STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING _____ B. WING _____	C 05/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #4DEG11. 05/31/16 Upon review of the facility's explanation and supporting documentation regarding the disputing of F250 (D), the survey team has deleted this citation from the 2567. Event ID #4DEG11.	F 000		
F 166 SS=E	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right	F 166		5/31/17

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

Electronically Signed | 05/24/2017

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F 166	Continued From page 1	F 166		

to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions

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F 166	Continued From page 2 regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure the grievance investigations and resolutions were provided in writing to 3 of 3 sampled residents and/or their responsible parties (Residents #25, #63 and #69) and the facility failed to update the grievance policy to include requirements to issue written grievance decisions to residents. Findings included: A review of a facility policy titled Investigating Grievances/Complaints that was not dated revealed in part the facility investigated all grievances and complaints filed with the facility however the policy did not include requirements to issue written grievance decisions to residents.	F 166	How the corrective action will be accomplished for the resident(s) affected. On 5-22-17, The Resident Grievance Policy/Procedure was updated to reflect the inclusion of issuing a written grievance decision to the resident and/or designee filing the grievance(s). On 5-22-17, resident(s) and/or designee(s) #25, #63, and #69 all received a formal written summary of their individual resident grievance(s) and the corrective action(s) taken to address the concern(s). Documentation of receipt of the written grievance findings by the resident and/or designee will be kept with the original grievance complaint.	

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F 166	Continued From page 3 1. Resident #25 was admitted to the facility on 06/05/15 with diagnoses which included dementia, high blood pressure, chronic pain, heart disease, osteoarthritis and anxiety. A review of the most recent annual Minimum Data Set (MDS) dated 04/11/17 indicated Resident #25 was cognitively intact for daily decision making and was independent with eating but required supervision for all other activities of daily living. A review of a grievance dated 01/09/17 submitted by Resident #25 revealed a concern her medications were not given. The report indicated Resident #25 stated when a nurse brought her medications around 8:00 AM or 8:30 AM she did not get her pain medication. The report further indicated Resident #25 asked the nurse for her pain medication and was told the nurse did not have time and would bring them later. The grievance revealed Resident #25 asked again on her way to exercise at 10:00 AM but did not receive it but at 1:15 PM her nurse finally brought her pain medication to her. The grievance indicated Social Worker #2 followed up with the nurse who did not give the medication and was told Resident #25 had asked for pain medication once that morning. She explained she was giving another resident medication and forgot and Resident #25 had not asked her about pain medication again. The grievance further indicated on 01/10/17 the findings were discussed with Resident #25 but there was no indication a letter had been provided to her. During an interview on 05/05/17 at 3:45 PM with Social Worker #1 she confirmed she was responsible for the oversight of the grievance system in the facility. She stated she was unsure when the policy was written since it was not	F 166	How the corrective action will be accomplished for those resident(s) with the potential to be affected by the same practice. On 5-22-17, all logged grievances will include providing a written grievance decision to the resident and/or designee per the updated policy/procedure. Documentation of receipt of the written grievance findings by the resident and/or designee will be kept on file with the original grievance complaint. Measures put in place to ensure practices will not occur. Effective 5-22-17, all logged grievances will include providing a written grievance decision to the resident and/or designee per the updated policy/procedure. The Social Work Department began providing education on 5-24-17 to current employees regarding the Resident Grievance Policy revision to include providing a written grievance decision response to the resident. All new employee orientation education will include the updated policy revision. How the facility plans to monitor and ensure correction is achieved and sustained. The Director of Social Work will report all resident grievances to the Administrator per policy within 5 working days. The Director of Social Work will review all resident grievances to ensure written grievance responses were issued to each individual resident(s) and/or designee(s) within 10 working days.	

