STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. BUILDING _____ B. WING _____	C 03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HILLS A PERSONAL CARE	864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589

(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 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 review, the facility failed to provide a privacy bag to cover an indwelling urinary catheter drainage bag for 1 of 2 residents (Resident #5) who was observed with an indwelling urinary catheter. Findings included: Resident 35 was admitted to the facility on 11/25/15 with diagnoses that included pressure ulcers. The care plan for Resident #5, with a 12/15/15 review date, identified the resident was at risk for urinary tract infections due to an indwelling catheter that had been placed due to multiple pressure ulcers. Interventions did not include covering the catheter drainage bag to promote Resident #5 ' s dignity. A 1/29/16 Significant Change Minimum Data Set (MDS) coded Resident #5 as moderately cognitively impaired with no behaviors, required staff to provide extensive/total assistance with all activities of daily living and identified Resident #5 had an indwelling urinary catheter. Observations were made on 3/14/16 at 9:40 AM, 2:25 PM and 3:50 PM. Each observation found Resident #5 lying in bed with her urinary catheter drainage bag uncovered and the contents of the bag clearly visible from the hallway. Resident #5 was again observed in bed on	F 241	Warren Hills Nursing Center acknowledges and submitted as written allegation of compliance. Proposes this plan of corrections to the extent that the summary of finding is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of residents. The Plan of Corrections is submitted as a written allegation of compliance. Warren Hills Nursing Center's response to this statement of deficiencies and plan of correction does not denote agreement with statement of deficiencies nor does it constitute an admission that a deficiency is accurate. Furthermore, Warren Hills reserve the right to refute any deficiency on this statement of deficiencies through Informal Dispute Resolution, formal Appeal and/or Administrative or Legal Procedures. F241 The facility shall promote care for residents in a manner and in an	4/10/16

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

Electronically Signed | 04/08/2016

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F 241	Continued From page 1 3/15/16 at 8:15 AM. The resident ' s urinary drainage system was uncovered with the contents of the urinary drainage bag clearly visible from the hallway. Nursing Assistant (NA) #1 was interviewed on 3/15/16 at 10:40 AM. The NA stated she had been assigned to care for Resident #5 that day and the day before. She added she had not noticed the urinary drainage bag had not been covered. NA #1 stated she knew it should have been. On 3/15/16 11:15 AM, Nurse #1 was interviewed. She stated no one had reported to her the urinary drainage bag did not have a privacy bag to cover the contents. She stated while she had cared for Resident #5 for the past 2 days, she had not noticed it was uncovered. The Staff Development Coordinator (SDC) was interviewed on 3/15/16 at 11:34 AM. She stated she expected the NAs to report the absence of a catheter drainage bag cover. She added the nurse and/or the NA should have noticed the privacy bag was missing yesterday and had the privacy bag replaced. The SDC stated the privacy bag was important to cover the bags to protect the port from germs and to preserve the resident ' s dignity. The Director of Nursing (DON) was interviewed on 3/15/16 at 1:30 PM. She stated she expected all urinary drainage bags to be covered to maintain the dignity of the resident.	F 241	environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The facility shall provide a privacy bag to cover an indwelling urinary catheter for resident #5 and all in house residents with indwelling urinary catheters. Shall also place on all in house residents Interim Care Plan/and Care Plan for the urinary catheter to be covered of residents with indwelling catheter by MDS Nurses, per RAI Assessment Schedule. All in house residents including Resident #5, have had added to their treatment sheets for charge nurse on the hall with indwelling catheter's to check and sign that privacy bag (fig bag catheter) are in place every shift. (See enclosed picture of fig bag catheters, order sheet for them, and invoice that has arrived at facility.) Nursing staff shall be in-serviced on observing each shift for privacy bags on residents with indwelling catheters and for CNA's to report to licensed nurses to replace if not in place. Nurses are to observe every shift and sign treatment sheet that the indwelling urinary catheter privacy bag is in place every shift. In house residents, New admissions/re-admissions shall have added to their treatment sheet that privacy bag on urinary catheters are in place every shift by charge nurse on hall on their treatment sheet.	

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F 241	Continued From page 2	F 241	A QA monitor sheet shall be used randomly 3 x wk x 1 year to monitor that the privacy bag (fig bag catheter) are in place on each resident that has an indwelling urinary catheter by Staff Developer Nurse, LPN's, and MDS Nurses. The Director of Nursing, Medical Director, Staff Developer, Administrator, and Licensed Nurses shall review/revise the Quality Assurance monitor sheet to monitor compliance quarterly.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to provide on-going checks of a cardiac pacemaker for 1 of 1 resident (Resident #1) that was reviewed with a cardiac pacemaker. Findings included: Resident #1 was readmitted on 3/10/16 with diagnoses that included hypertension and coronary artery disease with pacemaker placement. The resident's 12/30/15 Quarterly Minimum Data	F 309	F309 The facility shall provide the necessary care and services to attain or monitor the highest practicable, physical, mental, and psychosocial well being in accordance with the comprehensive assessment and plan of care.	4/10/16

