STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	06/23/2016

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LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #WC8F11.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		7/8/16

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

Electronically Signed | 07/15/2016

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review, family and staff interviews, the facility did not notify family of the development of a pressure ulcer for 1 of 3 residents (Resident #40) who were reviewed for pressure ulcers. Findings included: Resident #40 was admitted to the facility on 06/04/15 and readmitted on 05/31/16. Cumulative diagnoses included malignant penile cancer, hypertension, chronic obstructive pulmonary disease and fractured left femur. The most recent Significant Change Minimum Data Set (MDS) assessment of 06/07/16 indicated Resident #40 had no pressure ulcers. The most recent care plan, updated 06/08/16, identified several problem areas including impaired function, needing assistance with all activities of daily living, potential for skin breakdown and risk for falls. A physician's telephone order of 06/17/16 written by Nurse #2 indicated to cleanse the open area to the left side of Resident #40's buttock with normal saline, apply silver hydrogel and a dry dressing daily. There was no nurse's note describing the discovery of Resident #40's sacral wound and no note indicating his family had been notified. A physician's progress note of 06/17/16 documented Resident #40 had metastatic penile cancer. It also documented a wound to his buttock and treatment was implemented.	F 157	F157 Standard Disclaimer: This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice. Family legal representative(s) (FLR) has been informed of Resident # 40 wound status and overall condition. All FLR's for residents with pressure ulcers have been informed of resident's status on weekly basis and or/change in condition. All Nursing Staff have been in-serviced on Notification of Changes, including wound status, development of wounds and changes in condition/orders. The DON. and/or designee will monitor for appropriate FLR notification of skin changes utilizing Nursing FLR Notification Checklist: Wkly skin audits, 24 Hr. Reports, Daily Order reviews and nurse note audits on a weekly basis x 4 wks. and monthly thereafter. The Administrator and/or designee will perform random audits of nursing documentation for compliance with notification of skin changes. Any identified discrepancies shall be reported and remediated immediately.	

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F 157	Continued From page 2 During a family interview, on 06/21/16 at 2:27 PM, it was reported that Resident #40 had been home for Father's Day on 06/18/16 and an open wound was discovered by the family. It was also reported that the family had not been notified of the new area and expressed concern. During an observation of personal care on 06/22/16 at 11:15 AM, Nurse Aide #2 (NA #2) was completing a bed bath. A dressing was noted in place to Resident #40's sacral area. A note from the palliative care physician of 06/22/16 indicated that Resident #40 was comfort care due to terminal end stage metastatic cancer. It noted that he had a new wound to his left buttock/sacrum which was most likely related to the cancer. During an interview with the palliative care physician on 06/22/16 at 3:00 PM, he reported he had been notified that Resident #40 had developed a new pressure wound due to his progressive decline. He reported his family as being very involved in his care. Wound care was observed being provided to Resident #40 on 06/23/16 at 9:30 AM. Upon observation it was noted that Resident #40 had a stage 2 pressure ulcer that measured approximately 1 centimeter by 1 centimeter with pink and yellow tissue in the wound bed. Nurse #3 was interviewed on 06/23/16 at 9:45 AM. She stated Resident #40's family visited daily and earlier in the week his family was here. Nurse #3 stated the family member expressed concerns about not being notified of an open wound on his sacrum. She stated apparently the	F 157	The plan of correction for this alleged deficient practice shall be included as an addendum to the facility's most recent QAPI Committee meeting minutes. Additionally, the DON, Administrator and/or designee shall report any episodes of non-compliance in FLR notification to QAPI Committee monthly for three months and then quarterly thereafter. Completion 7/8/16 .	

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F 157	Continued From page 3	F 157		

family was providing care over the weekend and saw the wound. Nurse #3 stated it was the hall nurse's responsibility to notify family members any time there was a change in their condition. She commented that she had written a note and placed it on the front of Resident #40's chart indicating that family wanted to be notified of every change no matter what the change was.

The Administrator was interviewed on 06/23/16 at 9:50 AM. She stated a nurse's note should be written any time any skin changes were discovered. She stated the family should be notified as soon as possible but staff didn't usually wake family members up on third shift unless it was an emergency. The Administrator stated family members should be contacted the next morning if it was discovered on third shift.

During an interview with the Director of Nurses (DON), on 06/23/16 at 1:10 PM, she stated the hall nurses were responsible for notifying family members of any changes including new open areas, abnormal laboratory results and any changes in treatments. She stated notification should be done as soon as feasible and the nurse should not wait several days to report it to the families. The DON stated she was not sure which nurse had originally discovered Resident #40's sacral wound. She commented if it was found on third shift the nurse would not call and wake the family unless it was an emergency but they should be passing it on to the oncoming nurse for notifying them the next day.

