STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345492	A. BUILDING _____ B. WING _____	C 01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS NURSING HOME	**214 COCHRAN AVENUE FAYETTEVILLE, NC 28301**

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff and family interviews and record review, the facility failed to notify the responsible family member of changes in medication for 1 of	F 157	Step 1 1. For resident #1, Dliantin levels were drawn and physician made adjustments to	2/2/15

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

Electronically Signed | 02/02/2015

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F 157	Continued From page 1 4 residents reviewed (Resident # 1). Findings included: Resident # 1 was readmitted on 11/20/14 with diagnoses that included congestive heart failure, hypertension and diabetes. On 12/2/14, a physician's order was received to increase Resident # 1's Dilantin. On 12/3/14, the order was clarified by Nurse # 1. Review of the 12/3/14 nurse's notes did not document the family member had been notified of the increase in the Dilantin dosage. The responsible family member was interviewed on 1/7/15 at 5:00 PM. She stated she did not learn about the increase in Dilantin until she noticed a change in Resident # 1's condition and requested to see his medication list. On 1/9/15 at 11:00 AM, the Director of Nursing was interviewed. She stated the expectation was for the family members to be notified for any changes outside of a resident's normal, including medication changes. Nurse # 1 was interviewed on 1/9/15 at 12:52 PM. She validated she had been the nurse to clarify the order during her 7:00 AM to 7:00 PM shift on 12/3/14. Nurse # 1 stated she had been taught to call family members with changes in medication. The nurse stated she had not notified the family member about the increase in the Dilantin and she was unable to explain why she had not called the family member.	F 157	the medication. Responsible family member was notified of the medication changes. Step 2 1. Potential to affect all responsible family members and alert and oriented residents. Step 3 1.A Resident Change in Condition Tracking Tool was implemented by the Director of Nursing (RN) and Quality Assurance Coordinator (RN), and is completed daily by the Unit Manager (RN) to verify responsible family members are notified of new or discontinued orders, changes in the resident's condition, and any changes in appointments. The tracking tool includes who the resident is, the change in conditon of the resident, and who the responsible family member was that the facility notified. 2. All RN's and LPN's will be in-serviced upon hire during orientation and as needed on F-157 Notify of Changes (Injury/Decline/Room, Medication Changes,ETC). Step 4 1.Monitoring of the notification to responsible family members will be monitored by the Quality Assurance Coordinator (RN), Unit Managers (RN), and Director of Nursing (RN)to ensure all responsible family	

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F 157	Continued From page 2	F 157	members are notified of changes (Injury/Decline/Room, Medication Changes, ETC.) Monitoring includes no less than 50% of all orders that reflect changes, and we will adjust our monitoring accordingly. Continued monitoring will then occur daily x 4 weeks, 3 x weekly x 2 weeks, monthly x 3 months. Results of the monitoring with tracking and trending will be reported by the Quality Assurance Nurse (RN) monthly to the Quality Assurance Committee for recommendations and suggestions for improvements or changes.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews with staff and record review the facility failed to arrange transportation that met the resident's needs for 1 of 4 sampled residents (Resident # 1) reviewed for a transportation need. Findings include: Resident # 1 was re-admitted on 11/20/14 with diagnoses that included congestive heart failure,	F 250	Step 1 Resident #1 will attend follow up appointment as scheduled via non emergent ambulance transport and responsible family member was notified. Step 2 - All resident's have potential to be affected. 1. Social Worker's conducted an audit on	2/2/15