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F 309	Continued From page 3 Set (MDS) indicated Resident #1 was cognitively intact. The MDS did not reflect the presence of a cardiac pacemaker. Resident #1 ' s care plan, last reviewed on 1/13/16, identified she was at risk for syncope/collapse, irregular heart rate due to the presence of a cardiac pacemaker. Nurse's notes for 1/28/16 at 10:05 AM indicated the Responsible Party (RP) called the facility regarding Resident #1 ' s complaints that her strength was declining. There was no indication an assessment was completed, no indication the nurse spoke with the resident and no indication the primary care physician (PCP) was notified of the concern. Review of the PCP ' s progress notes dated 1/29/16 indicated Resident #1 complained of lower extremity weakness. Her heart was assessed with a regular rate and rhythm. Nurse ' s notes dated 3/2/16 at 1:40 PM indicated the nurse had called to check on a pacemaker check for the resident. The last pacemaker check was documented as occurring on 5/8/15. The nurse documented when she called the company, she was notified Resident #1 had been discharged on 6/9/15, because she was no longer seeing the cardiologist. The nurse documented the pacemaker company advised her that the cardiologist who was seeing the resident now needed to set the resident up with a new pacemaker check company. On 3/3/16 a physician's order was received to schedule a heart and vascular consultation. There was no documentation the consultation was scheduled. Nurse's notes for 3/5/16, no time documented, indicated Resident #1 told the nursing assistant (NA) she did not feel right. The nurse documented the resident ' s vital signs were	F 309	The facility shall provide for in house residents, new admissions/readmissions to include resident #1, that have cardiac pacemakers, to have the pacemaker checked routinely, under the direction of their cardiologist. The Staff Developer shall make their appointment as scheduled routinely by their cardiologist for pacemaker checks. If cardiologist sends letter with date and time for pacemaker to be checked using the device sent to the facility, the charge nurse/CNA on that hall shall have resident with pacemaker at desk and ready when the office calls to begin check. It shall be documented on the treatment sheet and on the chart that pacemaker was checked by the licensed nurse. On the Admission Information Sheet, done by the MDS Nurses on admission, the resident or RP shall be asked if they have a pacemaker, who is the cardiologist, and when it was last checked so that the Staff Developer can call and find out when it needs to be checked again and schedule appointment. The Staff Developer shall notify the resident and RP of scheduled appointments on weekly basis to include pacemaker check. Licensed nurses on hall have slips put on halls daily for scheduled appointments by Staff Developer or transporter to include pacemaker checks or appointments to cardiologist and other places. The Interim Care Plan /Care Plan shall reflect the presence of a pacemaker on all in-house residents, new admissions/readmissions	

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F 309	Continued From page 4 stable. There was no other assessment and no follow up to the resident ' s complaints of not feeling right. On 3/7/16 at 1:00 AM, the nurse ' s notes indicated Resident #1exited the facility due to a possible reaction to the antibiotic she had starting receiving on 3/4/16 for a urinary tract infection. The nurse documented the resident ' s blood pressure as 68/40 (normal range is systolic of 120 and diastolic of 70). There was no documentation of the resident ' s heart rate. The 3/10/16 Hospital Discharge Summary indicated Resident #1 had been admitted with dehydration probably due to poor intake of food and fluid. Review of the radiology report, dated 3/7/16 indicated the resident's heart was normal size with a dual chamber pacemaker leads that were satisfactorily positioned. There was no documentation the pacemaker was not functioning properly. The discharge diagnoses included dehydration and hypokalemia (low potassium level). Review of the consult section of the resident's medical record did not reveal a pacemaker check or a cardiac consult. A telephone interview was held with the resident's RP on 3/14/16 at 1:17 PM. The RP stated previously to being admitted to this facility in 12/2014, Resident #1 had a cardiologist. She stated the staff at the facility told her, on admission, there was no need for the resident to travel to see the cardiologist, but the facility would find Resident #1 a cardiologist closer to the facility. The RP stated with that said, she cancelled Resident #1 ' s cardiology appointment. The RP stated during January, Resident #1 began to complain of shortness of breath and stated it was hard to breathe. On asking the nurses about the last pacemaker check, she	F 309	to include resident #5, done by RN Supervisor or MDS Nurse on admission as well as per RAI Assessment Schedule. RN's, MDS Nurses, Staff Developer, and charge nurses shall be in-serviced on the process of making sure pacemakers are checked routinely as ordered by cardiologist. They are to report to Director of Nursing any issues/concerns during that process immediately. A QA monitor sheet shall be used by RN's, Staff Developer, and LPN's to maintain inventory of routine scheduled pacemaker checks per cardiologists schedule (ie: 3 months, 6 months, or 1 year). Primary Care Physician, residents and/or responsible party are to be informed of any issues with pacemakers being checked routinely by cardiologist, to be documented in resident's chart, and reported immediately to the Director of Nursing. The Director of Nursing, Medical Director, Staff Developer, Administrator, and Licensed Nurses shall review/revise the Quality Assurance monitor sheet to monitor compliance quarterly.	

