STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING ______ B. WING ______	11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 observations, staff interviews and record review, the facility failed to accurately code 4 of 17 Minimum Data Sets (MDS) reviewed for the following areas: dental, active diagnosis and reason for weight loss affecting Resident #4, Resident #51, Resident #63 and Resident #62	F 278	This plan of correction is the Center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or	12/17/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/14/2015

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 278	Continued From page 1 Findings included: 1. Resident #4 was readmitted on 7/21/15 with diagnoses that included hypertension and diabetes. The 5/28/15 Annual Minimum Data Set (MDS) indicated resident #4 was moderately cognitively impaired. She was not identified as being edentulous. An observation was made on 11/17/15 at 9:00 AM. The resident had no natural teeth and was not using dentures. Nursing Assistant (NA) #3 was interviewed on 11/18/15 at 1:28 PM and acknowledged Resident #4 had no teeth. An interview was held with the MDS nurse on 11/19/15 at 11:07 AM. The MDS nurse stated she knew Resident #4 had no teeth, but she had been trained by the corporate MDS nurse to code no problems with a resident's dental status if the resident used dentures. The MDS nurse reviewed the Resident Assessment Instrument (RAI) Manual's directions that indicated natural teeth should be used for determining dental status. After review of the RAI manual, the nurse stated the MDS was coded inaccurately. 2. Resident #51 was admitted on 8/14/14 with diagnoses that included anemia and dementia. Review of the 8/19/15 Annual MDS identified Resident #51 as severely cognitively impaired. Resident #51 was not identified as edentulous. An observation was made on 8/17/15 at 8:45 AM. Resident #51 had no natural teeth and was not using dentures. An interview was held with the MDS nurse on 11/19/15 at 11:07 AM. The MDS nurse stated she knew Resident #4 had no teeth, but she had been trained by the corporate MDS nurse to code no problems with a resident's dental status if the resident used dentures. The MDS nurse	F 278	conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F278 1) The Minimum Data Set (MDS) assessments for Residents #4, #63, and #62 were reviewed and the appropriate modifications were made to include coding of dental status, diagnosis, and planned weight loss to accurately reflect the resident's current condition by the Facility Nurse Consultant and Director of Nursing initiated and completed on 12/11/15. The MDS assessment for Resident #51 was reviewed by the Director of Nursing on 12/11/15 and the appropriate correction was made and a Significant Correction Assessment will be completed by 12/17/15. 2) A 100% audit of the last completed MDS assessment for all residents was initiated on 12/11/15 by the DON and Nurse Consultant to ensure the most recent MDS assessment accurately reflects the resident's current condition to include coding of dental status, vision diagnoses, and planned weight loss. For all areas of concern identified, a modification or significant correction of prior assessment (Quarterly/Comprehensive) was completed by the Director of Nursing as indicated by the RAI Manual on 12/11/15. In servicing was initiated for the MDS Nurse and the Dietary Manager on 12/14/15 by the Facility MDS Nurse	

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F 278	Continued From page 2 reviewed the Resident Assessment Instrument (RAI) Manual's directions that indicated natural teeth should be used for determining dental status. After review of the RAI manual, the nurse stated the MDS was coded inaccurately. 3. Resident #63 re-entered the facility on 12/16/15 with diagnoses that included hypertension and diabetes. Review of an eye consult, dated 4/7/14 indicated Resident #63 had diagnoses that included both cataracts and glaucoma. Ophthalmology consult notes, dated 2/3/15, revealed Resident #63 had end stage glaucoma both eyes with optic nurse damage in both eyes. The physician documented there was no chance of visual improvement Review of the resident's November 2015 physician's orders indicated she received Artificial Tears for treatment of dry eyes, Zioptan drops and Pataday drops for the treatment of glaucoma. The Quarterly MDS for Resident #63, dated 9/16/15, failed to capture glaucoma and cataracts as active diagnoses. The resident was assessed with adequate vision and use of corrective lenses. The Director of Nursing (DON) was interviewed on 11/19/15 at 8:45 AM. The DON stated expected glaucoma to be captured on the MDS as an active diagnoses. During an interview with the MDS nurse on 11/19/15 at 10:30 AM, she stated cataracts and glaucoma were only captured on the comprehensive assessments such as annuals and admission assessments. The MDS nurse added she did not have the ability to add pertinent diagnoses to the quarterly MDS. She added the Medical Records director was responsible for adding diagnoses. The Medical Records Director was interviewed on 11/19/15 at 11:17 AM. She acknowledged she	F 278	Consultant regarding proper coding of the MDS assessments per the Resident Assessment Instrument (RAI) Manual for coding of dental, diagnosis, and planned weight loss. The Care Plan team to include the MDS Nurse, the Social Worker, Activities Director, and Dietary Manager will also review a Teleconference on accurate MDS completion by 12/15/15. When coding the MDS assessment, the MDS Nurse and the Dietary Manager will follow the instructions for proper coding found in the Resident Assessment Instrument (RAI) Manual and ensure that the assessment accurately reflects the resident's current condition. 3) An audit of 25% of completed Minimum Data Set (MDS) assessments will be conducted weekly x 4 weeks, then bi-weekly for 4 weeks then 10% monthly x 2 months by the Director of Nursing to ensure compliance and accuracy of the MDS to include coding for Dental, diagnoses, and planned weight loss utilizing a MDS Audit Tool. All identified areas of concern will be addressed immediately by the Director of Nursing through retraining and by modification or significant correction of the MDS Assessment by the MDS Nurse to accurately reflect the resident's current condition. 4) The Administrator will present the results of the monitoring to the Quality Improvement Executive Committee monthly x 3 months for further recommendations, take action as appropriate, and to monitor continued compliance.	

