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 _____	C 06/24/2016

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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure resident's privacy by failing to knock before entering 4 of 4 residents rooms during observation of the medication pass by 1 of 2 nurses. Findings included:	F 164	The statements made on this Plan of Correction are not an admission to and donot constitute an agreement with thealleged deficiencies.To remain in compliance with all Federal and State Regulations the facility has taken or will	7/15/16

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

Electronically Signed | 07/14/2016

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F 164	Continued From page 1 During the medication pass observation on 6/23/2016 with nurse #1 the following was observed: 1) At 8:15 AM, Nurse #1 entered resident #39's room and stated she was going to wash her hands prior to medication preparation. The door to the room was partially closed when Nurse #1 entered. Nurse #1 did not knock upon entering the room. Resident #39 was sitting in a wheelchair beside the bed when nurse #1 entered the room and Nurse #1 informed resident #39 she was going to wash her hands. Nurse #1 went into the bathroom, washed her hands and returned to the medication cart to prepare medications for resident #39. The medications were prepared at the medication cart and at 8:28 AM Nurse #1 entered resident #39's room to administer her medications. 2) At 8:55 AM, Nurse #1 stated she was going to wash her hands and entered room #107. The resident was seated in a geriatric specialty chair facing the window with her back to the door. Nurse #1 walked into the bathroom in room #107, washed her hands and exited the room. 3) At 8:58 AM, Nurse #1 entered resident #15's room to administer medications. 4) At 9:08 AM, Nurse #1 entered resident #15's room again to wash her hands. 5) At 3:45 PM, Nurse #1 entered room #211A to administer medications. The door was partially closed. The resident was sitting in a wheelchair visiting with his spouse. In an interview on 6/23/2016 at 4:15 PM, Nurse # 1 stated she had " only worked at the facility for a couple of months" and was aware she did not knock or announce her presence before she entered the resident's rooms. Nurse #1 stated " I	F 164	take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation ofcompliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F164 A corrective action for affected resident: For residents #39, 107, 15 and 26, the nurse involved was educated by the Director of Nursing on 06/23/2016 regarding privacy practices and knocking on resident doors and awaiting a response prior to entering. All current residents have the potential to be affected by the alleged deficient practice. An audit of staff knocking on doors prior to entering a residents room was completed by the nurse management team by rounding and observing for privacy practices. This audit was completed on 07/11/2016. Systemic changes made were: Inservice education on privacy and knocking on resident doors prior to entering the room will be completed by the Staff Development Coordinator by 07/15/2016. All full time, part time and PRN staff will be educated. The facility specific in-service was sent to each	

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F 164	Continued From page 2 guess I just didn't think about it ". During an interview with the Director of Nursing (DON) on 6/23/2016 at 4:45 PM, the DON reported it was her expectation for every employee to knock and announce themselves when entering resident ' s rooms. The DON stated the facility was home to all the residents and all employees were expected to respect resident's privacy at all times.	F 164	Hospice Provider and Agency Provider whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training by 07/15/2016 will not be allowed to work until training has been completed. 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. The facility plans to monitor its performance by: The Administrator will monitor this issue using the Providing Privacy Quality Assurance Tool for monitoring staff knocking on doors before entering. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by theAdministrator or DON to ensure correctiveaction initiated as appropriate. Compliancewill be monitored and ongoing auditing program reviewed at the weekly QAMeeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		7/15/16

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F 272	Continued From page 3	F 272		

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
Identification and demographic information;
Customary routine;
Cognitive patterns;
Communication;
Vision;
Mood and behavior patterns;
Psychosocial well-being;
Physical functioning and structural problems;
Continence;
Disease diagnosis and health conditions;
Dental and nutritional status;
Skin conditions;
Activity pursuit;
Medications;
Special treatments and procedures;
Discharge potential;
Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
Documentation of participation in assessment.

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F 272	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to accurately assess the dental status for one of eight residents (Resident #39) sampled, which could lead to dental issues for the resident. Findings included: Resident #39 was admitted on 5/15/2014 with diagnoses of stroke, depression and osteoarthritis. The annual Minimum Data Set (MDS) dated 8/25/2015 noted Resident #39 was cognitively intact and was independent for all Activities of Daily Living (ADLs). In section L0200. Dental there were lettered choices that could have been checked. Choice D. was " Obvious or likely cavity or broken natural teeth. " The last choice was selected and indicated " none of the above were present. " On 6/21/2016 at 9:30 AM Resident #39 was observed to have missing teeth and two teeth were black, with one of those teeth angled at the edge of the tooth. At that time Resident #39 stated she only had two teeth. On 6/23/2016 at 1:43 PM, in an interview, the MDS nurse stated she had done the assessment for Resident #39, and Resident #39 had dentures. The MDS nurse stated she would check her assessment. The MDS nurse immediately went to her office and returned and stated the Nursing Assessment was correct, but her annual MDS assessment was incorrect. On 6/23/2016 at 1:51 PM, in an interview, the	F 272	The statements made on this Plan of Correction are not an admission to and donot constitute an agreement with thealleged deficiencies.To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation ofcompliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F272 Corrective Action for Resident Affected: On 07/11/2016, Resident #39, the MDS assessment was reviewed by the MDS Coordinator. Section L will be coded accurately on the annual MDS assessment with ARD of 07/15/2016. Corrective Action for Resident PotentiallyAffected All current residents have the potential to be affected by this practice. On 07/11/2016, an audit of all current residents dental status was conducted by the MDS Coordinator and compared to the residents most recent MDS assessment for accuracy. If incorrect coding was noted, a modification assessment will submitted by 07/15/2016 and the plan of care updated if indicated by the MDS Coordinator.	