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found out Resident #1 ' s pacemaker had not been checked since May of 2015. She also found out Resident #1 had not had a heart consult since December 2014 when she was admitted. The RP stated she had asked several nurses over the course of time about Resident #1 ' s pacemaker checks, but had not received a response until two weeks ago when one of the nurses told her she could find no evidence of a cardiologist consult or a pacemaker check.
The Director of Nursing (DON) was interviewed on 3/15/16 at 1:20 PM. She stated the RP had not reported the lack of pacemaker checks to her; adding the RP had told the Admissions Coordinator (AC) who then reported it to her. On calling the cardiologist, the facility had been told the RP had cancelled the appointment.
On 3/15/16 at 2:25 PM, the AC was interviewed. She stated she had been told by the RP a couple of weeks ago that she had spoken to the nurse on Resident #1 ' s hall about a cardiology appointment and a pacemaker check. The AC stated she called the number on the pacemaker checking device and was told the box had been turned off at the request of Resident #1 ' s cardiologist, because he was no longer Resident #1 ' s cardiologist. The AC stated she then called the cardiologist ' s office and was told the RP had cancelled the appointment because Resident #1 was to be seen by another cardiologist. The AC added the last documented appointment made to the Cardiologist by Resident #1 prior to her admission to the facility. The AC stated on admission she told families the facility ' s PCP would take care of resident needs, but all specialist would remain the same with the facility providing transportation to any specialist appointments. She denied telling Resident #1 ' s RP that the facility would make an appointment

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for Resident #1 with a cardiologist closer to the facility. She stated she was aware the RP thought the facility had told her they would arrange for a new cardiologist, but thought that was just a misunderstanding on the part of the RP.

The Staff Development Coordinator (SDC) was interviewed at 2:55 pm on 3/15/16. She stated resident ' s pacemakers were typically checked every 1-3. Months either at the facility or at the cardiologist office. She stated pacemaker was listed on the diagnosis list, so nurses should have been aware. In addition, the SDC stated she was the one that scheduled appointments. In the last few weeks she had been told to set up a cardiology appointment for Resident #1 and she had scheduled the appointment for the first of March. That appointment was cancelled when the resident entered the hospital.

At 3:00 PM on 3/15/16, the DON was interviewed. She stated she had been unaware Resident #1 ' s pacemaker had not been checked since May 2015 until approximately 2 weeks ago when the nurse on duty called the number listed on the pacemaker check device and found out the box had been disconnected. She stated she was unsure why the nurses had not questioned the lack of pacemaker checks and was unaware why the nurses had not alerted her.

Nurse #2 was interviewed by telephone on 3/15/16 at 3:15 PM. The nurse stated she had questioned in July 2015 why Resident #1 ' s pacemaker had not been checked. She was unable to remember to whom she had spoken, but remembered being told Resident #1 ' s RP had taken her out for cardiologist appointments to have her pacemaker checked. The nurse stated to the best of her knowledge, the resident had not seen a cardiologist or had her pacemaker

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checked since she (Nurse #2) started to work last June. Nurse #2 added she only questioned the lack of pacemaker checks one time because she had been given an answer when she had inquired.
Resident #1 ' s facility PCP was interviewed by phone on 3/15/16 at 3:40 PM. He stated he had been aware of the pacemaker issue since probably December 2015, noting he had talked with a nurse on the hall about the lack of checks and at that time ordered a cardiologist consult to be made. The PCP was unable to remember the name of the nurse he had spoken with in December 2015. He added until a couple of weeks ago, he had been unaware the consultation he had ordered in December 2015 had not been made when the issue was brought to his attention again. The PCP added on his assessments, Resident #1 ' s heart rate had been regular with a regular rhythm. The PCP acknowledged in December 2015 when he had spoken to the RP, he had suggested a cardiologist closer to the facility be found.
On 3/15/16 at 4:30 PM, Nurse #3 was interviewed by phone. She stated she was aware the resident had a pacemaker. Nurse #3 stated about 2 weeks ago, Resident #1 ' s PCP called her and said the RP was sitting in his office and he needed to know the last time Resident #1 ' s pacemaker was checked. Nurse #3 stated she found the device to check Resident #1 ' s pacemaker, called the number and found Resident #1 ' s service had been discontinued. Nurse #3 acknowledged that even prior to a couple of weeks ago, Resident #1 ' s RP had inquired about the last time the resident had her pacemaker checked. The nurse stated she had searched for the checking device and was unable to locate the device. Nurse #3 stated she had

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F 309	Continued From page 8 notified another nurse about the RP ' s concerns, but was unable to recall to whom she had spoken. The DON was interviewed on 3/15/16 at 5:08 PM. She stated when a resident with a pacemaker was admitted, she expected the nurses to find out the name of the resident ' s cardiologist, the date of the last consultation and expected staff to continue to schedule appointments as ordered by the cardiologist. The DON added the cardiologist was expected to send a notice with instructions for checking pacemakers. The DON stated she had expected the nurses to notify her or one of the supervisors Resident #1 ' s pacemaker was not being checked so an appointment could have been made with the cardiologist. She added the danger of not checking the pacemaker regularly included a low heart rate, low blood pressure or the pacemaker battery could have died. The DON added when Nurse #3 first received the concern from Resident #1 ' s RP, that concern should have been communicated to the nurse supervisor or her so an appointment could have been made immediately. If there had been no response after questioning staff, the DON stated she would have expected Nurse #2 and Nurse #3 to continue telling administrative nursing staff until the issue was resolved.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		4/10/16

