STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345504	A. BUILDING _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
J ARTHUR DOSHER MEM HOSP	924 N HOWE STREET SOUTHPORT, NC 28461

(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 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. 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 record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) Assessments by not completing the Pneumococcal Vaccine area and the area of incontinence was inaccurate on the Admission and Quarterly MDS for 2 of 22 residents reviewed	F 278	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations, the facility has	8/24/15

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

Electronically Signed | 08/13/2015

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F 278	Continued From page 1 (Resident #18 and Resident #7) The findings included: 1. Resident #18 was admitted to the facility on 3/23/15 and had diagnoses of Hypertension, Coronary Artery Disease, Diabetes Mellitus and Dementia. The Admission MDS dated 4/5/15 under section O0300 asked if the resident ' s Pneumococcal Vaccine was up to date and if not received, the reason: 1. Not Eligible. 2. Offered and declined. And 3. Not offered. There was no information to indicate the status of the resident ' s vaccination status. The Director of Nursing stated in an interview that an outside company had been assisting the facility with their MDS Assessments and the nurse that did the assessment should have followed through when there was no documentation on the chart regarding the Pneumococcal Vaccine. 2. Resident #7 was admitted to the facility on 11/24/14 and had diagnoses of Hypertension, Diabetes Mellitus and Depression. A Physical Assessment form dated 11/24/14 under Genitourinary Assessment showed the resident was not continent of urine. A form titled Bladder Assessment dated 11/24/14 under bladder function showed the resident had functional incontinence and read: " Cannot tell when she needs to go. " A progress note dated 11/24/14 at 3:05PM read: " Incontinent of bladder. Cannot tell if she is going or not. " The Admission MDS dated 12/4/14 revealed the resident was occasionally incontinent of urine. A Quarterly MDS dated 3/1/15 revealed the resident was occasionally incontinent of urine. A Quarterly MDS dated 6/1/15 revealed the resident was totally incontinent of urine.	F 278	taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Resident Affected: For resident #18, the next scheduled OBRA MDS Assessment due on 10/4/2015, will reflect updated pneumococcal immunization status. For resident #7, the most current MDS was accurately coded for this resident and no further action is required. Corrective Action for Resident(s) Potentially Affected: All residents have the potential to be affected by this practice. On 8/12/15 the MDS Nurse audited all current residents' most recent MDS to ensure that the pneumovax and continence status was accurately coded. No coding errors were identified during the audit on 8/12/2015 for pneumovax and/or continence status. Systemic Changes: An in-service was conducted on 8/13/2015 by the DON with the MDS Coordinator. The in-service topics included: For Continence: Review of all current residents' medical records including bowel and bladder incontinence flow sheets and quarterly nursing assessments, interviewing staff	

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F 278	Continued From page 2 The Charge Nurse stated in an interview on 7/30/15 at 9:53AM that she had not seen a change in the resident regarding her incontinence status. The Charge Nurse stated Resident #7 had been incontinent since admission. The Director of Nursing (DON) stated in an interview on 7/30/15 at 10:58AM that he did the resident ' s MDS Assessments dated 12/4/14 and 3/1/15. The DON stated he was new at the time and misread the NA ' s (Nursing Assistants) documentation sheet. The DON stated he should have coded the resident as being totally incontinent.	F 278	members who routinely work with residents (from all shifts if possible) and interviewing residents and/or family if and when possible. The RAI manual will be referred to for guidance as needed. For vaccinations: Staff education was provided on proper and accurate determination of all new and existing residents' immunization status through review of medical records, resident and/or family interviews and MD documentation. The in-service also reviewed the facility's current policy and procedure of the pneumovax immunization as well as the importance of accurate MDS data. This information has been integrated into the standard orientation training for MDS nurses and into the required in-service refresher courses for MDS nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The DON will monitor this issue using the QA Survey Tool. The Survey Audit tool will review up to 10 MDS Assessments completed over the last week to ensure that coding of the pneumovax and continence status is correct. Any issues will be reported to the administrator. This will be done weekly for one month then monthly for two months or until resolved by the Quality Assurance Committee. Reports will be presented to the QA Committee by the DON to ensure corrective action initiated is appropriate	

