STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING _____ B. WING _____	C 03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365

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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to cover the indwelling urinary catheter collection system for 2 of 3 sampled residents (Residents # 2 and # 3) reviewed for indwelling urinary catheters. Findings included: 1. Resident #2 was admitted on 3/2/15 with diagnoses of pressure ulcers requiring the use of an indwelling urinary catheter. An Admission Minimum Data Set (MDS), dated 3/9/15, identified the use of the indwelling urinary catheter. Review of the 3/3/15 care plan developed for the indwelling urinary catheter did not include an intervention to keep the collection system covered for privacy. On 3/25/15 at 10:20 AM, Resident #2 ' s urinary catheter collection system was observed hanging from the side of the bed facing the door and was clearly visualized from the hall. There was no privacy bag covering the collection system. An observation was made on 3/25/15 at 3:05 PM. The indwelling urinary catheter bag was easily	F 241	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Mount Olive Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. F 241-D " Residents #2 and #3 have proper catheter bag covers in place to assure resident dignity. " ADNS completed an audit of residents with indwelling catheters on 04/09/15 to assure that each had the appropriate catheter bag cover in place. The Care Plans for residents with indwelling catheters were reviewed on 04/09/15 per ADON to assure that proper interventions for keeping the bag covered are in place. " Licensed and CNA staff received	4/10/15

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

Electronically Signed | 04/10/2015

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F 241	Continued From page 1 visualized from the hall and was not covered for privacy. On 3/26/15 at 8:20 AM, Resident #2 ' s indwelling urinary catheter collection system remained uncovered and visible from the hall. An observation made on 3/26/15 at 11:35 AM revealed the indwelling urinary catheter collection system was not covered and was easily visualized from the hall. On 3/26/15 at 11:28 AM, Nursing Assistant (NA) #1 was interviewed. She stated she had been taught to provide privacy bags for urinary collection systems. She stated she had only worked a short time in the facility and was not aware if the facility provided privacy bags. The NA acknowledged Resident #2 ' s indwelling urinary catheter collection system was not covered for privacy. The Treatment Nurse was interviewed on 3/26/15 at 11:47 AM. The nurse stated both nurses and NAs were taught to cover the urinary catheter collection system for privacy. She stated the facility offered a collection system that provided privacy and also offered bags in which the collection system could be placed. The nurse stated she had just noticed there was no cover on Resident #2 ' s urinary catheter collection system. On 3/26/15 at 3:00 PM the Director of Nursing was interviewed. She stated urinary catheter collection systems should be covered at all times. The DON added privacy bags were provided by the facility.	F 241	inservice training on the proper placement of catheter bag covers to preserve resident dignity on 03/30/15, 04/08/15, 04/09/15 per DON. Training included assuring that the bag and cover are properly assembled after catheter care. RN Supervisors/charge nurses will round on residents identified with indwelling catheters 2 times per shift to assure residents with indwelling catheters have catheter bag covers in place. Any noted deficient practice will be immediately corrected by the staff member finding the problem. Rounding results will be recorded on an audit tool developed to track placement of covers for catheter bags. " DNS or ADNS will round on residents identified with indwelling catheters daily Monday □ Friday to verify staff compliance with this requirement. Audit sheets will be reviewed daily at the Clinical Staff Meeting and results of monitoring will be presented to the QAPI Committee for 3 months. Additional corrective measures will be taken based on the results of daily rounds, audits and QAPI findings.	

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F 241	Continued From page 2 2. Resident #3 was admitted on 6/21/13 with Parkinson ' s disease and wounds requiring an indwelling urinary catheter. Review of Resident #3 ' s Minimum Data Set (MDS), dated 2/2/15, captured the use of the indwelling urinary catheter and identified the resident had 2, Stage IV pressure ulcers. An observation was made on 3/25/15 at 10: 13 AM. Resident #3 was in bed. The urinary collection system was hanging on the side of the bed and easily visible from the hall. There was no privacy bag covering the collection system. Observations were made on 3/25/15 at 2:30 PM. Resident #3 ' s urinary catheter collection system remained uncovered and visible from the hallway. On 3/.26/15 at 8:20 AM, the urinary catheter collection system remained uncovered. The system was easily visualized from the hall. During an observation of catheter care on 3/26/15 at 2:10 PM, it was noted the urinary catheter collection system had been covered Nursing Assistant (NA) #2 was interviewed on 3/26/15 at 2:45 PM. She stated she had cared for Resident #3 on 3/25/15 and 3/26/15. She acknowledged the urinary catheter collection system had not been covered either day. The NA added she could not remember the last time the system had been covered. NA #2 stated she knew the system was supposed to be covered, but she did not tell the nurse it was not because she had not been specifically instructed to notify the nurse. The NA added while the system was	F 241		