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F 250	Continued From page 3 diabetes, hypertension and dementia. Review of physician's orders for 9/15/14, revealed an order had been written for a dermatology consult. The appointment schedule was reviewed and a dermatology appointment for Resident # 1 had been scheduled for 10/30/14. There was a hand written note beside the entry that indicated the appointment had to be rescheduled due to transportation. Review of the most recent Minimum Data Set (MDS), a quarterly dated 11/11/14, indicated the resident was cognitively intact. The MDS also identified the resident as requiring extensive assistance with activities of daily living. An interview was held with the Scheduler on 1/9/15 at 9:02 AM. She stated she was responsible for scheduling appointments and arranging transportation. The facility was able to transport residents able to sit up. She added for those residents that required a stretcher, non-emergency transportation was arranged with an ambulance service. The scheduler added appointments scheduled through the ambulance service could be cancelled if something came up to prevent the company from transporting residents. The scheduler described Resident # 1 as having transportation needs that varied based on the type of appointment. She added if Resident # 1 was going to the eye doctor, then the facility could transport, but if he were going to the dermatologist, he would need to be lying down; therefore, the ambulance service would need to transport the resident. The scheduler stated she knew about the dermatology	F 250	appointments that had been re-scheduled in the past 3 months to ensure transportation was arranged to meet the resident's needs. Step 3 - 1. Quality assurance checklist implemented by the Social Services Director and completed by the Ward Clerk for re-scheduled and canceled appointments to ensure arrangements are made for the proper transportation to meet the resident's needs. 2. The Ward Clerk, transportation driver's, and transportation aides will be in-serviced at this time and upon hire on ensuring the facility arranges transportation to meet the resident's needs. Education was conducted by the Social Services Director and included double-check system when appointments are scheduled to ensure transportation is arranged to meet the resident's needs. Step 4 - 1. Monitoring of the arrangement of transportation to meet the resident's needs will be done by the Quality Assurance Coordinator (RN), Social Services Director, Director of Nursing (RN), and the Administrator. Continued monitoring will then occur daily x 4 weeks, 3 x weekly x 2 weeks, monthly x 3 months. Results of the monitoring with tracking and trending will be reported by	

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F 250	Continued From page 4 appointment from the day it was made, 9/15/14. She added the nurse practitioner thought 2 or 3 staff could go with the resident to help transfer him. The scheduler stated she knew from "day 1", that the non-emergency transport company would need to transport Resident # 1 to his dermatology appointment. The scheduler reviewed the calendar and acknowledged the 10/30/14 appointment had been rescheduled because the correct type of transportation had not been arranged. The scheduler added she did not know why she had not arranged proper transportation since she had known what he would need from the 9/15/14 order date. The Director of Nursing was interviewed on 1/9/15 at 11:00 AM. She stated given the 6 week time frame between when the order for the dermatology consult was written and when the appointment was scheduled, she would have expected the scheduler to make arrangements for the proper type of transportation.	F 250	the Quality Assurance Coordinator (RN) monthly to the Quality Assurance Committee for recommendations and suggestions for improvements or changes.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		2/2/15

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F 278	Continued From page 5 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to correctly assess and classify a pressure ulcer and failed to accurately code the pressure ulcer on the Minimum Data Set (MDS) for 1 of 3 sampled residents (Resident # 2) that was reviewed for actual skin impairment. Findings included: Resident # 2 was admitted on 7/31/13 with diagnoses that included dementia, anemia and degenerative joint disease. Review of the 10/16/14 Documentation and Observation and Assessment Form, indicated Resident # 3 had a left gluteal fold open area. The wound was classified as full thickness. There were no measurements documented. The form omitted a stage (Pressure ulcers are staged from I-no actual skin breakdown, to a Stage IV which indicates tissue and bone may be visualized) for the pressure ulcer. The area was described as having 40% eschar (dark	F 278	Step 1- 1. Resident #2 is affected 11/3/2014 per treatment note. Area was identified, however, indicated a full thickness open area. Step 2 - Resident's with potential to be affected are any residents with a wound (s) not described per policy. Step 3 - 1. Lead Wound Care Nurse (RN) and all RN's will be in-serviced on wound care staging as evidenced by completion of assigned coursework in Pruitt University- entitled "Pressure Ulcers: Prevention, Care and Management" as assigned and tracked by the Clinical Competency Coordinator to be completed by 2/2/2015.	