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F 312	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to change the bath water and bath cloth and/or provide proper perineum and catheter care for 3 of 3 sampled residents (Residents #1, 5 and 7) whose perineum care was observed. Findings included: 1. Resident #1 was readmitted to the facility on 3/10/16 with diagnoses that included hypertension, diabetes and chronic pain The resident's 12/30/15 quarterly Minimum Data Set indicated she was cognitively intact, had no behaviors and required extensive to total assistance for bathing, toilet use and personal hygiene. The care plan for Resident #1, last reviewed on 1/13/16, identified she was frequently incontinent of bowel and bladder and noted she received a diuretic daily. Interventions included providing incontinent care as needed to prevent urinary tract infections. Laboratory results, reported 3/2/16, revealed Resident #1 had a urine culture that included an Escherichia coli colony count greater than 100,000 per milliliter of urine (Urine cultures should contain no Escherichia coli). The physician was called and an antibiotic ordered. At 8:45 am on 3/15/16 Nursing Assistant (NA) #2 was observed providing Resident #1 ' s morning care including perineum care. The NA bathed the resident ' s face and upper body, rinsed her body and dried her with a towel. After removing the resident ' s brief, and without changing the washcloth or the water, the NA began cleansing the resident ' s perineum area using back to front strokes making 3 swipes of the perineum area. When asked to verify how he had washed	F 312	F312 Residents who are unable to carry out activities of daily living shall receive the necessary services to maintain good nutrition, grooming, and personal & oral hygiene. Admission/Readmissions and in-house residents, to include resident #1,5,and 7 shall have bath water/bath cloth changed as per bathing policy and provide proper perineum and catheter care by nursing staff daily. The nursing staff shall be re-in-serviced on when to change bath water/cloth and to wipe from front to back when providing perineum and catheter care by Staff Developer to maintain good personal hygiene and decrease risk of infections of residents by wiping front to back and changing water per bathing policy. A monthly QA infection control log and a monthly infection control summary shall be done on halls to compare source, symptoms exhibited, culture results, treatment, etc. to monitor for any patterns of organisms on residents/halls by the Director of Nursing/or Staff Developer and/or RN Supervisors. The RN Supervisor and Staff Developer shall use a QA monitor sheet to observe perineum/catheter care being done by CNA's on halls 3 x weeks 4 months then weekly x 1 year. They shall educate any staff member during observation of perineum/catheter care	

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F 312	Continued From page 10 Resident #1 ' s perineum, the NA replied he had gone from back to front, but had been taught to wash from front to back. The NA acknowledged he had used the same bath cloth and the same water he had used to bathe her upper body. NA #2 was interviewed at 11:02 AM on 3/15/16. He stated he had made an honest mistake in bathing Resident #1 ' s perineum from back to front. He stated he had also been taught to change the water and the bath cloth prior to providing perineum care, but stated he was nervous and had forgotten. NA #2 added it was important to change the water and the cloth and important to cleanse the perineum from front to back to minimize bacteria in the urinary tract system. On 3/15/16 at 11:11 AM, Nurse #1 was interviewed. The nurse stated when providing perineum care, the area should be cleansed from front to back and the water and bath cloth should be changed to help prevent urinary tract infections. The Staff Development Coordinator was interviewed on 3/15/16 at 11:29 AM. She stated staff were trained to provide perineum care to a female by using clean water and a clean cloth and cleansing from front to back. The Director of Nursing (DON), was interviewed on 3/15/16 at 1:20 PM. She stated NAs were taught to wash the resident ' s perineum from front to back to decrease the risk of infection. The DON stated she expected the NAs to change the bath water and use a clean bath cloth when bathing the perineum to decrease the risk of infection. 2. Resident #5 was admitted to the facility on 11/25/15 with diagnoses that included an Escherichia coli (E. coli) urinary tract infection, coronary artery disease and multiple pressure	F 312	when needed immediately. If CNA/Licensed Nurse continue to provide improper perineum/catheter care, it shall be reported to the Director of Nursing for further disciplinary actions. The QA monitor sheet being used to document whom they observed, the date, if they educated them for any reason and given to the Director of Nursing weekly. The Director of Nursing, Medical Director, Staff Developer, Administrator, and Licensed Nurses shall review/revise the Quality Assurance sheet to monitor compliance quarterly.	

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ulcers.
Review of laboratory results dated 12/18/15 revealed the resident ' s urine culture had grown more than 500,000 colonies of E. coli per milliliter of urine (there should be no E. coli in urine). Results of the urine culture were reported to the physician and an antibiotic was ordered.
A 1/29/16 change in status Minimum Data Set coded Resident #5 as moderately cognitively impaired with no behaviors. Staff was required to provide extensive/total assistance with all activities of daily living and the resident had an indwelling urinary catheter.
The care plan with a 2/12/16 review date identified the resident was at risk for urinary tract infections (UTI) due to an indwelling urinary catheter placement related to multiple pressure ulcers. Interventions to prevent a UTI included washing and cleansing the perineum area front to back.
Review of a lab, dated 2/11/16, revealed Resident #5 ' s urine culture grew 50,000-100,000 colonies of E.coli and 10,000-50,000 colonies of Providencia stuartii per milliliter of urine. The physician was notified and an antibiotic was ordered.
Nursing assistant (NA) #1 was observed providing a bed bath, including perineum/catheter care on 3/15/16 at 8:28 AM. The NA bathed Resident #5 ' s upper body, rinsed her and dried her skin with a towel. Using the same bath cloth and water, the NA bathed the resident ' s perineum area. She washed the catheter using the same bath water and bath cloth using back to front strokes. After providing the resident ' s perineum care, NA #1 stated she changed the water after washing the resident ' s upper body and before providing perineum care.
ON 3/15/16 at 10:40 AM, NA #1 was interviewed.