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F 278	Continued From page 3 was responsible for adding diagnoses that were captured on the MDS under active diagnoses. She added she added diagnoses that were included on the hospital discharge summaries and from the FL-2 (a state form that includes information about a resident). The Medical Records Director stated the MDS nurse had not asked her to add cataracts or glaucoma to Resident #63's quarterly MDS; adding the MDS nurse had the capabilities to add diagnoses as needed. 4. Resident #62 was admitted to the facility on 10/8/15 with diagnoses which included metabolic encephalopathy, urinary tract infection, congestive heart failure and dehydration. The discharge Minimum Data Set (MDS) dated 10/21/15 revealed Resident #62 was not on a prescribed weight loss regimen. The 5 day MDS dated 11/2/15 indicated Resident #62 was on a prescribed weight loss regimen. The discharge MDS dated 11/8/15 indicated she was on a prescribed weight loss regimen. On 11/19/15 at 9:00 AM a medical record review of the doctor's orders since admission revealed no written order for Resident #62 to be on a weight loss regimen. On 11/19/15 at 10:35 AM the MDS nurse reported she obtained information for the MDS from the resident family and staff interviews along with reviewing the resident's chart. She stated if she needed she would go assess the resident. She stated the Dietary Manager completed the MDS section for nutritional status which included weight loss. On 11/19/15 at 10:35 AM the Dietary Manager (DM) stated that Resident #62 was discussed in the weekly weight meeting and based on the resident's medications which included Lasix, it was decided that this qualified the resident for	F 278		

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F 278	Continued From page 4 being on a weight loss program. She stated she was not sure if there were doctor's orders for the resident being on a weight loss program. She stated the members of the weekly weight loss meeting included the MDS nurse, the treatment nurse, the DON and the administrator. The DM added that the team decided she should be coded as being on a weight loss program based on her ideal body weight, her weight loss and her diagnosis. She stated there was no actual order for weight loss. On 11/19/15 at 11:24 AM the MDS nurse, DON and Administrator were present and reported that the DM misunderstood the information from the weight meeting and had coded the MDS incorrectly. The MDS nurse stated she told the DM the she had to have a doctor ' s order for prescribed weight loss in order to code the MDS as such.	F 278		
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 interviews and review of medical records, the facility failed to	F 315	1) The indwelling urinary catheter for Resident #51 was removed per	12/17/15