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F 278	Continued From page 6 brown/black tissue usually indicative of dead tissue). On 10/29/14, a Report of Consultation indicated the area had become deeper over the past weeks. Under findings, the physician documented the resident presented with a Stage 4 ischial necrosis. Under Diagnosis, the physician documented a Stage 4 ischial pressure ulcer. Resident # 3's care plan, with no review date, indicated the resident had an open lesion. A note at the bottom indicated after 10/29/14, the open area to the left ischium would be staged as a Stage IV pressure ulcer. The Quarterly MDS, dated 11/3/14, coded Resident # 3 as at risk for developing pressure ulcers, but did not capture the Stage IV pressure ulcer identified in the 10/29/14 Report of Consultation or identified on the care plan (10/29/14). Treatment notes, dated 11/3/14, indicated on the left gluteal fold was a full thickness open area measured 5 cm by 2.5 cm by 6.5 cm. The TN coded the left gluteal fold open area with 65% epithelial tissue (the type of tissues that composes skin), 10% granulation tissue (new tissue that forms as a wound heals) and 25% slough. There was no documentation of stage and no indication the area was considered pressure. A Tissue Tolerance Test, completed by TN # 1 on 11/28/14, indicated Resident # 2 did not have a history of pressure ulcers, but added "per hospital D/C (discharge) summary, St. (stage) IV L (left with a circle around) ischium". Resident # 2's most current Minimum Data Set (MDS), a significant change in status assessment, indicated the resident was cognitively impaired. He required extensive	F 278	2. Medical Director to assess all wounds, and if warranted, will prescribe a new wound treatment regimen. 3. The Medical Director will review all wound care documentation, and if warranted, will discuss with the Wound Care Team the documentation parameters to increase the accuracy of the documentation in the charts. 4. Once the Medical Director has completed his evaluation, any discrepancies found in wound care documentation will be corrected. If applicable, MDS will open documentation and update the treatment 5. Wound Care Audit Tool developed by Quality Assurance Coordinator (RN)to be used by the Lead Wound Care Leader (RN). 6. 100% body audits to be completed on all residents. Unit Managers will turn in a list of residents on their units to the Quality Assurance Coordinator showing that the body audits were completed. 7. The staff nurse(s) admitting/readmitting a resident will complete a body audit within 8 hours of the resident returning to the facility. (Body Audits-NURS B.107). The staff nurse(s) will also complete the Braden Scale. 8. A Wound Care Nurse will complete a separate body audit on the admitting/ readmitting resident.	

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F 278	Continued From page 7 assistance for all activities of daily living. The MDS indicated the resident had a surgical wound. On 1/7/15 at 1:00 PM, TN # 2 presented a list of pressure and non-pressure ulcers. Resident # 3 was listed on the non-pressure ulcer record. She added the facility had no in house acquired pressure ulcers. An interview was held with the Director of Nursing (DON) on 1/8/15 at 2:36 PM. She stated only the treatment nurses staged wounds. The DON added she expected the TN to stage wounds as the wound specialist staged the wound. She added pressure ulcers were expected to be captured on the MDS. TN # 1 was interviewed on 1/8/15 at 4:25 PM. The nurse stated Resident # 2's left ischial wound started in the facility as a partial skin loss. TN # 1 stated the reason she had not classified the left ischial wound as a pressure ulcer was because she had been taught to classify the wound according to the origin of the wound. TN # 1 added she only used the term pressure ulcer if the affected body part was unable to move. Since Resident # 2 was able to slide back and forth in his chair, the left ischial wound would not be a pressure ulcer. On 1/9/15 at 11:00 AM, the DON was interviewed. She stated she defined pressure ulcer as any wound that occurred over a pressure point. This included open and non-opened wounds. The DON added Resident # 2's left ischial wound would be considered a pressure area since it was over a pressure point. TN # 1 was again interviewed on 1/9/15 at 11:46. TN # 2 was also present. TN # 1 defined a pressure ulcer as an area over a bony prominence caused by unrelieved pressure. Pressure ulcers, the TN added was defined as Stage I through IV, depending on their severity.	F 278	9. Body audit tracking tool developed by the Quality Assurance Coordinator to be used by the Unit Manager for completion of the body audit and Braden Scale process. Step 4 - 1. Weekly assessment of wound care documentation and compared with the Medical Director (Wound Care Clinic physician when available) by the Quality Assurance Coordinator or Director of Nursing using the Weekly Wound Documentation Monitoring Tool. 2. Unit Managers will complete the body audit tracking tool to be submitted to the Quality Assurance Coordinator weekly for monitoring. Continued monitoring will then occur daily x 4 weeks, 3 x weekly x 2 weeks, monthly x 3 months. Results of the monitoring with tracking and trending will be reported by the Quality Assurance Coordinator (RN) monthly to the Quality Assurance Committee for recommendations and suggestions for improvements or changes.	