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F 166	Continued From page 4 dated. She explained anyone could file a grievance and once the grievance was submitted she verbally contacted the resident or family or the individual who had submitted the grievance to discuss it with them. She stated they gave out information on how to file a grievance when a resident was admitted and they told them if they had any grievances to notify them. She explained if someone was unable to fill out the grievance forms she filled them out for them. She stated once she received the grievance she determined which departments were to be involved and sent the grievance to the appropriate Department Manager. She explained she attached all related documents to the grievance and requested for the Department Manager to respond and she logged it when she received the grievance. She stated she preferred to get responses and resolutions back immediately but sometimes it took time to investigate them but she followed up with Department Managers and it was her goal to have them resolved in 5 days. She explained she and other staff in the facility had attended training in October 2016 regarding new regulations regarding grievances. She confirmed she had not provided any written letters to inform residents of grievance decisions because she preferred to meet and discuss the resolution face to face with them. She verified she had not provided a written letter of the grievance decision for Resident #25's grievance. During an interview 05/05/17 at 4:14 PM the Administrator confirmed the grievance policy had not been updated with new regulatory requirements to provide written letters to residents regarding resolution of grievances. He explained he and several of his staff had attended training last year but they moved into the new	F 166	The Director of Social Work will report the total number of grievances filed and written grievance decision responses to the Quality of Assurance Performance Improvement Committee (QAPI) monthly x (3) months to ensure compliance with changes is sustained, with a decision for continued monitoring if needed.	

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facility in January 2017 and it had not been done. He further stated it was his expectations for SW #1 to provide written letters to residents with the decision and resolution of the grievance.

2. Resident #63 was re-admitted to the facility on 08/05/16 with muscle weakness, vitamin deficiencies, dementia, chronic pain, heart disease, depression and Parkinson's disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 02/10/17 indicated Resident #63 was moderately impaired in cognition for daily decision making and required supervision with eating but extensive assistance with all other activities of daily living.

A review of a grievance dated 02/06/17 revealed Resident #63's family called a Team Leader to report she had received a telephone call from Resident #63 who had stated he had his call light on for an hour and a half because he was waiting to get up and have his shower. The grievance indicated the Team Leader immediately went to the floor to speak with staff and Resident.#63 The grievance further indicated on 02/11/17 the findings were discussed with Resident #63 and family but there was no indication a letter had been provided to Resident #63 or to family.

During an interview on 05/05/17 at 3:45 PM with Social Worker #1 she confirmed she was responsible for the oversight of the grievance system in the facility. She stated she was unsure when the policy was written since it was not dated. She explained anyone could file a grievance and once the grievance was submitted she verbally contacted the resident or family or the individual who had submitted the grievance to discuss it with them. She stated they gave out

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F 166	Continued From page 6	F 166		

information on how to file a grievance when a resident was admitted and they told tell them if they had any grievances to notify them. She explained if someone was unable to fill out the grievance forms she filled them out for them. She stated once she received the grievance she determined which departments were to be involved and sent the grievance to the appropriate Department Manager. She explained she attached all related documents to the grievance and requested for the Department Manager to respond and she logged when she received the grievances. She stated she preferred to get responses and resolutions back immediately but sometimes it took time to investigate them but she followed up with Department Managers and it was her goal to have them resolved in 5 days. She explained she and other staff in the facility had attended training in October 2016 regarding new regulations regarding grievances. She confirmed she had not provided any written letters to inform residents of grievance decisions because she preferred to meet and discuss the resolution face to face with them. She verified she had not provided a written letter of the grievance decision for Resident #63's grievance.

During an interview 05/05/17 at 4:14 PM with the Administrator he confirmed the grievance policy had not been updated with the new regulatory requirements to provide written letters to residents regarding resolution of grievances. He explained he and several of his staff had attended training last year but they moved into the new facility in January 2017 and it had not been done. He further stated it was his expectations for SW #1 to provide written letters to residents with the decision and resolution of the grievance.

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F 166	Continued From page 7	F 166		

3. Resident #69 was re-admitted to the facility on 05/13/16 with diagnoses which included asthma, chronic respiratory failure, diabetes, heart disease and anxiety. A review of the most recent quarterly Minimum Data Set (MDS) dated 01/28/17 indicated Resident #69 was cognitively intact for daily decision making and was independent with eating but required extensive assistance with all other activities of daily living.