Nurse #2 was interviewed via telephone on 06/23/16 at 2:15 PM. She stated a new open wound was discovered some time during the third shift on 06/17/16 but couldn't remember what

07/08/16

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F 157	Continued From page 4 time. She stated she obtained a physician's order for treatment. She denied telephoning the family because it was early morning. Nurse #2 stated she should have passed it on to the oncoming nurse so they could notify his family but she couldn't say for sure that she did that.	F 157		
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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to remove the facial hair from 1 of 4 sampled residents (Resident #12) whose bath and morning care were observed. Findings included: Resident #12 was readmitted on 9/9/15 with diagnoses that included hypertension, cardiac arrhythmia and osteoporosis. Review of the 9/22/15 Change in Condition Minimum Data Set (MDS) coded Resident #12 with short and long term memory impairment and severely impaired cognitive skills for daily decision making. Rejection of care was not identified. The MDS also indicated Resident #12 required extensive to total assistance for all activities of daily living.	F 312	F312 Standard Disclaimer: This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice. Resident #12 has had appropriate care for facial hair with care plan updated and is free of facial hair. All residents have been assessed and are free of facial hair unless care plan indicates otherwise as personal preference. All Licensed Nursing Staff have been in-serviced on grooming expectations to	7/8/16

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F 312	Continued From page 5 Resident #12's care plan reviewed on 5/26/16 indicated she would remain clean and neat. Observations were made of Resident #12 on 6/20/16 at 3:21 PM, 6/21/16 at 3:40 PM, 6/22/16 at 10:00 AM at which time white and gray facial hair was seen on the resident's chin. On 6/22/16 at 11:04 AM, Nurse Assistant (NA) #1 was observed providing Resident #12 with a bed bath. The NA did not remove Resident #12's facial hair. NA #1 was interviewed on 6/22/16 at 2:44 PM. The NA stated female residents were to be shaven every other day and as needed. She stated she had last shaven Resident #12 on 6/19/16. The NA acknowledged Resident #12 had needed to be shaven when she bathed her earlier, but she had not had time to shave the resident. An observation was made on 6/23/16 at 9:15 AM. Chin hair was visible on Resident #12. Nurse #1 was interviewed on 6/23/16 at 9:33 AM. She agreed female residents needed to be shaven if facial hair was present. During with an observation made with Nurse #1 at this time, she acknowledged Resident #12 needed to be shaven. On 6/23/16 at 11:15 AM, the Administrator was interviewed. She stated female residents should be shaven based upon need. During and interview with the Director of Nursing (DON) on 6/23/16 at 1:20 PM, she stated female	F 312	include facial hair removal for male and female residents. The DON, Administrator and/or designee shall ensure compliance by randomly monitoring resident grooming and removal of facial hair 3xwkly for 4 weeks and weekly thereafter. All resident grooming will be observed during daily rounds. Any identified discrepancies shall be remediated immediately. The plan of correction for this alleged deficient practice shall be included as an addendum to the facility's most recent Quality Assurance Committee meeting minutes. Additionally, the Administrator and/or DON shall report any episodes of non-compliance with removal of facial hair for male or female residents to QAPI Committee monthly for three months and then quarterly thereafter.	

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F 312	Continued From page 6 residents were expected to be shaven as needed. The DON added NA #1 had not informed her she was running behind and had been unable to complete her grooming tasks on 6/22/16.	F 312		
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	F 441		7/8/16

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F 441	Continued From page 7 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, a staff member failed to wash hands before and after direct contact with a resident, failed to wash hands before and after wearing gloves and failed to perform clean tasks before dirty tasks for 1 of 4 residents (Resident #37) who was observed receiving personal care. The facility staff also placed dirty linens on the floor while providing personal care for 2 of 4 residents (Resident #37 and #40) whose care was observed. Findings included: 1. A review of the facility's Standard Precautions policy, revised January 2001, indicated all nursing home staff will follow standard precautions at all times when providing direct care to residents. The procedure for the policy indicated the following: A. Hands to be washed before and after direct contact with each resident. B. Gloves should be worn when handling items soiled with blood or body fluids and when emptying the trash and gloves should be changed after each instance of direct resident contact. C. Soiled linen should be handled as little as possible to prevent contamination of the air and of persons handling the linen. Linens soiled with blood or body fluids should be placed and transported in containers that prevent leakage. During an observation of resident #37's ADL care on 06/22/16 at 9:45 AM, Nursing Assistant (NA) #1 was observed to knock when entering the	F 441	F441 Standard Disclaimer: This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice. The staff members that provided care to Resident□s #37 and #40 have been educated on correct handwashing, bathing, management of soiled linen and Standard Precautions via demonstration and return demonstration □ NA #1 and NA #2. All Nursing Staff has been in-serviced on hand washing, bathing, management of soiled linen and Standard Precautions via demonstration and random selection of return demonstration with co-workers in group setting. DON and/or designee will complete random audits for compliance in handwashing, bathing and soiled linen management 3x wkly x 4 weeks, weekly thereafter. Variances will be reported to Administrator.	

