STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING ______ B. WING ______	C 10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARBORO NURSING CENTER	**911 WESTERN BOULEVARD TARBORO, NC 27886**

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F 000	INITIAL COMMENTS IDR 12/15/14. F 176 was deleted by the team after reviewing the facility submitted written information to dispute the tag. F 257 was deleted by the IDR panel.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to develop an interdisciplinary care plan for an indwelling urinary catheter for 1 of 3 residents (Resident # 17) that was reviewed. Findings included:	F 279	Submission of the response to The Statement of Deficiencies by The undersigned does not Constitute an admission that the deficiencies existed, that they were cited correctly, or	11/13/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/13/2014

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 279	Continued From page 1 Resident # 17 was readmitted on 2/28/14 with diagnoses that included hypertension, diabetes and hypothyroidism. Review of a nurse's note, dated 8/20/14 at 10:10 PM, indicated an order was received to place an indwelling urinary catheter for Resident # 17 at the resident's request. The quarterly Minimum Data Set (MDS), dated 10/13/14, indicated Resident # 17 was cognitively intact. An indwelling urinary catheter was identified. The care plan, last reviewed on 10/15/14, did not include identification of the indwelling urinary catheter, measurable goals or approaches to minimize any risks that could be associated with the catheter. The MDS nurse was interviewed on 10/22/14 at 5:00 PM. She stated the last quarterly review for Resident # 17 occurred on 10/15/14. The MDS nurse stated she knew the resident had an indwelling urinary catheter and knew she was supposed to have care planned the catheter. The MDS nurse reviewed the resident's care plan and stated a care plan for a catheter was not included; adding it was an oversight.	F 279	that any correction is required. F 279 DEVELOP COMPREHENSIVE CARE PLANS Criteria #1 Resident # 17 had a care plan Implemented by the Minimum Data Set Coordinator, to reflect the Indwelling urinary catheter. 10/22/14 Criteria #2 All residents with an indwelling urinary catheter has the potential to be affected by this alleged deficient practice, therefore, an audit of current residents with indwelling catheters was conducted to ensure that devices were included on the residentMs most recent comprehensive assessment and that it was reflected in the residentMs individualized care plan. 11/07/14 Criteria #3 In-service was provided by Director of Reimbursement/Minimum Data Set to the Minimum Data Set Coordinator regarding the requirement that the facility must develop a comprehensive care plan for each resident based on the care needs identified in the Comprehensive Assessment. 11/10/14 Criteria #4 The Corporate Consultant, Director of Nursing, Minimum Data Set Coordinator and/or ADON will complete an audit of all new admissions and	

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F 279	Continued From page 2	F 279	readmission to ensure that the residentMs care needs are reflected in the plan of care to include: appropriate problems, goals and interventions as indentified in the most recent Comprehensive Assessment weekly x 4 weeks and then monthly x 2 months. The Director of Nursing will incorporate POC into the facilityMs monthly QAA meeting to evaluate effectiveness and compliance. 11/10/14	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and review of records, the facility failed to provide indwelling catheter care per facility policy for 1 of 2 residents (Resident # 17) whose catheter care was observed. Findings included: The facility identified the Lippincott Manual of	F 315	Submission of the response to The Statement of Deficiencies by The undersigned does not Constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. F 315 NO CATHETER,	11/13/14

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F 315	Continued From page 3 Nursing Practice, 9th edition as their source for indwelling catheter care procedure. In Chapter 21, Page 785, the policy indicated the catheter should be cleaned around the area where it enters the urethral meatus with soap and water during the daily bath to remove debris. Resident # 17 was readmitted on 2/28/14 with diagnoses that included hypertension, diabetes and hypothyroidism. Review of nurse's notes and a physician's order, dated 8/20/14, indicated an indwelling urinary catheter was placed per the resident's request. Review of the October 2014 orders indicated catheter care was ordered for completion on every shift. The quarterly MDS, dated 10/13/14, indicated the resident was cognitively intact and had no behaviors or rejection of care. The MDS did identify the presence of an indwelling urinary catheter and identified the resident as requiring extensive assistance for personal hygiene. The care plan, with a review date of 10/15/14, did not address the indwelling urinary catheter, a measurable goal or interventions to minimize the risks associated with an indwelling urinary catheter. On 10/22/14 at 10:14 AM, Nursing Assistant (NA) # 1 was observed providing morning care, which included indwelling catheter care. The resident was lying on her right side. After completing bathing the resident's upper body, the NA changed the water and retrieved a clean washcloth. The NA then washed the resident's	F 315	PREVENT UTI, RESTORE BLADDER Criteria #1 NA #1 was re-educated and retrained regarding indwelling catheter care by the Staff Development Coordinator through 1 on 1 training. Proper return demonstration was provided by NA #1 to the Staff Development Coordinator. Proper indwelling catheter care was provided to resident # 17. 10/23/14 Criteria #2 All residents with an Indwelling urinary catheter has the potential to be affected by this alleged deficient practice, therefore, an audit was conducted to identify all residents with an indwelling urinary catheter. 11/04/14 Criteria #3 All Nursing staff was re-educated by the Staff Development Coordinator on the facility policy and appropriate procedure for providing Indwelling catheter care to include: hand washing, donning gloves, cleaning of the area of insertion away from the body, avoiding the use of powders and sprays, avoiding tension on the catheter during cleaning, doffing gloves and hand washing. All staff that has not been in-serviced by the target date will be removed from the schedule until they have been re-educated. Random pericare and catheter care audits were conducted	

