #1 placed a towel on the overbed table and placed her supplies on the towel. - Nurse #1 put on a pair of gloves and pulled back Resident #74 brief and revealed no dressing currently on wound. Nurse #1 cleaned the wound with NS (Normal saline) and 4x4 gauze, wiping upward from Resident #74 sacral area towards the wound then began cleaning around in circles with the same gauze. Nurse #1 changed gloves	F 314	scissors that were cleaned with a germicidal wipe. 2. All Residents have the potential to be affected, but no other Residents were found to be affected. Wound report audited by Director of Nursing on 03/19/2014., to identify all Residents with wound treatments. Education provided 03/19/2014 by DON to all nurses on: a) step-by-step procedure using Aseptic technique with dressing changes, including cleansing wound in a circular motion, starting in the center of the wound moving outwards to surrounding tissue, b) wounds near sacral area should be cleaned from wound towards sacral area, c) treatments with creams and ointments should be applied to wound bed with an applicator, d) infection control practices regarding the cleaning of scissors prior to and after each use with a germicidal disposable wipe and allowed to dry, e) establishing a clean area, using a nonporous barrier, to place supplies and scissors upon. Nurse #1 also completed the SPICE Infection Control Program on 04/02/2014. On 04/16/2014, a Certified Wound Nurse Consultant made rounds with Nurse #1, on all Residents with wounds to observe/audit and document nurse competency, regarding correct technique with treatments and infection control practices while providing treatments. Treatment carts were re-organized on 03/20/2014 by the Nurse Supervisor to include barriers for equipment and supplies and germicidal wipes. A competency checklist will be completed on all staff nurses by the	

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F 314	Continued From page 7 and then pulled a pair of scissors out of her scrub top pocket and cut a piece of packing foam without cleaning scissors and then packed the foam inside the wound using a Q-tip. The wound was covered as ordered and wound vac placed. At the end of the procedure Nurse #1 placed the scissors back in her scrub top pocket without cleaning them. During an interview on 3/19/14 at 3:00pm Nurse #1 indicated she cleans her scissors between each resident using an alcohol prep pad. Nurse #1 stated " I keep my scissors in my pocket, you know how uniforms are, we have multiple pockets, and they (scissors) are either in my pants or my top. Nurse #1 indicated the night shift nurse removes the old dressing prior to leaving her shift in preparation for the new dressing/wound vac change. During an interview on 3/19/14 at 3:08pm the DON (Director of Nursing) indicated her expectations would depend on the wound. The scissors would have to be wiped with a wipe or the nurse can get a new pair of scissors. Once the scissors are cleaned, they should be placed on the field that was created. The DON further indicated with [Resident #74] she would expect the nurse to wash her hands, clean the table with wipes, lay supplies on the table, remove the wound vac and discard in a plastic bag. The nurse would then change gloves open package of new supplies and lay on table. The nurse would clean the wound inward out in a circular motion and re-apply the wound vac. During an interview on 3/20/14 at 2:40pm with Nurse #1 stated " I would clean the wound from inside out (circular wound), following MD (medical	F 314	Director of Nursing on 04/15/2014 (including return demonstration) for using correct aseptic technique with wound care and dressing changes; Infection control practices in setting up a barrier for supplies and cleansing of scissors with germicidal wipes. Wound care and Infection Control Practices will be placed on all new nurse competencies by the Director of Nursing on 04/15/2014. 3. The Director of Nursing will audit 4 Resident□s wound care treatments for correct technique; weekly during wound rounds for 1 month, then twice a month for 3 months. The results of the observations will be documented on the Privacy/Infection Control/Wound Care Audit form. All new nurse hires will be educated on correct wound care procedures and infection control procedures during new hire orientation by the Director of Nursing or Nursing Supervisor. 4. The audits will be reviewed monthly by the Director of Nursing and findings will be reported to Quality Assessment & Assurance Committee monthly for 3 months to ensure proper compliance and determine if further action is warranted. The Administrator will be responsible to ensure compliance of all audits.	