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She stated she was not taught to change the bath water or bath cloth prior to providing perineum care or catheter care.
Nurse #1 was interviewed on 3/15/16 at 10:55 AM. The nurse stated NAs were expected to change both the bath water and bath cloth prior to providing perineum or catheter care; adding the perineum should be washed from front to back.
The Staff Development Coordinator was interviewed on 3/15/16 at 11:29 AM. She stated staff were trained to provide perineum care to a female resident by using clean water and a clean cloth and cleansing from front to back.
The Director of Nursing (DON), was interviewed on 3/15/16 at 1:20 PM. She stated NAs were taught to wash the resident ' s perineum from front to back to decrease the risk of infection.
The DON stated she expected the NAs to change the bath water and use a clean bath cloth when bathing the perineum to decrease the risk of infection.

3. Resident #7 was readmitted 6/6/12 with diagnoses which included stroke and dementia.
The most recent Quarterly Minimum Data Set (MDS) of 1/7/16 indicated she was cognitively intact, had verbal behaviors and was totally dependent on staff for bathing and always incontinent of bowel and bladder. She was identified as having impaired movement on one side involving both her upper and lower extremities.
On 3/15/16 at 10:18 AM NA #3 was observed providing Resident #7 ' s morning care including perineum care. NA #3 bathed the residents upper body then rinsed with a separate cloth from a second basin of rinse water. NA #4 dried the upper body with a towel. NA #3 used the same cloth and wash water to wash the resident ' s

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front perineum area with a back and forth motion. She place the wash cloth back in the soapy water and used the rinse wash cloth to rinse the front perineum area. NA #4 dried the area with a new towel. NA #3 went back to the soapy water and retrieved the same wash cloth and washed the front of the resident ' s legs then used the same rinse cloth to rinse the front of the legs. NA #4 dried the legs with a clean towel. NA #4 turned the resident on her right side. NA #3 obtained a clean wash cloth and wet it in the same soapy water then washed Resident #7 ' s back and buttocks. She used moistened paper towels to clean fecal material from the resident. She disposed of the soiled paper towel in the resident ' s toilet and returned to the bedside without removing her gloves or washing her hands. She then used the same wash cloth and the same soapy water to clean the resident ' s buttock area in a back and forth motion. NA #3 then used the same rinse cloth to remove soap from the area and a clean towel to dry. Clean under pads and an adult brief were placed under the resident and she was positioned on her back and dressed. NA #4 brought the lift in to the room. NA #3 was observed leaving the room with gloved hands carrying a battery pack for the lift. She returned to the room with the same gloved hands carrying a new battery pack. The lift was then removed by NA #4 because it was still not working. NA #3 left the room with gloved hands, retrieved the soiled linen hamper and rolled it to the door of the room, placed the soiled linen in the hamper, removed her gloves and washed her hands.
An interview was conducted on 3/15/16 at 11:20 AM with NA #3. She stated she was trained to use 2 pans of water, 2 wash clothes and 1 towel for bathing and perineum care. She further stated she was trained to change the washcloth

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F 312	Continued From page 14 after performing perineum care. She stated she was taught to change her gloves when they became soiled or very wet. She stated she could not always see feces on her gloves and probably should have changed them after cleaning the feces. NA # 3 stated she was taught to wash her hands after removing linens from the room, disposing of her gloves and then return to the same room and wash hands. She stated she probably should have washed her hands after removing feces from the resident. An interview was conducted on 3/15/16 at 11:34 AM with the Staff Development Coordinator (SDC). She stated during orientation new NAs are given the facility policy on perineum care and bathing. The new NA is paired with a seasoned NA for completion of skill validation. Currently, there is no nurse interaction to validate skills other than random observations. She stated there is no documentation of these random observations. She stated the NAs are expected to change the water and washcloth before performing perineum care to avoid contaminating the area and prevent urinary tract infections. She further stated that she would expect the NA to wash her hands and re-glove after cleaning the perineum or removing feces. An interview was conducted on 3/15/16 at 1:20 PM with the Director of Nursing (DON). She stated NAs were expected to wash the perineum from front to back to decrease risk of infection. The DON stated she expected the NAs to change the bath water and use a clean bath cloth when bathing the perineum to decrease the risk of infection. She stated she expected hands to be washed and gloves changed after cleaning fecal material.	F 312		
F 315	483.25(d) NO CATHETER, PREVENT UTI,	F 315		4/10/16