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F 315	Continued From page 4 perineal area with a back and forth motion. The NA did not fold the washcloth and use a clean section for each swipe of the catheter and the perineal area. The resident's labia were not separated and the point at which the catheter entered the resident's body was not cleansed. The resident was not laid on her back in order to provide better access to the catheter. An interview was held with NA # 1 on 12/22/14 at 10:42 AM. The NA stated she had been taught to complete catheter care using alcohol wipes. She stated she was taught to wipe the perineal area from front to back and the catheter tubing from where the tubing entered the body out. She acknowledged that she did not wash from front to back, but instead used a back and forth motion. The NA added she could not separate the resident's labia and clean the catheter insertion site with the resident lying on her right side. She stated she was nervous. Nurse # 1 was interviewed on 10/22/14 at 10:51 AM. During catheter care, staff were trained to clean from the urinary meatus out using a different section of the cloth with each swipe. With females, staff are taught to always clean from front to back. Without spreading the labia you cannot clean the meatus. An interview was held with the staff development coordinator (SDC) on 10/22/14 at 11:47 AM. She stated staff were taught to wash females from front to back. Catheters should be washed from the urinary meatus outward. She added staff were not taught to use back to front motions or alcohol wipes to complete catheter care.	F 315	by Staff Development Coordinator on varying shifts and units to ensure that proper pericare and indwelling catheter care procedure is carried out by staff. 11/12/14 Criteria #4 Director of Nursing, Assistant Director of Nursing, Staff Develop Coordinator and RN Supervisors will continue random audits weekly of indwelling urinary catheter care on varying shifts and units to ensure proper catheter care is being provided to all identified residents. A minimum of 3 audits will be conducted 1 x week x 4 weeks, a minimum of 3 audits every 2 weeks x 1 month and a minimum of 3 audits monthly x 1 month. Results will be recorded on the Pericare/Indwelling Catheter Care Audit tool and will be kept in the Director of Nursings office. The Director of Nursing will incorporate the POC into the facilityMs monthly Quality Assurance and Assessment meeting. The Director of Nursing will report any occurrences of inappropriate pericare or catheter care.from the follow-up to the	

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F 315	Continued From page 5 The nurse Team Leader (TL) was interviewed on 10/23/14 at 8:51 AM. The TL stated in order to perform indwelling catheter care, the woman's labia should be separated and the catheter tubing cleansed from the urinary meatus outward.	F 315	Quality Assurance Committee for 3 months or as deemed necessary. 11/12/14	
F 371 SS=B	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 and staff interviews the facility failed to ensure one of one convection oven was clean and free of burnt material in the bottom of the oven. On 10/22/14 at 4:30pm during a tour of the kitchen an observation of the convection oven revealed an area 2 inches deep along interior front edge of the oven was covered with a layer of burnt food which extended the width of the oven. During an interview with the Assistant Dietary Manager on 10/22/14 at 4:45pm she stated she was working as the cook. She stated the oven was last cleaned the first of the month and had not been cleaned more recently due to not having enough staff. She stated she was working as the	F 371	Submission of the response to The Statement of Deficiencies by The undersigned does not Constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. Criteria #1 The oven was deep cleaned on 10/22/14 Criteria #2 All residents have the potential to be affected by this alleged deficient practice, therefore, all dietary staff were in-serviced on the cleaning list and daily/weekly cleaning of the oven. The in-service was conducted by the Dietary	11/13/14

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F 371	Continued From page 6 fill in cook and had not cleaned the oven when it became dirty. The corporate support dietitian was present during the tour and interview on 10/22/14 at 4:40pm. She stated she felt the oven should have been cleaned.	F 371	Manager. 10/23/14 Criteria #3 The oven will be monitored daily by the dietary manager, dietary assistant and or cook on duty for the next month. The oven will be monitored weekly for 4 months by the dietary manager, dietary assistant and or cook on duty. Results will logged and kept in the Dietary Manager's office. Results will be given by the Dietary Manager at QAA meetings monthly for 3 months.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		11/13/14