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F 314	Continued From page 8 doctor) order of what to clean the wound with. 2. Resident #114 was identified as having a stage 2 pressure ulcer to her right heel on 1/16/14. Resident current cumulative diagnoses protein calorie malnutrition, anemia, CHF (congestive heart failure) and vitamin D deficiency. The most recent MDS (Minimum Data Set) was coded as a quarterly assessment with an ARD (Assessment Reference Date) of 1/8/14. The resident had been assessed as being cognitively intact. Her functional status was assessed as needing extensive assistance with two persons to provide physical assistance for transfers and dressing. She was independent with eating and bed mobility with set up help only. The MDS further indicated Resident #114 had no pressure ulcers. The most recent care plan identified the resident as having a potential in alteration in skin integrity related to her limited mobility. The interventions were listed as: pressure reduction mattress, cushion for wheelchair, weekly skin assessments, apply protective cream as ordered, reposition as needed, increase out of bed activity and maintain adequate nutrition and hydration. Resident care plan was updated to include a stage 2 pressure ulcer to the right heel. Record review of the wound notes dated August 2013 through March 2014 indicated the dressing was changed as ordered. Observation of Resident #114 wound on 3/19/14 at 2:45pm revealed the following: - Resident #114 had a stage 2 pressure ulcer	F 314		

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F 314	Continued From page 9 to her right heel. - Nurse #1 placed a clean pad on the floor and placed dressing supplies on mattress that had a sign posted " sanitized 3/19/14 " . - Nurse #1 put on a pair of gloves and pulled a pair of scissors out of her scrub top pocket and cut off old dressing and then placed scissors down on pad. Scissors were not cleaned prior to use. Nurse #1 changed gloves and then cleaned the wound (circular in shape) by wiping up and down with the same gauze. Nurse #1 then placed a small amount of Santyl on the tip of her gloved right index finger and applied the ointment to the wound using the tip of her gloved finger. Nurse #1 then placed moistened gauze over the wound and then covered with an allevyn pad, wrapped with kerlix and cut the kerlix with the same scissors. After dressing change procedure was complete, Nurse #1 placed the scissors back in her pant pocket without cleaning them. During an interview on 3/19/14 at 3:00pm Nurse #1 indicated she cleans her scissors between each resident using an alcohol prep pad. Nurse #1 stated " I keep my scissors in my pocket, you know how uniforms are, we have multiple pockets, and they (scissors) are either in my pants or my top. " During an interview on 3/19/14 at 3:08pm the DON (Director of Nursing) indicated her expectations would depend on the wound. The scissors would have to be wiped with a wipe or the nurse can get a new pair of scissors. Once the scissors are cleaned, they should be placed on the field that was created. The DON further indicated with [Resident #114] she would expect the nurse to wash her hands, clean the table with wipes, lay supplies on the table, remove the	F 314		

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F 314	Continued From page 10 dressing and discard in a plastic bag. The nurse should then change gloves as clean the wound as ordered, clean inward out in a circular motion, apply Santyl to the wound using a Q-tip and apply dry dressing. The nurse should then remove her gloves, wash hands and take the plastic bag out of the room with her. During an interview on 3/20/14 at 2:40pm with Nurse #1 stated " I would clean the wound from inside out (circular wound), following MD (medical doctor) order of what to clean the wound with. "	F 314		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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. 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. 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. The facility must provide separately locked,	F 431		4/17/14