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F 315 SS=D	Continued From page 15 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 observation, staff interviews and record review, the facility failed to secure a urinary catheter for 1 of 2 sampled residents (Resident #5) who were reviewed for the use of an indwelling urinary catheter. Findings included: Resident #5 was admitted to the facility on 11/25/15 with diagnoses that coronary heart disease and multiple pressure ulcers requiring the use of an indwelling urinary catheter. The resident ' s care plan, last reviewed on 12/15/15, identified the use of a urinary catheter, but did not include an intervention of securing the catheter to prevent accidental dislodgement. A 1/29/16 significant change in status Minimum Data Set (MDS) coded Resident #5 as moderately cognitively impaired, requiring staff to provide extensive to total assistance with activities of daily living and having an indwelling urinary catheter. Nurse progress notes for 2/9/16 at 11:15 AM indicated during treatment, Resident #5 ' s catheter came out with the bulb inflated	F 315	F315 Residents who enter the facility without an indwelling catheter shall not be catherized unless the resident's clinical condition demonstrates the necessity; and incontinent bladder residents shall receive appropriate treatment and services to prevent UTI and restore as much normal bladder functions as possible. Admission/Readmission and all in-house resident to include resident #5 shall have their urinary catheter secured with the use of a catheter holder leg band. All in-house residents to include resident #5 have catheter holder leg bands in place. We have placed on each in-house residents treatment sheet, that have catheters, to check every shift by licensed nurse that the privacy bag (fig leaf catheter bag) and the catheter holder	

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F 315	Continued From page 16 Nursing Assistant (NA) #1 was observed providing a bed bath on 3/15/16 at 8:28 AM. Resident #5 ' s urinary catheter was not secured to her thigh. On 3/15/16 at 10:40 AM, NA #1 was interviewed. NA #1 acknowledged she had been assigned to care for Resident #5 today and yesterday. She added she had been aware Resident #5 had no leg strap to secure the catheter. She was unable to remember the last time she had seen a leg strap securing Resident #5 ' s catheter and stated some residents had leg straps and some did not. The NA added she had not informed anyone about the missing leg strap because she was unsure why a resident would need a leg strap. Nurse #1 was interviewed on 3/15/16 at 10:55 AM. Nurse #1 stated it was the responsibility of the nurse to make sure catheters were secured with a leg strap. She stated the absence of a leg strap had not been reported and she had not noticed the leg strap was missing. On 3/15/16 at 11:34 AM, the Staff Development Coordinator (SDC) was interviewed. The SDC stated the expectation was for the assigned nurse to place a leg band to secure catheters on all residents with catheters. She added this was done to decrease the risk of pulling the catheter out. The SDC added the NA would be expected to report the leg band ' s absence so the nurse could replace the device. The Director of Nursing (DON) was interviewed on 3/15/16 at 1:30 PM. The DON stated all catheters should be secured with a leg band to keep the catheter from pulling. The NA should report it to the nurse if a leg band was not present.	F 315	leg bands are in place. The Care Plans for in-house residents, to include #5, admissions/readmissions with catheters shall have the privacy bag and catheter holder band on them by MDS Nurses for each assessment per the RAI manual assessments to achieve and maintain compliance. The nursing staff shall be in-serviced on maintaining use of the urinary privacy bag and catheter holder band for each resident in-house. The CNA's shall observe during ADL care of residents for these items also. The CNA's are to report to the RN Supervisor and charge nurse on the hall daily if they find there items soiled or not in place so that the licensed staff can correct it immediately. A QA monitor sheet shall be used by Staff Developer and LPN's to monitor placement of privacy bag and catheter leg band holder 3 x week x 3 months then 2 x month x 1 year for all in-house residents with urinary catheter. The Director of Nursing, Medical Director, Staff Developer, Administrator, and Licensed Nurses shall review/revise the Quality Assurance sheet to monitor compliance quarterly.	
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		4/10/16

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F 441 SS=D	Continued From page 17 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		

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F 441	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to wash hands after handling dirty linens and removing gloves and prior to distributing food items for 1 of 1 observation of staff handing dirty linens. Findings included: On 3/15/16 at 10:12 AM Nursing Assistant (NA) #3 was observed coming out of Resident #8 ' s room with gloved hands carrying linens. She walked to the soiled linen hamper which was positioned 2 rooms up the hall and deposited the linen in the hamper, removed her gloves, deposited the gloves in a trash bag tied to the handle of the hamper and walked to the nurse ' s station to retrieve morning nourishments. She delivered resident nourishments to the first two rooms on the hall. On 3/15/16 at 10:15 AM an interview was conducted with NA #3. She stated after depositing linen in the soiled linen hamper, gloves are removed and disposed and the NA was to return to the room they came out of to wash hands. When asked if she had washed her hands before going to the nurse ' s station to retrieve morning nourishments, she stated, " Oops, I guess I didn ' t, I usually do. " On 3/15/16 at 11:34 AM an interview was conducted with the Staff Development Coordinator. She stated the NAs are expected to remove dirty linens by holding them with gloved hands away from their body. The soiled linen hampers are to be placed at the midpoint of the hall. Gloves are to be removed and disposed in a trash bag attached to the linen hamper. The NA is then expected to return to the room they came out of and wash hands. She stated not washing	F 441	F441 The facility shall establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of diseases and infection. The nursing staff shall wash hands after handling dirty linen and removing gloves before distributing food items. In-house residents, admissions/readmissions, including resident #8, shall have food items distributed daily by nursing staff after washing hands. Staff have been re-in-serviced on when hands should be washed including before distributing of food. Hand washing procedures was discussed during the in-service also. A QA monitor sheet shall be used by charge nurses, Staff Developer, and RN Supervisor to observe 3 CNA's while on halls, coming out of rooms, taking linen to barrel, removing gloves and going back in the same room and washing their hands before proceeding to do anything else for a resident, to include passing of food items 3 x week x 3 months then weekly x 1 year. They shall report any issues/concerns directly to the Director of Nursing immediately for guidance.	