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F 441	Continued From page 7 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 interviews and review of records, the facility failed to follow proper handwashing techniques when removing gloves and failed to remove gloves between dirty and clean tasks for 1 of 2 Nursing Assistants (NA #1) observed providing personal care to residents. Findings included: The facility policy, titled Handwashing, with a revision date of 10/2014, indicated handwashing was the single most important means of preventing the spread of infection. The guidelines indicated appropriate hand washing was performed under conditions that included before and after handling items potentially contaminated with blood, body fluids, excretions or secretions and after removing gloves. Resident # 17 was readmitted on 2/28/14 with diagnoses that included hypertension and	F 441	Submission of the response to The Statement of Deficiencies by The undersigned does not Constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS Criteria #1 NA #1 was re-educated and retrained on the facility handwashing policy and techniques by the Staff Development Coordinator through 1 on 1 training. Proper return demonstration was provided by NA #1 to the Staff Development Coordinator. 10/23/14	

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F 441	Continued From page 8 diabetes. The quarterly Minimum Data Set (MDS), dated 10/13/14, indicated Resident # 17 was cognitively intact and required extensive to total assistance for bathing, toilet use and personal hygiene. An observation was made of Nursing Assistant (NA) # 1 providing morning care to Resident # 17 on 10/22/14 at 10:14 AM. The NA donned gloves, removed the resident's clothing and turned her on her right side. When the resident was turned to her right side, it was apparent she had a bowel movement. The NA cleaned the resident and then removed one pair of gloves, leaving a pair of gloves on her hands. With the second set of gloves, the NA continued providing care. She made no attempt to wash her hands after cleaning the bowel movement and before proceeding with washing the resident's lower extremities. Prior to cleaning the perineal area, NA # 1 emptied the water. She removed the gloves, but did not wash her hands prior to donning clean gloves. After completing the bath, the NA emptied the water and dried her hands. With the same gloves, NA # 1 placed a clean fabric pad underneath the resident, helped her dress and handed her the oxygen tubing. NA # 1 was interviewed on 12/22/14 at 10:42 AM. NA # 1 stated she had been taught to wash her hands each time gloves were changed and on completion of care and prior to exiting a resident's room. The NA stated she did not wash hands between glove changes. The NA acknowledged she had touched the oxygen tubing and clean pad before removing her dirty gloves. She stated she was nervous.	F 441	Criteria #2 All residents have the potential to be affected by this alleged deficient practice, therefore, all Nursing staff were re-educated by the Staff Development Coordinator on the facility Handwashing Policy and the guidelines and proper techniques of handwashing to include: Handwashing is the single most important means of preventing the spread of infection, appropriate conditions in which wash hands, The use of gloves do not replace hand washing, hand washing following 5-7 alcohol based applications and handwashing must be done for all residents with diarrhea instead of alcohol based products. All staff that has not been in-serviced by the target date will be removed from the schedule until they have been re-educated. Criteria #3 All Nursing staff were re-educated on the facility policy and guidelines and techniques of handwashing by the Staff Development Coordinator on the facility Handwashing Policy and the guidelines and proper techniques of handwashing to include: Handwashing is the single most important means of preventing the spread of infection,	

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F 441	Continued From page 9 An interview was held with Nurse # 1 on 10/22/14 at 10:51 AM. She stated staff were taught to wash their hands before and after gloving and in between dirty and clean tasks. The Staff Development Coordinator (SDC) was interviewed on 10/22/14 at 11:47 AM. She stated handwashing was the first line of defense against infection. Staff were taught to wash hands for 15-20 seconds. Staff are also taught hands should be washed prior to entering a resident's room, before leaving the room, after contact with residents and when gloves are taken off. The SDC added nursing assistants were taught to wash hands and change gloves between dirty and clean tasks; adding it would not be ok to handle a clean pad or oxygen tubing with the same gloves used during the bath.	F 441	appropriate conditions in which wash hands, The use of gloves do not replace hand washing, hand washing following 5-7 alcohol based applications and handwashing must be done for all residents with diarrhea instead of alcohol based products. All staff that has not been in-serviced by the target date will be removed from the schedule until they have been re-educated. Random handwashing audits were conducted by Staff Development Coordinator on varying shifts and units to ensure that proper handwashing techniques were carried out by staff. 11/12/14 Criteria #4 Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and RN Supervisors or will continue a minimum of 3 random audits weekly of handwashing on varying shifts and units to ensure proper handwashing is being performed for all identified residents. A minimum of 3 audits will be conducted 1 x week x 4 weeks, a minimum of 3 audits every 2 weeks x 1 month and monthly x 2 months. The results will be kept in the Director of Nursing	

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F 441	Continued From page 10	F 441	Office. The Director of Nursing will incorporate the POC into the facilityMs monthly Quality Assurance and Assessment meeting. The Director of Nursing will report any findings of inappropriate handwashing and the report of re-education to the identified employee to the Quality Assurance Committee for 3 months or as deemed necessary. 11/12/14	