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F 278	Continued From page 8 The TN identified Resident # 2's left ischium as a bony prominence, but stated his wound was not a pressure ulcer because it started as an abraded area. TN # 1 stated she was aware the wound specialist had classified Resident # 2's wound as Stage IV pressure ulcer, but she did not consider it a pressure ulcer.	F 278		
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 observations, staff interviews and record review, the facility failed to correctly assess and classify an open ischial area as a pressure ulcer for 1 of 3 sampled residents (Resident # 2) that was reviewed for an actual pressure ulcer Findings included: Resident # 2 was admitted on 7/31/13 with diagnoses that included dementia, anemia and degenerative joint disease. The 6/9/14 Monthly Observation Form, completed by nurses, indicated Resident # 2 had no skin ulcers or other skin problems. A Body Audit form (a form completed by nurses indicating any open areas, pressure ulcers or	F 314	Step 1- 1. Resident #2 is affected 11/3/2014 per treatment note. Area was identified, however, indicated a full thickness open area. Step 2 - Resident's with potential to be affected are any residents with a wound (s) not described per policy. Step 3 - 1. Lead Wound Care Nurse (RN)and all RN's will be in-serviced on wound care staging as	2/2/15

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F 314	Continued From page 9 other skin impairments), dated 8/25/14, did not identify any gluteal or ischial wounds. The Body Audit form, dated 9/1/14, indicated a red, open area in the left ischial area. Review of the 10/16/14 Documentation and Observation and Assessment Form, indicated Resident # 3 had a left gluteal fold open area. The wound was classified as full thickness. There were no measurements documented. The wound was described as having 40% eschar (dark brown/black tissue usually indicative of dead tissue). On 10/20/14, the left gluteal open area was measured. Measurements documented on the Wound and Observation form were 5.5 centimeters (cm) by 2.3 cm by 5.7 cm. The wound bed was documented with 40% slough (a term used to describe dead tissue on a sore or wound). The open area was defined as "full thickness" On 10/23/14, Treatment Nurse (TN) # 1 documented on a Body Audit Form that Resident # 2 had a left gluteal fold area that had previously been open. A note dated 10/23/14, written by TN # 1, indicated treatment of Santyl would continue daily to the left gluteal fold open area. TN # 1 also documented an appointment for possible debridement at the wound clinic was pending. Review of the Documentation of Wound Observation and Assessment Form, dated for 10/23/14 indicated the left gluteal fold, full thickness, open area measured 5.8 cm by 2.5 cm by 6.0 cm. The wound bed was described as containing 40% eschar. There was no stage assigned to the wound, but the wound was documented with an "F" which meant it was full thickness. The TN noted the resident would continue to be treated with Santyl (an agent that debrides dead tissue on a sore or wound) to the	F 314	evidenced by completion of assigned coursework in Pruitt University- entitled "Pressure Ulcers: Prevention, Care and Management" as assigned and tracked by the Clinical Competency Coordinator to be completed by 2/2/2015. 2. Medical Director to assess all wounds, and if warranted, will prescribe a new wound treatment regimen. 3. The Medical Director will review all wound care documentation, and if warranted, will discuss with the Wound Care Team the documentation parameters to increase the accuracy of the documentation in the charts. 4. Once the Medical Director has completed his evaluation, any discrepancies found in wound care documentation will be corrected. If applicable, MDS will open documentation and update the treatment 5. Wound Care Audit Tool developed by Quality Assurance Coordinator (RN)to be used by the Lead Wound Care Leader (RN). 6. 100% body audits to be completed on all residents. Unit Managers will turn in a list of residents on their units to the Quality Assurance Coordinator showing that the body audits were completed. 7. The staff nurse(s) admitting/readmitting a resident will complete a body audit within 8 hours of the resident returning to the facility. (Body Audits-NURS B.107). The	