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F 315	Continued From page 5 code a valid supporting diagnoses for the use of an indwelling urinary catheter for 1 of 2 sampled residents (Resident #51) who was reviewed for the use of an indwelling urinary catheter. Findings included: Resident #51 was admitted on 8/14/14 with diagnoses that included cancer, dementia and hypertension. Review of the 8/19/15 Annual Minimum Data Set (MDS) identified Resident #51 as severely cognitively impaired. The resident was identified as requiring extensive assistance for bed mobility, totally dependent for transfer, eating, toilet use, dressing and personal hygiene. The resident was identified as having an indwelling catheter. Active diagnoses did not include neurogenic bladder or obstructive uropathy. Additional diagnoses did not include urinary retention. A 10/20/15 Significant Change in Status MDS indicated Resident #51 used an indwelling urinary catheter. Active diagnoses did not include urinary retention or any explanation for the use of the catheter. The MDS indicated Resident #51 had received no scheduled or as needed (PRN) pain medication during the previous 5 days. Non medication interventions were not coded as used for pain relief. The MDS indicated Resident #51 had denied pain during the past 5 days. The care plan for Resident #51, last reviewed on 10/28/15, indicated the resident had an indwelling catheter due to intractable pain (intractable pain is defined as pain that is difficult or impossible to manage with standard nursing or surgical measures. Intractable pain is resistant to ordinary analgesics) with incontinent care. Physician progress notes were reviewed for 4/2/15, 6/5/15, 8/1/15 and 10/2/15. The use of an indwelling urinary catheter for Resident #51 was not addressed. Review of the notes failed to	F 315	physician's order on 11/18/15 at approximately 5:20 pm by the charge nurse. 2) A 100% audit of all residents with an indwelling urinary catheter was completed on 12/11/15 by the Director of Nursing to ensure residents with an indwelling catheter have a clinical condition that demonstrate that the indwelling catheter is necessary. No concerns were found with current use of indwelling urinary catheters. An in-service for all licensed nursing staff was initiated by the Staff Facilitator on 11/18/15 on clinical conditions that demonstrate that indwelling catheterization is necessary and to clarify with the MD if appropriate clinical condition is not noted for the use of the catheter. All newly hired nurses will receive the in-service material during orientation by the Staff Facilitator. 3) When a resident receives a new order for an indwelling catheter or is admitted or readmitted with an indwelling catheter, the hall nurse is responsible for ensuring that the use of the catheter has a clinical condition that demonstrate that the indwelling catheter is necessary and clarify with the MD for any concerns noted. All residents with a new indwelling urinary catheter and residents newly admitted or readmitted with an indwelling catheter, orders will be reviewed weekly x 8 weeks then monthly x 1 month to ensure the use of the catheter has a clinical condition that demonstrate that the indwelling catheter is necessary and that the hall nurse has clarified with the MD for any concerns noted by the Staff Facilitator	

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F 315	Continued From page 6 document a supporting diagnosis for the catheter or the presence of intractable pain. Review of Resident #51's electronic medical record failed to include a supporting diagnoses for the use of the indwelling urinary catheter and failed to list intractable pain as a diagnosis. Review of the October 2015 Medication Administration Record (MAR) revealed an entry for an ice pack to be used for pain relief. Documentation indicated the ice pack had not been required to relieve pain for Resident # 51. An entry for Tylenol (an analgesic) had been used 3 times (10/12/, 10/26/ and 10/27/). An entry for Roxanol (an opioid pain reliever), PRN had been discontinued on 10/15/15 for non-use. The November 2015 physician's orders indicated the resident required an indwelling urinary catheter for intractable pain. Review of the orders failed to include a pain medication, routinely administered for Resident #51's intractable pain, but did include Tylenol to be used every 6 hours as needed. Orders also included the use of an ice pack PRN for pain. Review of the November 2015 MAR indicated no routine pain medication had been scheduled to control any intractable pain for Resident #51. The PRN ice pack had not been used. Documentation indicated the PRN Tylenol had been given to Resident #51 6 days during November (11/1/15, 11/3/15 x 2, 11/5/15, 11/6/15 and 11/18/15). An observation was made on 11/18/15 at 9:37 AM. The resident was lying in her bed without signs or symptoms of pain such as moaning or grimacing. In talking with Resident #51, she stated she was having pain in her legs but had been given pain medication. On 11/18/15 at 10:39 AM, Nursing Assistant (NA) #3 was observed providing morning care to	F 315	using an Indwelling Urinary Catheter QI Tool. The Director of Nursing will review and initial the audit tools weekly X 8 weeks then monthly x 1 month for completion and to ensure all identified areas of concern have been corrected. 4) The Director of Nursing will present the results of the QI Foley Cath Audit Tool to the Executive Quality Improvement Committee monthly for three months for trends. Monthly audits of indwelling urinary catheter use will continue.	