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F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 334		8/24/15

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F 334	Continued From page 4 already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to determine the Pneumococcal Vaccine status for 1 of 5 resident ' s whose immunization documentation was reviewed (Resident #18). The findings included: Resident #18 was admitted to the facility on 3/23/15 and had diagnoses of Hypertension, Coronary Artery Disease, Diabetes Mellitus and Dementia. The Nursing Admission Assessment dated 3/23/15 included a section titled Immunization	F 334	Corrective Action for Resident Affected: Resident #18 received the pneumococcal vaccine on 7/28/2015 per family request. Verbal consent was obtained/received via telephone and documented in resident's permanent record. Corrective Action for Residents Potentially Affected: All residents have the potential to be affected by this practice. On 8/12/2015,	

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F 334	Continued From page 5 Screening and revealed information about a Pneumococcal Vaccine, whether or not the resident had had one and the date received. There was no information recorded on the form regarding a Pneumococcal Vaccine. Review of a form titled Immunization Review revealed a Flu Vaccine was given on 3/24/15. There was not a date to indicate if or when the resident had received a Pneumococcal Vaccine. The Admission MDS dated 4/5/15 under section O0300 asked if the resident ' s Pneumococcal Vaccine was up to date and if not received, the reason: 1. Not Eligible. 2. Offered and declined. And 3. Not offered. There was no information to indicate the status of the resident ' s vaccination status. On 7/28/15 at 2:16PM the Charge Nurse stated in an interview the admitting nurse was responsible for documenting the information regarding the Pneumococcal Vaccine. The Charge Nurse stated she admitted Resident #18 and would call the physician ' s office to see when the resident last received a Pneumococcal Vaccine. The Charge Nurse stated in an interview on 7/28/15 at 2:41PM the physician ' s office was unable to determine when the resident last received the Pneumococcal Vaccine and would check with the responsible party. On 7/28/15 at 3:07PM the Charge Nurse stated in an interview she had called the responsible party and was told the resident had never had a Pneumococcal Vaccine and would like for her to have one. Review of the Immunization Review form revealed the Pneumococcal Vaccine was administered on 7/28/15. The Charge Nurse stated in an interview on 7/30/15 at 9:29AM she could not remember if she had a discussion with the responsible party	F 334	the DON and MDS Nurse audited all current residents' charts to ensure that the pneumococcal vaccination status was documented on all current residents. No residents were identified as needing the pneumovax at this time. Systemic Changes: An in-service was conducted by the DON for the MDS Nurse on 8/13/2015. This in-service included review of the importance of checking the vaccination status of a resident upon admission or readmission and also to review the current policy and procedure for the pneumovax immunization. The Admission Packet for all admission/readmissions to the nursing center will now include the Vaccine Information Sheet(VIS) for the pneumococcal vaccine along with a consent/declination form, to ensure that each resident has the opportunity to accept or decline immunization. This information has been integrated into the standards orientation training for nurses and in the required in-service refresher courses for all nurses. It will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The DON will monitor this issue using the QA Survey Tool. This review will include all new admissions and readmissions that have occurred in the last week to ensure that pneumococcal vaccination is documented on the consent/declination form and that the vaccine was administered with physician approval if	