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F 314	Continued From page 10 left gluteal fold. She also documented there was a wound clinic consult pending for debridement. A Report of Consultation, dated 10/24/14, documented under findings an ischial ulcer. Under diagnosis, the wound specialist documented an ischial pressure ulcer. Recommendations included debridement. On 10/29/14, a Report of Consultation indicated the facility was unable to debride the left ischial wound. The consultation also indicated the area had become deeper over the past weeks and Santyl was ineffective due to the thickness of slough. Under findings, the physician documented the resident presented with a Stage 4 ischial necrosis. Under Diagnosis, the physician documented a Stage 4 ischial pressure ulcer. Recommendations included wound debridement, removal of necrotic fascia and muscle to the ischial bone. Resident # 3's care plan, with no review date, indicated the resident had an open lesion. A note at the bottom indicated after 10/29/14, the open area to the left ischium would be staged as a Stage IV pressure ulcer. The Quarterly Minimum Data Set (MDS), dated 11/3/14, identified Resident # 3 as being at risk for developing pressure ulcers. The MDS was coded to reflect the resident had no pressure ulcers. Treatment notes, dated 11/3/14, indicated on the left gluteal fold was a full thickness open area measured 5 cm by 2.5 cm by 6.5 cm. The TN coded the left gluteal fold open area with 65% epithelial tissue (the type of tissues that composes skin), 10% granulation tissue (new tissue that forms as a wound heals) and 25% slough. There was no documentation of stage and no indication the area was considered pressure.	F 314	staff nurse(s) will also complete the Braden Scale. 8. A Wound Care Nurse will complete a separate body audit on the admitting/ readmitting resident. 9. Body audit tracking tool developed by the Quality Assurance Coordinator to be used by the Unit Manager for completion of the body audit and Braden Scale process. Step 4 - 1. Weekly assessment of wound care documentation and compared with the Medical Director (Wound Care Clinic physician when available) by the Quality Assurance Coordinator or Director of Nursing using the Weekly Wound Documentation Monitoring Tool. 2. Unit Managers will complete the body audit tracking tool to be submitted to the Quality Assurance Coordinator weekly for monitoring. Continued monitoring will then occur daily x 4 weeks, 3 x weekly x 2 weeks, monthly x 3 months. Results of the monitoring with tracking and trending will be reported by the Quality Assurance Coordinator (RN) monthly to the Quality Assurance Committee for recommendations and suggestions for improvements or changes.	

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F 314	Continued From page 11 Review of the 11/9/14 TN ' s documentation of the wound observation and assessment, indicated the left gluteal fold open area measured 5.3 cm by 2.5 cm x 6.6 cm. The type of tissue was coded as 75% epithelial and 25% slough. A Tissue Tolerance Test, completed by TN # 1 on 11/28/14, indicated Resident # 2 did not have a history of pressure ulcers, but added "per hospital D/C (discharge) summary, St. (stage) IV L (left with a circle around) ischium". Under current skin integrity, she documented the resident had debridement of an open wound to the left ischium. Resident # 2's most current Minimum Data Set (MDS), a significant change in status assessment, dated 12/24/14, indicated the resident was cognitively impaired. He required extensive assistance for all activities of daily living. The MDS indicated the resident had a surgical wound. On 1/7/15 at 1:00 PM, TN # 2 presented a list of pressure and non-pressure ulcers. Resident # 3 was listed with the non-pressure ulcers. She added the facility had no in house acquired pressure ulcers. Resident # 3 ' s wound was listed on the non-pressure wound sheet. At 12:15 PM on 1/8/15, an observation was made of TN # 1 providing wound care. The wound bed was clean with the exception of a small area of yellow slough on the upper left edge of the base. The wound was cleaned and packed with gauze soaked in Dakin ' s solution (a normal saline-chlorine bleach mixture used to control odor and prevent infection). An interview was held with the Director of Nursing (DON) on 1/8/15 at 2:36 PM. She stated only the treatment nurses staged wounds. The DON added she expected the TN to stage wounds as the wound specialist staged the wound.	F 314		