A review of a grievance dated 02/06/17 revealed on 02/05/17 Resident #69 rang her call light and asked her nurse for her breathing treatment at 1:00 PM. The grievance indicated family was visiting until 3:00 PM and stated Resident #69 never received the treatment. The grievance indicated an investigation was started on 02/06/17 but there was no indication a letter had been provided to Resident #69 or to family.

A review of a second grievance dated 02/06/17 revealed family was visiting with Resident #69 and felt the room was dirty because there were crumbs on floor, the floor had not been mopped and furniture was dusty. The grievance indicated Social Worker #1 and the Environmental Services Supervisor went to Resident #69's room and assessed concerns. The grievance further indicated a message was left with a family member regarding the resolution and on 03/03/17 Social Worker #1 met with a family member in person to discuss the resolution but there was no indication a letter had been provided to Resident #69 or to family.

During an interview on 05/05/17 at 3:45 PM with Social Worker #1 she confirmed she was responsible for the oversight of the grievance

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system in the facility. She stated she was unsure when the policy was written since it was not dated. She explained anyone could file a grievance and once the grievance was submitted she verbally contacted the resident or family or the individual who had submitted the grievance to discuss it with them. She stated they gave out information on how to file a grievance when a resident was admitted and they told them if they had any grievances to notify them. She explained if someone was unable to fill out the grievance forms she filled them out for them. She stated once she received the grievance she determined which departments were to be involved and sent the grievance to the appropriate Department Manager. She explained she attached all related documents to the grievance and requested for the Department Manager to respond and she logged when she received the grievances. She stated she preferred to get responses and resolutions back immediately but sometimes it took time to investigate them but she followed up with Department Managers and it was her goal to have them resolved in 5 days. She explained she and other staff in the facility had attended training in October 2016 regarding new regulations regarding grievances. She confirmed she had not provided any written letters to inform residents of grievance decisions because she preferred to meet and discuss the resolution face to face with them. She verified she had not provided a written letter of the grievance decision for either of the grievances submitted by Resident #69.

During an interview 05/05/17 at 4:14 PM with the Administrator he confirmed the grievance policy had not been updated with the new regulatory requirements to provide written letters to

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F 166	Continued From page 9 residents regarding resolution of grievances. He explained he and several of his staff had attended training last year but they moved into the new facility in January 2017 and it had not been done. He further stated it was his expectations for SW #1 to provide written letters to residents with the decision and resolution of the grievance.	F 166		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to follow physician orders for dressing changes to pressure ulcers for 1 of 3 residents (Resident #149). The findings included: Resident #149 was admitted to the facility on 04/18/17 with diagnoses which included repair of	F 314	How the corrective action will be accomplished for the resident(s) affected. On 5-5-2017, Nurse #6 was provided immediate verbal education with regard to wound care orders for resident #149. Education included following Primary Care Physician (PCP) orders without exception(s). Additionally, nurse #6 was instructed to call the PCP or skin integrity	6/2/17

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F 314	Continued From page 10 left hip fracture, hypertension and major depressive disorder. Review of Resident #149's Minimum Data Set (MDS) dated 05/02/17 revealed that he was cognitively intact. The MDS indicated Resident #149 required the extensive assistance of 1 to 2 persons with activities of daily living and was occasionally incontinent of urine and always continent of stool. The skin section of the MDS was not completed. Review of the interim care plan dated 04/18/17 revealed Resident #149 was at risk for break in skin integrity and had a break in skin integrity. The Braden scale for predicting pressure sore risk was completed and the resident's score was 17 indicating he was at mild risk of developing pressure ulcers. The care plan also indicated that Resident #149 had a deep tissue injury (DTI) to the sacrum on admission. The care plan indicated on 04/21/17 a pressure reducing cushion was added to the resident's wheelchair. The care plan also indicated on 04/23/17 he developed DTI's to both heels and a low air loss mattress was added to the bed as well as the resident was given foam boots to wear while in bed. Review of the physician's order written 04/18/17 for wound care revealed an order that read: Change dressing to coccyx every 5 days and as needed for soiling under edges of dressing. Cleanse open areas with aloe vesta foam cleanse and warm water, pat dry, apply no sting and adhesive foam dressing. Review of the physician's order written 04/25/17 for wound care revealed an order that read: Santyl ointment - lift edge of foam dressing daily, cleans debris and	F 314	nurse for clarification of order(s) if he/she finds the current order to be unclear. On 5- 4-17, all wound care orders for resident #149 were reviewed and clarification of orders were initiated. How the corrective action will be accomplished for those resident(s) with the potential to be affected by the same practice. All current wound care orders will be reviewed for possible conflicting information and written to reflect standardized verbiage by June 2, 2017. Measures put in place to ensure practices will not occur. Current licensed nursing staff will be educated on the expectation of delivery of treatment(s)/wound care. Expectations include wound care and treatment(s) should be delivered to residents as written. Additionally, licensed nursing staff will be educated to ask for clarification of any wound care order(s) considered unclear or confusing. Initial education will be completed by June 2, 2017 and ongoing thereafter. Licensed nursing staff will receive education with regard to following treatment care per PCP orders during initial orientation. An annual validation of competencies will be performed by all staff responsible for treatments. Validation of competencies will be by one of the following methods; return demonstration, annual education, and/or education and	