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F 315	Continued From page 7 Resident #51. The indwelling urinary catheter was secured to the resident's right leg. The NA used front to back strokes to clean the perineal area and cleaned the catheter tubing using in to outward strokes of the cloth. During the provision of catheter care, the resident did not grimace, moan or verbalize pain. When the NA turned the resident to her right side, she was seen grimacing and said "OH". The resident did not yell out and as soon as the turn had been completed, there were no more grimaces or verbalizations of discomfort observed. NA #3 was interviewed on 11/18/15 at 1:34 PM. The NA stated Resident #51 complained of her knees hurting, but that was usually only during weather changes. She stated there were entire weeks the resident had no complaints of pain or discomfort and complaints of pain and grimaces were only now and then. Medication Aide (MA) #2 was interviewed on 11/18/15 at 1:47 PM. The MA stated Resident #51 did not have a lot of pain. She stated at times the resident complained about her legs hurting, but that was not even a daily complaint. MA #2 stated she had not observed Resident #51 having major pain that caused her to scream or yell out in pain, even during the provision of care. The Director of Nursing (DON) was interviewed on 11/19/15 at 8:52 AM. The DON acknowledged Resident #51 did not and had not had intractable pain. The DON stated the diagnoses of intractable pain was added at the strong encouragement of ancillary staff to justify the use of the catheter. The DON stated Resident #51 had received hospice services until about 2 weeks ago. During an interdisciplinary meeting last week, a discussion was held regarding the need to remove Resident #51's indwelling urinary catheter. The DON stated she had instructed	F 315		

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F 315	Continued From page 8 the charge nurse to contact the physician for an order to remove the resident's catheter, but the charge nurse had called for the order. The DON acknowledged there had been no supporting diagnoses for the use of the indwelling urinary catheter.	F 315		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to be free of a medication error rate of 5% or greater as evidenced by two (2) med errors out of 29 opportunities for error resulting in a medication error rate of 6.89% (Residents #46 and #62). Findings Included: 1. Resident #46 had been readmitted to the facility on 4/07/2014. Diagnoses included left above the knee amputation, thrombocytopenia, Vitamin D deficiency, vascular dementia, hypertension, diabetes, iron deficiency anemia and cerebral infarction. The most recent Quarterly MDS dated 10/01/2015 indicated Resident #46 had severely impaired cognition. Review of the November 2015 physician orders indicated Miralax (a laxative for constipation relief) 17 grams (gms) was ordered to be given twice daily with the first dose scheduled for 9:00 AM. On 11/18/2015 at 8:53 AM, medication pass with MA #2 was conducted for Resident #46. The	F 332	1) Resident #46 was administered Miralax 17 grams per physician's orders on 11/18/15 at 9:05 am by Medication Aide #2 and verified as given by the Director of Nursing as given. Resident #62 received Potassium 10mEq on 11/17/15 per physician's orders on 11/17/15 at 10:00 am by Medication Aide #1 and checked by the Staff Facilitator to ensure the medication was administered. 2) On 11/18/15, a 100% medication pass audit with all Medication Aides to include Medication Aide #1 and #2 and license Nurses was initiated by the Staff Facilitator to include administering medications to Residents #46 and #62 to ensure each Nurse and Medication Aide is in compliance with medication administration by having an error rate of less than 5% during the observation and will be completed by 12/17/15. Any issues identified during the medication pass audit	12/17/15