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F 314	Continued From page 12 On 1/8/15 at 3:49 PM, Nurse # 3 was interviewed. He stated he worked with Resident # 2. Prior to the surgical debridement, the nurse stated the resident ' s wound was dark brown or black and " pretty deep " . He stated he was not sure if it was to the bone, but the wound was getting close to the bone. TN # 1 was interviewed on 1/8/15 at 4:25 PM. The nurse stated Resident # 2's left ischial wound started in the facility as a partial skin loss. The treatment nurse stated she called it an abrasion since Resident # 2 slid back and forth in his wheelchair. TN # 1 stated the reason she had not classified the left ischial wound as a pressure ulcer was because she had been taught to classify the wound according to the origin of the wound. TN # 1 added she only used the term pressure ulcer if the affected body part was unable to move. Since Resident # 2 was able to slide back and forth in his chair, the left ischial wound would not be a pressure ulcer. On 1/9/15 at 11:00 AM, the DON was interviewed. She stated she defined pressure ulcer as any wound that occurred over a pressure point. This included open and non-opened wounds. The DON added Resident # 2's left ischial wound would be considered a pressure ulcer since it was over a pressure point. TN # 1 was again interviewed on 1/9/15 at 11:46. TN # 2 was also present. TN # 1 defined a pressure ulcer as an area over a bony prominence caused by unrelieved pressure. Pressure ulcers, the TN added was defined as Stage I through IV, depending on their severity. The TN identified Resident # 2's left ischium as a bony prominence, but stated his wound was not a pressure ulcer because it started as an abraded area. TN # 1 stated she was aware the wound specialist had classified Resident # 2's wound as	F 314		

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F 314	Continued From page 13 Stage IV pressure ulcer, but she did not consider it a pressure ulcer.	F 314		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions 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	F 441		2/2/15

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F 441	Continued From page 14 infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of records, the facility failed to sanitize equipment used in an isolation room prior to storing for other residents use for 1 of 1 resident on contact isolation (Resident # 3). The facility also failed to change gloves and wash hands while completing treatments on 2 wounds for 1 of 2 sampled residents (Resident # 3) whose wound care was observed. Findings included: 1. a. The facility policy titled Methicillin Resistant Staphylococcus Aureus (MRSA) General Recommendations for Healthcare Centers, dated 2008, indicated under PROCEDURE, Paragraph 3 and bullet 6, that resident equipment should be disinfected between residents. Laboratory results received on 12/9/14, indicated Resident # 3 had a heavy growths of MRSA (MRSA is a bacterial infection that is resistant to many antibiotics. MRSA is difficult to kill and may live on non-porous surfaces for 48 to 72 hours), Proteus mirabilis and Enterococcus faecalis in his right gluteal wound. The physician ordered Bactrim DS (an antibiotic to which the MRSA is susceptible) twice daily for 10 days. During the initial tour of the facility on 1/7/15 at 12:45 PM, a contact isolation sign was noted on Resident # 3's door. Personal protective equipment had been placed outside the door for use. On 1/8/15 at 11:30 AM. an observation was made of Nursing Assistant (NA) # 2 as she left Resident # 3's room with a mechanical lift. The	F 441	Step 1 1. MD notified of breach in infection control practice during wound care. Resident #3 evaluated, lab results reviewed and wound culture negative as of 1/10/15. Patient removed from isolation status on 1/10/15. Step 2 1. All resident's with wounds on isolation precautions have the potential to be affected. Step 3 1. All staff to be in-serviced at this time, upon hire, and annually on "An Introduction to Infection Control". 2. NCSVH Skills Competency Checklist Form: Treatment Nurse/Treatment Procedure Wound & Skin Checklist" will be used to check off all Wound Care Team and licensed clinical staff at this time,upon hire during orientation, and annually by the Clinical Competency Coordinator (RN) or Quality Assurance Coordinator (RN) to ensure competency is met. 3. "Pressure Ulcers: Prevention, Care & Treatment" (found in Pruitt University) was assigned to Wound Care Team and licensed clinical staff by the Clinical Competency Coordinator (RN). Although it focuses on a pressure wound, this video	