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F 431	Continued From page 11 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to discard expired Lantus insulin from 1 of 6 medication carts. Findings included: A review of manufacturer's instructions for Lantus insulin indicated vials must be discarded 28 days after opening. During an observation on 03/20/14 at 4:00pm, an open vial of Lantus insulin marked with a date opened of 2/18/14 and an expiration date of 03/18/14 was found on the A Hall medication cart. Nurse # 3 confirmed the vial was for Resident #47 and it was the only vial of Lantus insulin in the cart for this resident. Nurse #3 indicated the insulin was to be given at bedtime for the named resident. Record review of the monthly physician orders for the month of March 2014 indicated Resident #47 was to receive Lantus insulin 5 units subcutaneously daily at HS (bedtime) for a diagnosis of DM (Diabetes Mellitus).	F 431	1. On 3/20/14 the identified Insulin vial was immediately removed from the medicine cart by the Nurse Supervisor and discarded. 2. All Residents receiving insulin have the potential to be affected. On 3/20/14, an audit of all facility medicine carts was conducted by the Nurse Supervisor and no other expired insulin was found on any of the medication carts. The results of the audit were recorded on the Expired Insulin Audit form. All nurses were in-serviced by the Director of Nursing on 03/20/2014, to check all insulin bottles for expiration dates before their shift begins. Additionally during the in-service, the policy on Storage of Medications within the Facility was reviewed with all nurses. A copy of the guidelines for expiration dates for open multi-dose medications was placed in front of the Medication Administration Record books by the Director of Nursing on every medication cart on 03/20/2014 and will be monitored by the Nurse Supervisor monthly. 3. The Nurse Supervisor or Director of	

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	345449	A. BUILDING _____ B. WING _____	C 03/20/2014

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F 431	Continued From page 12 Record review of the MAR (Medication Administration Record) for March 2014 for Resident #47 indicated Lantus insulin was given at bedtime daily. The MAR indicated resident had received Lantus insulin every night for March 1, 2014 through March 19, 2014. An interview with the Director of Nursing (DON) was conducted on 03/20/14 at 4:15pm. The DON confirmed staff are to check the insulin vials every shift. The DON indicated if there is not an extra vial of insulin in storage then the staff should call pharmacy and replace the insulin. In an interview with Nurse #3 on 03/20/14 at 4:50pm, Nurse #3 was asked how often the Lantus insulin expiration date is checked and she stated " Staff check the vials before they give it, so that would be everyday that it is checked. "	F 431	Nursing will audit all medicine carts to monitor for expired insulin: weekly for 3 months. The findings of the audits will be recorded on the Expired Insulin audit form by the Nurse Supervisor or Director of Nursing. A copy of the Storage of Medications within the Facility and guidelines for expiration dates for open multi-dose medications was placed in front of the Medication Administration Record on every medication cart for reference by the Director of Nursing on 04/15/2014. All new nurse hires will be educated about the Storage of Medications within the Facility policy and guidelines for expiration dates for open multi-dose medications during new hire orientation by the Director of Nursing or Nursing Supervisor. 4. The audits will be reviewed monthly by the Director of Nursing and findings will be reported to Quality Assessment & Assurance Committee monthly for 3 months to ensure proper compliance and determine if further action is warranted. The Administrator will be responsible to ensure compliance of all audits.	
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	F 441		4/17/14

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F 441	Continued From page 13 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to clean scissors prior to and after each use for 2 of 2 residents (Resident #74 and #114) observed with pressure ulcers. Findings included:	F 441	1. On 3/19/14 a physician order was received for Res. #13 by the Nurse Supervisor to monitor right arm AV fistula for Bruitt and Thrill every shift. Also an order to monitor right arm AV fistula for swelling, bruising, bleeding and infection. Both orders were placed on this Residents Medication Administration	