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F 272	Continued From page 5 Director of Nursing stated her expectation was the MDS assessment would be accurate.	F 272	Systemic changes: On 07/14/2016, the MDS Coordinator was in-serviced by the MDS Consultant on accurate coding of MDS item Section L Dental: MDS Coordinator will physically assess the resident during the 7day look back period for status of oral cavity, use of dental appliance and prescence of dental carries. This information has been integrated into the standard orientation training for MDS Coordinators and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The DON will audit three residents for MDS accuracy of section L. This will be completed weekly times 4 weeks then monthly for two months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by theAdministrator or DON to ensure correctiveaction initiated as appropriate. Compliancewill be monitored and ongoing auditing program reviewed at the weekly QAMeeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312		7/15/16

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F 312	Continued From page 6 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide personal care for one of two residents observed (Resident #41) during personal care, which could have resulted in the resident ' s perineal area becoming irritated from being unclean. Findings included: Resident #41 was admitted on 5/1/2015 with diagnoses of vascular dementia, stroke, anxiety and history of urinary tract infection (UTI). The significant change Minimum Data Set (MDS) dated 4/29/2016 noted Resident #41 to be severely impaired for cognition and needed extensive to total assistance for all Activities of Daily Living (ADLs), with the physical assistance of one person. The Care Area Assessment (CAA) noted the ADL function was addressed in the care plan. The care plan dated 7/9/2015 noted a focus of the resident would participate in grooming, personal hygiene, toileting, transfer and bathing with one person assist. The goal was the resident would remain clean and free of odor for 90 days. Interventions included: Assist the resident with toileting, pericare, combing hair and dressing every shift. Provide whirlpool bath 2 times per week. Perineal care after each incontinent episode. Assist to toilet as requested and	F 312	The statements made on this Plan of Correction are not an admission to and donot constitute an agreement with thealleged deficiencies.To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation ofcompliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 312 A corrective action for affected resident: For resident #41, the Nursing Assistant involved was reeducated on 06/21/2016 by the Staff Development Coordicator. Topics discussed were providing perineal care after elimination and during the AM care. All current residents who require assistance with incontinence have the potential to be affected by the alleged deficient practice. All current residents ADL flow sheets were audited by the Nurse Mangers to identify	

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F 312	Continued From page 7 needed. On 6/23/2016 at 10:41 AM, an observation was made of morning care with Nursing Assistant (NA) #1. NA #1 brought a wet washcloth to the bedside and wiped Resident # 41 ' s eyes and face. NA #1 got Resident #41 up and walked her to the bathroom, assisted Resident #41 to sit on the toilet and the Resident urinated. NA #1 gave Resident #41 tissue paper and the Resident cleaned herself. NA #1 took off Resident #41 ' s pajamas, brief, bra and socks, washed the Resident ' s underarms, applied deodorant and put on clean socks, brief, bra and clean pajamas and assisted Resident #41 back to bed. On 6/23/2016 at 10:58 AM, in an interview, NA #1 stated she was oriented when she started two weeks ago. NA #1 indicated between spa bath days every other day, Resident #41 would be washed off. When asked what that would include, NA #1 stated it would include face washed, under arms washed and pericare. When asked if she provided pericare, NA #1 said " no. " In an interview on 6/23/2016 at 11:10 AM, the Director of Nursing (DON) stated NAs were oriented when they were hired and there was a checklist they must be checked off on. The DON stated that pericare was a part of ADLs every day. A review of the Nurse Aide New Hire Skills Checklist for NA #1 revealed all ADL skills were marked as satisfactory and the checklist was signed by NA #1 and the Staff Development Coordinator (SDC). On 6/23/2016 at 2:36 PM, in an interview, the SDC nurse stated new NAs were oriented with	F 312	residents who require are incontinent of bowell or bladder. This was accomplished by reviewing each residents Continence documentation in the ADL book for the past 14 days. This audit will be completed by 07/13/2016. Residents noted with any bowell or bladder incontinence atleast once during the 14 day look back will be careplanned by the MDS Coordinator for incontinence and interventions to manage the incontinent episodes were care planned. This process will be completed by 07/15/2016. Systemic changes made were: Inservice education on providing perineal care during bathing and incontinence care will be completed by the Staff Development Coordinator by 07/15/2016. All full time, part time and PRN Nurses and CNA's will be educated. The facility specific in-service was sent to each Hospice Provider and Agency Provider whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training by 07/15/2016 will not be allowed to work until training has been completed. 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. The facility plans to monitor its	

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F 312	Continued From page 8 another NA for about a week. The SDC nurse noted NA #1 did not provide pericare, and required more education.	F 312	performance by: The Staff Development Coordinator will monitor this issue using the ADL Care Quality Assurance Tool for monitoring perineal care during bathing. This will be completed weekly for 4 weeks monitoring 5 residents weekly for timely incontinence care then monthly times 2 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by theAdministrator or DON to ensure correctiveaction initiated as appropriate. Compliancewill be monitored and ongoing auditing program reviewed at the weekly QAMeeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	