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F 441	Continued From page 15 resident stated the NA removed Lift # 1 because he was tired of waiting for the treatment nurse to arrive. The NA did not use any method of sanitizing the lift prior to placing the lift in a location designated for storage until the lift was needed by the next resident. At 11:45 AM on 1/8/15, NA # 1 brought a mechanical lift into the room. The lift was used to stand the resident for a dressing change. At this time, the resident grabbed the handrests and also touched the lift control. After completion of the dressing change, the NA removed the lift from the resident's room. Without sanitizing the lift, it was placed next to the solarium on the resident's hall. The Director of Nursing (DON) was interviewed on 1/8/15 at 2:36 PM. She stated equipment taken out of a room designated as on contact isolation should be cleaned with wipes containing bleach (bleach is one of the agents that kills MRSA) in order to kill the organisms that may be present. The DON identified bleach containing wipes as the agent used to clean contaminated equipment. NA # 1 was interviewed on 1/8/15 at 3:10 PM. She stated prior to entering Resident # 3's room she did not sanitize the lift and she acknowledged she did not sanitize the lift with bleach upon leaving the resident's room. NA # 1 stated she placed the lift in the hall next to the solarium; adding, this was where the lift was kept until the next resident needed the lift. NA # 1 stated she knew Resident # 3 had MRSA and it was contagious. She added she knew she should have used the bleach wipes to disinfect the lift. NA # 1 stated disinfecting lifts was something that was not typically done between residents. The NA stated she also remembered readjusting the resident's brief with her gloved hand and then touched the lift's control. NA # 1 added she knew	F 441	will demonstrate how to properly perform wound care and when to wash hand/ changes gloves. Step 4 1.Clinical Competency Coordinator (RN) will monitor Pruitt University for completion of assignments. 2. Equipment Disinfection Monitoring Tool developed for all nurses (RN's andLPN's) to use to monitor a resident on isolation when equipment is in use that must be sanitized before being used by another resident. 3. Monitoring tool for infection issues to be used weekly by the Quality Assurance Coordinator (RN), Unit Manager (RN), RN Supervisor, or designee. 4. Tracking tool to be completed by all RN's for resident's on isolation developed to monitor the type of isolation, any equipment used for the resident, cleaning products placed on the isolation cart for cleaning the equipment, and that the staff is aware to clean the equipment being used for the resident. Continued monitoring will then occur daily x 4 weeks, 3 x weekly x 2 weeks, monthly x 3 months. Results of the monitoring with tracking and trending will be reported by the Quality Assurance Coordinator (RN) monthly to the Quality Assurance Committee for recommendations and suggestions for improvements or	

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F 441	Continued From page 16 that was an infection control issue. On 1/8/15 at 3:27 PM, NA # 2 was interviewed. She stated she knew Resident # 3 was on contact precautions, but she was not aware of the reason. The NA stated when she removed the lift from Resident # 3's room, she placed the lift in an area designated for storage until the next resident needed the lift. She stated she did not wipe the lift down with bleach cloths. She added she knew it would have been important to do so since anyone that touched the lift could catch whatever the resident had. The NA had no reason for why the lift was not disinfected. 1. b. Laboratory results received on 12/9/14, indicated Resident # 3 had a heavy growths of MRSA (MRSA is a bacterial infection that is resistant to many antibiotics. MRSA is difficult to kill and may live on non-porous surfaces for 48 to 72 hours), Proteus mirabilis and Enterococcus faecalis in his right gluteal wound. The physician ordered Bactrim DS (an antibiotic to which the MRSA is susceptible) twice daily for 10 days. During a wound observation on 1/8/15 at 11:45 AM, Treatment Nurse 1 donned gloves. She removed the dressing from the right wound and then the left gluteal wound. The removed dressings were placed in the trash. Without removing the gloves or washing her hands, the treatment nurse cleansed the left gluteal wound and the right gluteal wound. At this time, the treatment nurse placed the required dressing on the right gluteal wound and the left gluteal wound using the same gloves and without washing her hands. The observation revealed the TN used the same gloves and did not wash her hands during the treatment or between treatment to the	F 441	changes.	

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F 441	Continued From page 17 two separate wounds. The Director of Nursing (DON) was interviewed on 1/8/15 at 2:36 PM. She stated she expected the nurse to glove and complete the dressing on one wound and then wash her hands, glove and complete the treatment on the second wound. An interview was held with Treatment Nurse # 1 on 1/9/15 at 12:15 PM. She stated she had been taught to remove gloves and wash her hands after one treatment was completed and before proceeding to the treatment for the second wound. She stated this would have been especially important for Resident # 3 because of the MRSA. The treatment nurse acknowledged she used the same pair of gloves to remove the soiled dressings, clean both wounds and place clean dressings. The treatment nurse stated she had forgotten to change gloves and wash her hands because she had been distracted by the resident.	F 441		