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F 441	Continued From page 19 hands between handling dirty linens and passing food items was unacceptable. On 3/15/16 at 3:15 PM an interview was conducted with the Director of Nursing (DON). She stated it was her expectation that NAs removed dirty linen with gloved hands by holding it away from their body, then deposit gloves in a trash bag and return immediately to the room they just exited to wash their hands. She further stated hands should always be washed before passing morning nourishments.	F 441	The Director of Nursing, Medical Director, Staff Developer, Administrator, and Licensed Nurses shall review/revise the Quality Assurance sheet to monitor compliance quarterly.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		4/10/16

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F 520	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitoring practices to address interventions put into effect after the 10/15/15 recertification survey. During the survey of 10/15/15 the facility was cited at F309 for failure to provide care and services for the highest wellbeing. During the complaint survey of 3/15/16, the facility was recited at F309. The continued failure of the facility during two federal surveys of record shows a pattern of the facility ' s inability to sustain an effective Quality Assurance program. The findings included: This tag is cross referenced to F309 Provide care and services for highest wellbeing. Based on staff interviews and record reviews the facility failed to provide on-going checks of a cardiac pacemaker for 1:1 resident (Resident #1) that was reviewed with a cardiac pacemaker. During the recertification survey of 10/15/15, the facility was cited a deficiency at F309 for failure to assess a dialysis access site for 1 of 1 sampled residents (Resident #98) and failure to recognize a significant change in condition for 1 of 1 sampled residents (Resident #99) that was re-hospitalized within 30 days of admission. On the current complaint survey of 3/15/16, the facility failed to On 3/15/16 at 5:30 PM, an interview was conducted with the Director of Nursing (DON) and Administrator. The DON stated she had added the task to check shunt site for thrill and bruit for dialysis residents on return to facility to the	F 520	F520 The facility shall maintain a Quality Assessment and Assurance Committee that consists of the Medical Director, Director of Nursing, Staff Developer and Licensed Practical Nurses. The QA committee meets monthly x 3months quarterly to discuss issues to which quality assessment and assurance activities are necessary, implement plan of care to correct identified quality deficiencies. #1 E309 483.25 Survey date 3/15/16 – 3/16/16 The facility shall provide the necessary care and services to attain or monitor the highest practicable, physical, mental, and psychosocial well being in accordance with the comprehensive assessment and plan of care. The facility shall provide for in house residents, new admissions/readmissions to include resident #1, that have cardiac pacemakers, to have the pacemaker checked routinely, under the direction of their cardiologist. The Staff Developer shall make their appointment as scheduled routinely by their cardiologist for pacemaker checks. If cardiologist sends letter with date and time for pacemaker to be checked using the	

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F 520	Continued From page 21 Treatment Administration Record (TAR). Nurses were also expected to monitor and document blood pressure 2 hours after return from dialysis. The nurse on the hall was to report any abnormalities to the supervisor. The DON stated she had been monitoring the TAR for compliance. The DON further stated the nurses are to review the 24 hour report and report any changes to the Nursing Supervisor. She explained that the Nursing Supervisor was responsible for notifying the attending physician of any significant changes. The DON stated she made frequent rounds in the facility to monitor for significant changes in residents	F 520	device sent to the facility, the charge nurse/CNA on that hall shall have resident with pacemaker at desk and ready when the office calls to begin check. It shall be documented on the treatment sheet and on the chart that pacemaker was checked by the licensed nurse. On the Admission Information Sheet, done by the MDS Nurses on admission, the resident or RP shall be asked if they have a pacemaker, who is the cardiologist, and when it was last checked so that the Staff Developer can call and find out when it needs to be checked again and schedule appointment. The Staff Developer shall notify the resident and RP of scheduled appointments on weekly basis to include pacemaker check. Licensed nurses on hall have slips put on halls daily for scheduled appointments by Staff Developer or transporter to include pacemaker checks or appointments to cardiologist and other places. The Interim Care Plan /Care Plan shall reflect the presence of a pacemaker on all in-house residents, new admissions/readmissions to include resident #5, done by RN Supervisor or MDS Nurse on admission as well as per RAI Assessment Schedule. RN's, MDS Nurses, Staff Developer, and charge nurses shall be in-serviced on the process of making sure pacemakers are checked routinely as ordered by cardiologist. They are to report to Director of Nursing any issues/concerns during that process immediately.	