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F 334	Continued From page 6 regarding the Pneumococcal Vaccine at the time of admission. The Charge Nurse stated she was not sure what happened but looked like it was missed. The Director of Nursing stated in an interview on 7/30/15 at 11:25AM that an outside company had been helping them with MDS Assessments and the Nurse should have followed through when there was no documentation on the resident ' s chart regarding the Pneumococcal Vaccine.	F 334	indicated. Any issues will be reported to the administrator. This will be done weekly for one month then monthly for two months or until resolved by the Quality Assurance Committee. Reports will be presented to the QA committee by the DON to ensure corrective action initiated is appropriate.	
F 371 SS=E	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 observatons and staff interviews the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent food borne illness by failing to clean two of two steam tables. The findings included: Review of the facility's policy titled "Dosher Memorial Hospital Departmental Overall Cleaning and Sanitation" date revised 1/15/2006 reads as follows under procedure. "A weekly cleaning list for both cook and tray personnel will be posted at the start of each work week. The list will cover tasks for both shifts to be done and initialed after	F 371	Corrective Action for Resident Affected: No specific resident was identified. The steam tables were cleaned on 7/30/2015 by Dennis Jackson, Lead Cook. Corrective Action for Residents Potentially Affected: All residents have the potential to be affected by this practice. See Systemic Changes below for corrective actions for all residents.	8/24/15

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F 371	Continued From page 7 completion daily. If for any reason an employee can not complete their daily cleaning task, they are to notify the department supervisor or manager. Each employee is responsible in making sure their work area is kept clean and sanitary during their shift and follow the cleaning policy that pertains to the task given." 1. During the kitchen observation on 7/29/15 at 1:55 PM the kitchen steam table was observed. The 6 foot underside of the steam table shelf was observed to be covered with dried dark food particles. During a second observation on 7/30/15 at 11:20 AM the steam table was observed set up for noon meal service. The 6 foot underside of the steam table shelf was observed to be covered with dried dark food particles. 2. During the meal temperature observation on 7/29/15 at 12:31 PM the steam table on wheels was observed in the resident dining room. The sides of the steam table were observed with dried food spills. A second observation on 7/30/15 at 11:17 AM revealed the steam table on wheels was in the same condition. In an interview on 7/30/15 at 11:21 AM the Certified Dietary manager (CDM) stated that the cleaning schedule only showed that staff wiped down the top of the steam table shelf. The CDM stated she would add the underside of the shelf to the cleaning list.	F 371	Systemic Changes: On 7/31/2015, the Dietary Manager in-serviced all full time, part time and PRN dietary staff. Topics included the following policies for cleaning the steam tables. This information has been integrated into the standard orientation training and in the required refresher courses for all dietary employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. In-service included the following: Proper cleaning of equipment in the Dietetic Service Department, date: 7/31/2015, by educator Kathy Seagraves. Summary: Employees of the Dietetic Services Department will follow the policy and procedure for cleaning and maintaining the equipment within the department per Departmental Policy and Procedure Manual located within the department. Policy: Each employee is responsible for keeping all equipment clean and maintained according to the posted cleaning schedule. The cleaning schedule outlines the type of equipment, frequency of cleaning and the individual responsible for cleaning. Only approved cleaning supplies are to be used on equipment. Employees must wear cleaning gloves and goggles when cleaning equipment to ensure personal safety while handling cleaning chemicals. Procedures for Cleaning: Employees will follow the individualized cleaning procedures listed in the departmental policy and procedure manual when cleaning equipment. After employees complete the cleaning task, the individual should initial the cleaning	

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F 371	Continued From page 8	F 371	schedule. If an individual is not able to perform the cleaning schedule, the Dietetic Services Supervisor or the Assistant Supervisor must be immediately notified to make necessary changes to ensure that the equipment is cleaned according to the schedule. The Dietetic Services Supervisor and/or Assistant Supervisor will check that all equipment has been cleaned according to the posted schedule on a weekly basis and will post a new copy of the cleaning schedule each Monday. Completed cleaning schedules will be kept in a folder labeled "Completed Dietetic Services Cleaning Schedules". The Director of Dietetic Services will review the completed cleaning schedules on a monthly basis. Review cleaning procedure for convection ovens. Master Cleaning Schedule is posted. All employees were in-serviced on daily cleaning practices. The underneath of the patient serving line was added to the master cleaning schedule. The mobile buffet was added to the master cleaning schedule. The supervisor will check all equipment and assigned cleaning duties to ensure all employees are following their responsibilities on a daily basis. Quality Assurance: The Dietary Manager will monitor the issue using the QA Survey Tool. The survey audit tool will validate that the steam tables have been cleaned. Any issues will be reported to the administrator. This will be done three times per week for one month then	