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F 241	Continued From page 3 now covered, she had not been the one to cover it and did not know who had covered the collection system.	F 241		
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 staff interviews and record review, the facility failed to complete pressure ulcer treatments as the physician ordered for 1 of 3 sampled residents (Resident #1) reviewed for pressure ulcers. Findings included: Resident #1 was initially admitted on 1/21/15 with diagnoses that included pressure ulcers, fractured hip, anemia and hypertension. The Minimum Data Set (MDS), dated 1/28/15 assessed the resident as moderately cognitively impaired. Resident #1 was coded as requiring extensive assistance activities of daily living. During the initial assessment, the resident was identified with a pressure ulcer.	F 314	F 314-D " Resident # 1 was discharged from the facility on 3/16/15. " Residents with orders for wound care treatments were assessed on 04/09/15 to assure the orders specify dressing change frequency and orders have been verified to the MAR/TAR for accuracy per ADON. Treatment Nurse and supporting Licensed Staff received in-service training on 03/30/15, 04/08/15, 04/09/15 for proper wound management including the responsibility of nurses to complete wound treatments in the absence of the Treatment Nurse per DON. " ADNS or Designee will complete daily TAR audits to assure ordered treatments have been documented. ADNS or Designee will select 3 residents requiring	4/13/15

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F 314	Continued From page 4 Review of the resident ' s care plan, revised on 3/3/15, indicated Resident 31 had actual skin breakdown. Interventions to heal the pressure ulcers included providing wound treatment as ordered. Review of the facility ' s Wound Management Tool, dated March 2015, indicated Resident #1 had pressure ulcers on his right and left buttocks and his right and left heels. Review of the March 2015 Treatment Sheets indicated the resident received a treatment to a sacral pressure ulcer (described as buttock on some forms) that included cleansing the wound with wound cleanser and applying a hydrogel dressing. The dressing was ordered to be changed every 3 days and as needed. The treatment sheet had highlighted the days of March 11th and March 14th as days the dressing was to be changed. The blocks where the nurse initialed as completed were blank. The March 2015 also indicated Resident #1 received treatments to his right and left heel that included cleaning with normal saline and applying a dry dressing daily. The treatment sheet revealed there was no documentation of treatment completion on March 7th, March 13th, 14th and 15th. An interview with the Treatment Nurse (TN) on 3/26/15 at 11:54 AM. The TN stated she was responsible for weekly skin checks; adding if she was not able to complete the skin check then the nurse on the hall was responsible. Pressure ulcer prevention nterventions in place for Resident #1 included boots on his feet, air mattress, positioning wedges, heel elevators and	F 314	a dressing change per day to validate accuracy of information documented on the TAR. " Dressing change audits will be completed by the ADNS or Designee 3 x per week x 2 months than 2 x week x 2 months. Audit results will be discussed during daily clinical meetings and summary findings will be presented to the QAPI Committee for 3 months. Additional training and increase in audit frequency may be initiated based on findings.	

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an abduction pillow. The nurse added Resident #1 refused to turn and often would refuse other pressure ulcer prevention interventions. The TN stated the resident developed pressure ulcers on his heels and on his buttocks because he did not like to be out of bed and would often refuse to get out of bed. The TN stated she was aware the dressings for Resident #1 were not changed after she completed the treatment on 3/10/15. She added the resident ' s Responsible Party (RP) had called the Director of Nursing (DON) to discuss the lack of dressing change. After the RP called, the TN stated she conducted an in-service to remind nurses they were responsible for treatments when she was not in the building or assigned to work a medication cart. She added the Assistant Director of Nursing (ADON) was spot checking treatments to make sure treatments were completed as ordered.