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F 332	Continued From page 9 Miralax had not been noted during the medication preparation. An interview with MA #2 was conducted on11/18/2015 at 9:00 AM. The MA indicated she had missed giving the Miralax. 2. Resident #62 had been readmitted to the facility on 11/10/2015. Diagnoses included anemia, heart failure, hypertension, diabetes, acute kidney failure and chronic kidney disease. The Admission Minimum Data Set (MDS) dated 10/3/2015 indicated Resident #62 had moderately impaired cognition. Review of the November 2015 physician orders for Resident #62 indicated Potassium Chloride (a potassium supplement used to prevent or treat low potassium levels) 10 milliequivalents (mEq) had been ordered to be given daily at 8 AM. On 11/17/2015 at 8:55 AM, medication pass with Medication Aide (MA) #1 was conducted for Resident #62. The Potassium had not been noted during the medication preparation. An interview with MA #1 was conducted on 11/17/2015 at 9:50 AM. The MA indicated she was uncertain if the Potassium had been administered. An interview with the Director of Nursing (DON) was conducted on 11/19/2015 at 9:27 AM. The DON stated it was her expectation that medication pass be correct and free of errors at all times.	F 332	will immediately be corrected with retraining of the license nurse or medication aide by the Staff Facilitator. A 100% in-service to all licensed nurses and Medication Aides, to include Medication Aides #1 and #2, was initiated on 11/18/15 by the Staff Facilitator regarding medication administration to include the six rights of medication administration. All newly hired license nurses and medication aides will be in-serviced regarding medication administration to include the six rights of medication administration during orientation. 3) The Staff Facilitator will conduct medication pass audits 3x a week for 4 weeks, then 2x a week for 4 weeks then monthly x 1 month to include observation of Medication Aides #1 and #2, to ensure Nurses and Medication Aides are passing medications with an error rate of less than 5% utilizing a medication pass audit tool. The medication pass observations will include Resident #46 and Resident #62. Any license Nurse or Medication Aide with an error rate of greater than 5% will be immediately retrained on the correct procedure for medication administration by the Staff Facilitator. The DON will review and initial the results of the medication pass observation audit tool weekly x 8 weeks then monthly x 1 month for completion to ensure all identified areas of concern were addressed. 4) The Director of Nursing will present the results of the medication pass observation audits to the Executive Quality Improvement Committee x 3 months for trends and the need for continued	

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F 332	Continued From page 10	F 332	monitoring.	
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 infection.	F 441		12/17/15

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	345313	A. BUILDING ______ B. WING ______	11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

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F 441	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility staff failed to perform hand hygiene and change gloves after providing perineal care and catheter care and before putting their hand in the container of barrier cream and applying it for 1 of 2 residents (Resident #53) observed for catheter care. The facility staff failed to wear personal protective equipment when entering a contact isolation room for 1 of 1 residents (Resident #62) observed on contact isolation. Findings included: 1. On 11/18/2015 at 9:52 AM, an observation was conducted of catheter care for resident #53. The nursing assistant (NA #1) gathered the supplies, donned gloves and proceeded to clean the perineal area. She then cleaned the catheter. The NA turned the resident to her right side and proceeded to clean her bottom. Then, without performing hand hygiene or changing gloves, she opened the container of barrier cream, reached her hand in and scooped out a large amount of cream and applied it to the resident's bottom. After applying cream, she changed her gloves, put a clean brief on the resident and repositioned her in the bed. The barrier cream was labeled with the residents name and stored on a shelf next to her bed. An interview was conducted with NA #1 on 11/18/2015 at 10:03 AM. The NA stated she usually changed gloves before reaching into the barrier cream, and she should have done so today also. She indicated the container could still be considered clean because she didn't have any	F 441	1) Resident #53 was provided a new container of barrier cream and the old container was discarded by the Staff Facilitator on 11/18/15 at 10:45 am. NA#1 received re-education by the Staff Facilitator on 11/18/15 at 10:45 am on proper hand hygiene and changing of gloves to perform the clean duties of peri-care to include the use of barrier cream. The Staff Facilitator immediately in-serviced Medication Aide #2 and NA #2 on 11/16/15 at 12:30 pm following the observation of Resident #62 on removing and disposing of a gown and gloves and hand-washing when caring for resident on contact isolation. A return demonstration was observed by the Staff Facilitator for NA#2 and Medication Aide #2 after re-education on removing and disposing of a gown and gloves and hand-washing when caring for a resident on contact isolation without concern. Resident #62 is no longer on contact isolation as of 11/25/15. 2) The Staff Facilitator will observe 100% of all nursing staff to include NA#1 while providing peri-care to assure proper hand hygiene and changing of gloves to perform the clean duties of peri-care to included the use of barrier cream. An in-service for 100% of all nursing staff was initiated by the Staff Facilitator on 11/18/15 on proper hand hygiene and changing of gloves to perform the clean	