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	345240	A. BUILDING _____ B. WING _____	C 03/15/2016

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F 520	Continued From page 22	F 520	A QA monitor sheet shall be used by RN's, Staff Developer, and LPN's to maintain inventory of routine scheduled pacemaker checks per cardiologists schedule (ie: 3 months, 6 months, or 1 year). Primary Care Physician, residents and/or responsible party are to be informed of any issues with pacemakers being checked routinely by cardiologist, to be documented in resident's chart, and reported immediately to the Director of Nursing. The Director of Nursing, Medical Director, Staff Developer, Administrator, and Licensed Nurses shall review/revise the Quality Assurance monitor sheet to monitor #2 E309 Survey Date 10/12/15 – 10/15/15 The facility shall provide the necessary services to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care. The condition of the left arm dialysis access site of resident #98 and all in house dialysis residents, new admissions/readmissions with dialysis access site assessed. The conditions of the dialysis access site and or the presence of a bruit or thrill, when applicable, shall be evaluated and documented by charge nurse Q shift.	

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F 520	Continued From page 23	F 520	Care Plan updated as necessary by MDS nurse. Resident #98 condition of the left dialysis arm access site was checked by charge nurse on 10/14/15 for bruit/thrill, condition of site, checking for bleeding and removal of dressing in 24 hours and shall be documented by charge nurse on hall in chart/or on treatment sheet on the shift and every shift. All in house/readmission of residents with shunt site shall have shunt site assessed for bruit/thrill, bleeding, condition of site and removal of dressing from site 24 hours later after dialysis and documented Q shift by charge nurse on hall in chart/or treatment sheet and on new admissions admission sheet upon being admitted. Nursing Staff to include CNAs, housekeepers (visible only), and etc. to observe dressing when in dressing when in room, for any signs of bleeding and report any residents complaint of pain in upper or lower extremities to charge nurse on hall for evaluation immediately. Certified Nursing Assistants, housekeepers and other nursing staff in-serviced on 10-15-15 by Staff Developer to observe and report any observation of bleeding from residents, change in resident's condition (alertness, complaints of dizziness, profusely sweating) immediately to charge nurse on hall and/or RN supervisor. A Quality Monitor sheet to monitor residents with a dialysis access site shall be used 3 x week by RN supervisor, Staff Developer and charge nurses to check for	

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F 520	Continued From page 24	F 520	thrill/bruit, condition of site, bleeding, etc. x 3 months the weekly x 6 months. Also to check for documentation by charge nurse of this being done Q shift. Resident #99 was taken to the hospital on 7-7-15 and did not return to the facility. All in house residents shall be monitored for change in condition daily by charge nurses on hall, CNAs (sweating, increased confusion, any bleeding, complaints of dizziness, pain) and report to charge nurse their observations. Staff in-serviced by Staff Developer on 10-15-15 to report any changes to charge nurse/RN supervisor. The charge nurse needs to report to RN Supervisor her observations of the residents change. The RN supervisor shall assess for change in condition, (i.e.: skin color, moist skin, irregular heartbeat, fast heartbeat, shortness of breath, breathe sounds.) call MD, report and follow MD orders. The charge nurse on hall can call MD to notify him of BP, Pulse, Temp, skin color, etc. so that the MD can decide whether to send them out or not when RN Supervisor or DON are not available. May call DON 24 hrs./7 days a week to discuss their finding for guidance. If MD decides to send out to hospital, 911 should be called for transport and Responsible Party called about situation or any changes in condition, then Emergency Room called report by charge nurse on that hall as soon as possible. Nurses in-serviced by Staff Developer on 10-15-15 concerning checking bruit/thrill and on notifying RN Supervisor/DON or RN in building of any change in condition	

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F 520	Continued From page 25	F 520	immediately so they can be assesses and notify MD of change in condition for guidance. When RN/DON not available, charge nurse to call MD for guidance. A 24 hour Quality Assurance Report shall be used by charge nurses on hall daily. All changes/resident's concerns shall be addresses daily by RN Supervisor and, DON and RNs shall assess any resident in facility daily whenever informed or they observe any change of a resident and notify MD for guidance. The 24-hour Quality Assurance sheet and the Quarterly Monitor sheet for dialysis site shall be reviewed/revised by Medical Director, DON, RN Supervisor and charge nurses to maintain compliance Quarterly and as necessary. Goal #1 RN Supervisor, Staff Developer, Licensed Practical Nurse shall audit 10% of charts 2 x a month x 3 months then monthly to see if any care issues shall affect residents well being. The Staff Developer, RN's, DON and MDS nurses shall report any issues/concerns observed during audit to primary care physician of residents for guidance (examples: 1, change in fluctuation of BP, 2. FSBS for hyper and hypo, amount of insulin, PO oral agent given, lab values changes of WBC's, HCT, and abnormalities of labs, check medication that residents are on that could affect their values, 4. Check for intake, cardiac/kidney problems, 5. After chart audit of resident go to	

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F 520	Continued From page 26	F 520	CNA's/LPN's/RN on hall to find out if they have observed any changes in residents functioning, physical and mental conditions that shall be addressed per primary care physician for further guidance of care. The Director of Nursing, Medical Director, Staff Developer, Administrator, and Licensed Nurses shall review/revise the Quality Assurance sheet to monitor compliance quarterly.	