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F 371	Continued From page 9	F 371	monthly for two months or until resolved by the Quality Assurance Committee. Reports will be presented to the QA committee by the Dietary Manager to ensure corrective action initiated is appropriate.	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to ensure a safe environment by not providing an arm cushion on a wheelchair used for locomotion in 1 of 26 resident wheelchairs observed. The findings include: On 7/28/15 at 1:41 PM an observation was made of Resident #51 ' s wheelchair. The left arm rest cushion was observed to be missing and the Resident ' s arm was laying on the exposed steel framework. On 7/28/15 at 4:40 PM a second observation was made of Resident #51 ' s wheelchair. The left arm rest cushion was observed to be still missing. On 7/30/15 at 2:24 PM Resident #51 observed to have no skin bruises or scratches on her left arm and a new left arm cushion on her wheelchair.	F 465	Corrective Action for Resident Affected: The wheelchair arm cushion for resident #51 was replaced on 7/29/2015. Corrective Action for Residents Potentially Affected: All residents who use wheelchairs have the potential to be affected by this practice. On 8/12/2015, the administrator evaluated all wheelchairs to ensure that the arm cushions were present and in good repair. Torn or missing cushions were replaced. This was completed on 8/13/2015. Systemic Changes: By 8/24/2015, the DON will in-service all full time, part time and PRN nurses and CNAs, therapy staff, housekeepers and nursing center department managers. Topics will include the assignment of	8/24/15

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F 465	Continued From page 10 Resident #51 stated during an interview on 7/28/15 at 1:41 PM the facility provided use of a wheelchair with cushioned arm rests on admission. The Resident stated the arm rest cushion had cracked with age over time and the staff had torn off the cushion on the left arm rest so that the cracked cushion would not irritate her skin. The Resident stated the arm rest cushion had been off for a while and the staff were aware of it because they tore off the cushion and saw the wheelchair daily. The Resident further stated that she was able to move her own arms so the steel and cushion edges had not irritated her skin, but preferred to have a cushion on the arm rest on her wheelchair. The Administrator stated in an interview 7/29/15 at 2:48 PM the facility provided wheelchairs to residents on admission. He stated if the wheelchair needed maintenance, it was the staff ' s responsibility to report the need through the hierarchical chain. The Administrator stated if a resident was currently in physical or occupational therapy, the therapist would notice and correct any resident wheelchair issues. The Administrator stated that if a resident was not in therapy that he would handle any minor wheelchair maintenance. The Administrator stated he was not aware that Resident #51 had the cushion missing off the left wheelchair arm rest. A Physical Therapist stated in an interview on 7/29/15 at 3:14 PM that Resident #51 had been discharged from their services for over a month and he was not aware the arm cushion was missing off the wheelchair. The Therapist stated once a resident was discharged from therapy, it	F 465	monthly wheelchair audits to all nightshift CNAs per the audit tool and proper procedures for reporting any torn or missing wheelchair arm cushions and to document these findings on the audit tool and submit to the DON who will then assess and delegate for repair. All staff will be responsible for reporting to the DON or administrator any torn or missing wheelchair arm cushions any time they are observed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The DON will monitor this issue using the QA Survey Tool. 10 patient wheelchairs will be observed to ensure that the arm cushions are present and in good repair. Any torn or missing arm cushions will be reported to the DON. This will be done weekly for one month then monthly for two months or until resolved by the Quality Assurance Committee. Reports will be presented to the QA committee by the DON to ensure corrective action is appropriate.	

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F 465	Continued From page 11 was the responsibility of the facility to maintain their wheelchairs.	F 465		