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F 441	Continued From page 12 stool on her gloves, and the gloves were not contaminated. On 11/18/2015 at 4:17 PM, an interview was conducted with the Staff Development Coordinator (SDC). The SDC indicated she would have changed her gloves before dipping into the barrier cream, and she was going to do more education on that. An interview was conducted with the Director of Nursing (DON), on 11/18/2015 at 5:11 PM, who stated she expected the NA to follow the facility protocol for catheter care. She expected staff to change gloves before dipping into the barrier cream. 2. Review of Resident #62's chart indicated she had Vancomycin resistant enterococcus of the rectum. On 11/16/15 at 12:20 PM, an observation was made of Resident #62's room. On the door of Resident #62's room was an isolation bin containing gloves and gowns along with a contact isolation sign. On the contact isolation sign were the directions to don gloves and gowns prior to entering the room. At that time, Medication Aide (MA) #2 entered the room to serve Resident #62 her lunch. The MA did not don gloves and did not don a gown prior to moving the resident's over bed table and her television remote control. Noting the resident needed to slide up in bed prior to eating, the NA left the room to get assistance. She did not wash her hands prior to leaving the room. On re-entering the room, MA #2 and Nursing Assistant (NA) #2, without donning gloves, grabbed the pad laying under Resident #62 to pull her up in bed. On exiting the room, both the MA and the NA used hand sanitizer before resuming serving lunch trays to other residents.	F 441	duties of peri-care to include the use of barrier cream. 100% of all facility staff were re-educated by the Staff Facilitator beginning 11/18/15 on doffing and donning of a gown and gloves and proper hand-washing when caring for a resident on contact isolation. The Staff Facilitator will observe 100% of all facility staff to include Medication Aide #2 and NA#2 beginning 11/18/15 for return demonstration of proper donning and doffing of personal protective equipment (PPE), and hand-washing to ensure correct isolation precautions/isolation protocols are followed prior to entering another resident's room. All newly hired license nurses and NAs will be in-serviced during orientation on donning gloves and gown and hand-washing prior to entering resident's room when on contact precautions and proper hand hygiene and changing of gloves to perform the clean duties of peri-care to include the use of barrier cream. 3) The Staff Facilitator will observe 10% of nursing staff to include NA#1 while providing peri-care to assure proper hand hygiene and changing of gloves to perform the clean duties of peri-care to include the use of barrier cream 3x per week x 4 weeks, then weekly x weeks, then monthly x 1 month using a QI Resident Care Audit Tool. The Staff Facilitator will provide immediate retraining to the staff member being observed for any identified areas of concerns. The DON will review and initial the QI Resident Care Audit Tool weekly x 8 weeks then monthly x 1 month for	

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F 441	Continued From page 13 MA #2 was interviewed on 11/18/15 at 1:39 PM. The MA stated she was expected to put on a gown and gloves when a contact isolation sign was posted on a resident's door if there was a possibility she would contact body fluids. She stated she was unsure about the location of Resident #62's infection. She stated she knew the resident was on isolation due to the contact isolation sign posted on the door and the presence of the bin with gloves and gowns. The MA acknowledged she had not used gloves prior to touching the resident's personal items and pulling her up in bed and had been potentially contaminated with the organism that caused Resident #62's infection. NA #2 was not available for interview. The Director of Nursing (DON) was interviewed on 11/19/15 at 9:06 AM. The DON stated she expected staff to wear gloves at a minimum when they entered a resident's room that was on isolation. She added if linens or any items used by the resident was touched, staff were expected to use gloves. The DON added without wearing gloves when touching linens and personal items, the NA had the potential of bacterial contamination. She added after leaving a room of a resident on isolation, she would expect staff to use soap and water for hand washing and not hand sanitizer. The Infection Control (IC) Nurse was interviewed on 11/19/15 at 10:00 AM. She stated she does random observations during the provision of care to ensure gloves were worn by staff when needed. Staff were trained on isolation and what personal protective equipment should be used during their orientation. The IC nurse stated when going into an isolation room, and the possibility of touching linen, the call bell or any items used by the resident, a minimum of gloves	F 441	concerns. The Staff Facilitator will observe 10% of all facility staff to include Medication aide #2 and NA#2 for return demonstration of proper donning and doffing of personal protective equipment (PPE), and hand-washing to ensure correct isolation precautions/isolation protocols are followed prior to entering another resident's room 3 x per week x 4 weeks, then weekly x 4 weeks, then monthly x 1 month using a QI Resident Care Audit Tool. The Staff Facilitator will provide immediate retraining to the staff member being observed for any identified areas of concerns. The DON will review and initial the QI Resident Care Audit Tool weekly x 8 weeks, then monthly x 1 month for completion and to ensure all identified areas of concerns are addressed. 4) The DON will present the results of the QI Resident Care Audit Tools to the Quality Improvement Committee monthly x 3 months for trends and the need for continued monitoring.	

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F 441	Continued From page 14 should be worn to prevent the spread of infection.	F 441		