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F 441	Continued From page 8 resident's room, close the door to the room, put on gloves and fill the basin with water from the bathroom sink. NA #1 removed the resident's soiled gown and placed it on the floor and began the resident's bed bath. After NA #1 had washed the resident's upper body, NA #1 placed two soiled washcloths on the floor and refilled the basin with fresh water. NA #1 rolled the resident on her side and washed her back and the back of her legs and then her buttocks, which were soiled with bowel movement. NA #1 placed the soiled washcloth on the floor. NA #1 placed a clean pad underneath the resident, applied a barrier cream to the resident's buttocks and vaginal area, put a clean adult brief on the resident and put a clean top sheet over the resident. NA #1 placed a soiled pad and a soiled top sheet on the floor. NA #1 emptied the basin and removed her gloves. NA #1 raised the resident's head of bed using the manual levers at the foot of the bed, arranged the top sheet neatly over the resident and placed a towel under the resident's chin, across her chest. NA #1 put on gloves, gathered supplies to brush the resident's teeth and then brushed the resident's teeth. NA #1 removed her gloves, tied a knot in the trash bag and gathered the soiled linens, holding them with her bare hands and arms. NA #1 opened the door of the room with her soiled hand and disposed of the garbage and soiled linen in the hallway cart. NA #1 went into room #212 to be interviewed and closed the door with her soiled hand. During an interview with NA #1 on 06/22/16 at 10:16 AM, NA #1 stated she should have washed her hands before and after wearing gloves and stated she had been nervous and had forgotten to do so. When asked where she was supposed to put soiled linens, NA #1 did not answer. When asked why she put soiled linens on the floor, NA	F 441	Administrator will monitor compliance with Standard Precautions during daily rounds. Variances will be addressed immediately and reported to QAPI committee for further review. The plan of correction for this alleged deficient practice shall be included as an addendum to the facility□s most recent Quality Assurance/Performance Improvement Committee meeting minutes. Additionally, the Administrator, Director of Nursing and/or designee shall report any episodes of noncompliance with Standard Precautions, including hand washing, bathing, and soiled linen management to the QAPI Committee monthly for three months, then quarterly thereafter.	

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F 441	Continued From page 9	F 441		

#1 stated she had not been aware she could not put soiled linens on the floor of a resident's room. During an interview with the Administrator on 06/22/16 at 12:55 PM, the Administrator stated it was her expectation that staff washed their hands before putting on gloves and after removing gloves. The Administrator stated soiled linen should not be placed on the floor as it breaks infection control barriers.

2. Upon entrance into Resident #40's room, on 06/22/16 at 11:15 AM, the privacy curtain was pulled around the bed. There were several towels and wash clothes as well an adult brief noted on the floor. Nurse Aide #2 was in the process of providing a bed bath to Resident #40. She continued with the bath. Upon completion of the bed bath, she picked the linens and brief up from the floor and placed them in separate plastic bags. She walked down the hall and disposed of both bags into the hampers located on the hall.

NA #2 was interviewed immediately following the observation on 06/22/16 at 11:30 AM. She stated she had gotten busy with Resident #40's bed bath and had thrown the linens on the floor. She stated she had forgotten to place the dirty linens in a plastic bag. When questioned as to the facility's expectation for handling soiled linens, she responded that she was not to place dirty or soiled linens on the floor. When questioned about the brief that was on the floor, she stated it had stool on it and she should have placed it in the trash can rather than placing it on the floor.

The Director of Nurses (DON) was interviewed on 06/23/16 at 1:10 PM. She stated it was her expectation that soiled linens and/or briefs should

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F 441	Continued From page 10 not be placed on the floor at any time. She stated soiled linens should be bagged in a plastic bag and placed in the soiled linen hampers. The DON also stated briefs should be bagged in a plastic bag and disposed of in the trash receptacle.	F 441		