Nursing Assistant (NA) #3 was interviewed on 3/26/15 at 12:12 PM . The NA stated she had worked with Resident #1 during the week of 3/10/15 to 3/16/15. She stated she had seen the dressing dated 3/10/15 on the resident until he was sent out for his appointment on 3/16/15. The NA stated she reported the unchanged dressing to Nurse #5 that worked with the resident on the 7 to 3 shift. The NA stated Nurse #2 told her it was not her turn to do treatments.

Attempts were made unsuccessfully, to contact Nurse #5.
An interview was held with the RN, Day Shift Supervisor on 3/26/15 at 1:43 PM. The supervisor stated her main focus was Station I where Resident #1 had lived. She added when the treatment nurse was not in the building, the hall nurses were responsible to complete

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treatments. The supervisor added at one point, she was involved in treatment audits, but that had stopped a few months back. She stated she knew there had been an issue with treatments being completed on the weekends. The supervisor added she was not sure if it was an issue of nurses were in the habit of the TN completing treatments and they just forgot or if they just chose not to do the treatments. The supervisor stated on weekends, nurses would do 12 hour shifts instead of 8 hour shifts. She added she thought part of the problem was a lack of communication between nurses regarding any treatments not completed at the end of the shift or who was responsible for the treatments when a shift was split. The supervisor stated recently the facility had received concerns from a family member that a dressing had not been changed for several days. She added she was not part of the investigation and was not sure it the allegation was true. The supervisor added no one on her unit had reported seeing a dressing that had not been changed.

On 3/26/15 at 2:21 PM a telephone interview was held with Nurse #2. Nurse #2 stated she worked weekends. She added on weekends, the hall nurses were expected to complete any needed wound care. The 7 to 3 shift was responsible for even numbered rooms and the 3 to 11 shift was responsible for odd numbered rooms. The nurse added this system was put into place because most treatments were scheduled for day shift and there was no way the nurse could complete other tasks and all the treatments. Nurse #2 stated since Resident #1 lived in an odd numbered room, his treatment would have been assigned to the 3 to 11 nurse. Nurse #2 stated she could not remember who the 3-11 nurse was during the

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weekend of 3/13/15 to 3/15/15, but she knew Nurse #3 was relatively new. Nurse #2 stated she did not remind Nurse #3 that she would need to do treatments for the odd numbered rooms.

Nurse #4 was interviewed via telephone on 3/26/15 at 2:49 PM. Nurse #4 had worked during the 3/13/15 to 3/15/15 time period when Resident # 1 ' s dressing was scheduled to be changed. Nurse #4 stated when the treatment nurse was not available, the nurse on the hall was responsible for treatments. She stated she was unaware of a system in place that divided scheduled treatments between the 7 to 3 shift and the 3 to 11 shift. She did not remember completing a treatment for Resident #1 during her shift.

An interview was held with the Director of Nursing (DON) on 3/26/15 at 3:00 PM. The DON stated the facility utilized a system to make sure treatments were completed when the TN was absent. The system placed consisted of day shift nurses completing treatments for residents in even numbered rooms. The 3 to 11 nurses were responsible for completing treatments for residents in odd numbered rooms. She stated the system was in place when she started working 4 months ago. The DON added she had recently re-inserviced the nurses when she realized nurses were confused about who was to do what treatments. She realized treatments were missed. The DON recognized Resident #1 as a resident whose wound care was missed. The DON stated she initiated the in-service on treatments the same day she was notified of the missed treatments by the resident ' s RP. The DON added the ADON was doing a weekly audit of 3-4 treatments to make sure the treatments

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F 314	Continued From page 8 are done A telephone interview was held with Nurse #3 on 3/26/15 at 3:50 PM. Nurse #3 stated she had worked the 3-11 shift on 3/13/15. Nurse #3 added she remembered Resident #1. The Nurse stated she just worked weekends and the weekend of 3/13/15 was her first weekend working. During orientation, the nurse stated she had only been taught to complete treatments assigned to be completed during her shift. She was unaware of a system in place for the 3-11 shift to complete treatments for residents in odd numbered rooms. Nurse #3 stated she had not completed a treatment for Resident #3 on 3/13/15 because she was unaware she should have completed his wound treatment.	F 314		