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F 441	Continued From page 14 1. Observation of Resident #74 wound on 3/19/14 at 9:54am revealed the following: - Resident #74 has a stage 4 pressure ulcer to his sacrum. - Nurse #1 placed a towel on the overbed table and placed her supplies on the towel. - Nurse #1 put on a pair of gloves and pulled back Resident #74 brief and revealed no dressing currently on wound. Nurse #1 cleaned the wound with NS (Normal saline) and 4x4 gauze, wiping upward from Resident #74 sacral area towards the wound then began cleaning around in circles with the same gauze. Nurse #1 changed gloves and then pulled a pair of scissors out of her scrub top pocket and cut a piece of packing foam without cleaning scissors and then packed the foam inside the wound. The wound was covered as ordered and wound vac placed. At the end of the procedure Nurse #1 placed the scissors back in her scrub top pocket without cleaning them. During an interview on 3/19/14 at 3:00pm Nurse #1 indicated she cleans her scissors between each resident using an alcohol prep pad. Nurse #1 stated " I keep my scissors in my pocket, you know how uniforms are, we have multiple pockets, and they (scissors) are either in my pants or my top. " 2. Observation of Resident #114 wound on 3/19/14 at 2:45pm revealed the following: - Resident #114 had a stage 2 pressure ulcer to her right heel. - Nurse #1 placed a clean pad on the floor and placed dressing supplies on mattress that had a sign posted " sanitized 3/19/14 " .	F 441	Record by the Nurse Supervisor, to ensure monitoring and documenting daily. 2. All Dialysis Residents have the potential to be effected. The facility□s only other dialysis Residents□ Medication Administration Record was audited by the Director of Nursing on 03/19/2014 for physician orders to provide dialysis site monitoring on each shift and no other Residents were identified as being affected by alleged deficient practice. All nurses were educated by the Director of Nursing on 03/19/2014 for the examination and Medication Administration Record documentation for a Bruitt and Thrill daily on each shift for all dialysis Residents. The education also included how the Dialysis Communication Form is to be initiated and completed and the new guidelines were placed in the front of each Resident□s Medication Administration Record who receives dialysis. The current physicians Standing Orders were revised by the Director of Nursing and Medical Director on 03/27/2014 to include daily documentation and monitoring of a dialysis access. The approved, revised Standing Orders were placed in the Residents charts by the Director of Nursing on 03/27/2014. 3. Audits for the monitoring and documentation of Dialysis access sites and completion of Dialysis Communication will be conducted by supervisors and Director of Nursing; daily for 1 month, three times per week for 2 weeks and weekly x 3 months. Results will be documented on the Dialysis Audit form. All new nurse hires will be educated	

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F 441	Continued From page 15 - Nurse #1 put on a pair of gloves and pulled a pair of scissors out of her scrub top pocket and cut off old dressing and then placed scissors down on pad. Scissors were not cleaned prior to use. Nurse #1 changed gloves and then cleaned the wound (circular in shape) by wiping up and down with the same gauze. Nurse #1 then placed a small amount of Santyl on the tip of her gloved right index finger and applied the ointment to the wound using the tip of her gloved finger. Nurse #1 then placed moistened gauze over the wound and then covered with an allevyn pad, wrapped with kerlix and cut the kerlix with the same scissors. After dressing change procedure was complete, Nurse #1 placed the scissors back in her pant pocket without cleaning them. During an interview on 3/19/14 at 3:00pm Nurse #1 indicated she cleans her scissors between each resident using an alcohol prep pad. Nurse #1 stated " I keep my scissors in my pocket, you know how uniforms are, we have multiple pockets, and they (scissors) are either in my pants or my top. " During an interview on 3/19/14 at 3:08pm the DON (Director of Nursing) indicated her expectations would depend on the wound. The scissors would have to be wiped with a wipe or the nurse can get a new pair of scissors. Once the scissors are cleaned, they should be placed on the field that was created	F 441	and competencies evaluated during new hire orientation for monitoring and documenting of Bruitt and Thrill for dialysis Residents, by the Director of Nursing or Nursing Supervisor. 4. The audits will be reviewed monthly by the Director of Nursing and findings will be reported to Quality Assessment & Assurance Committee monthly for 3 months to ensure proper compliance and determine if further action is warranted. The Administrator will be responsible to ensure compliance of all audits.	