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F 314	Continued From page 11 digested material away, apply thin layer of santyl and re-adhere foam dressing. Change dressing to coccyx every 5 days and as needed for soiling under edges of dressing. Cleanse open areas with aloe vesta foam cleanse and warm water, pat dry, apply no sting and adhesive foam dressing. Review of the Treatment Administration Record (TAR) revealed orders written 04/18/17 for wound care to the coccyx daily and as needed for soiling of dressing. Remove old dressing and clean wound with foam cleanser and 4 by 4 gauze, pat dry, apply no sting to peri-wound, santyl to slough and cover with foam dressing. No sting and adhesive dressing to left heel. Change every 3 days. No sting and adhesive dressing to right heel. Change dressing to coccyx every 5 days and as needed for soiling under edges of dressing. Cleanse open areas with aloe vesta foam cleanse and warm water, pat dry, apply no sting and adhesive foam dressing. Review of a Resident Incident Report written on 04/23/17 at 12:00 PM by Nurse #8 and witnessed by nurse assistant (NA) #3, Resident #149 stated that his right heel was hurting. NA #3 examined the resident's heel and noted a bruise covering the heel. NA #3 reported to Nurse #8 the bruise on the resident's heel and Nurse #8 notified the physician and the residents' family member. Nurse #8 applied a foam dressing to the heel and elevated the right foot on a pillow. The resident stated that it felt better after the dressing was applied and leg was elevated. Nurse #8 wrote they would continue to encourage resident to float heels on pillow despite refusal at times and non-compliance. Wound nurse completed assessment and treatment for both heels was	F 314	written test. How the facility plans to monitor and ensure correction is achieved and sustained. The Skin Integrity Nurse/designee will conduct random audits for at least one resident treatment each day (Monday-Friday) daily x (2) weeks; then weekly x (2) months; then monthly. Failure of compliance with the written PCP order(s) will result in immediate action to include additional education and/or disciplinary action. The Skin Integrity Nurse will present/discuss the audit results in the risk meeting with the Interdisciplinary Care Team at least monthly. The DON/designee will report findings to Quality Assurance Performance Improvement Committee (QAPI) monthly x (3) months to ensure compliance with changes is sustained, with a decision for continued monitoring if needed. Failure to achieve compliance will result in education and/or disciplinary action and/or continuation of monitoring.	

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ordered.

Review of a nurses note written on 04/25/17 stated the wound care nurse wrote on 04/24/17 that given the resident's cardiac history, areas of impaired skin integrity were likely unavoidable.

Review of the physician's order written 04/25/17 revealed an order that read: No sting and adhesive dressing to left heel. Change every 3 days. No sting and adhesive dressing to right heel.

Observed wound care on 05/04/17 at 1:33 PM performed by Nurse #6 on Resident #149. Nurse #6 removed the old dressing, washed her hands, applied clean gloves and applied Santyl ointment to the open area with yellow exudate and placed Mepilex (foam) dressing over the area. Resident #149 tolerated the dressing change well without any pain. Nurse #6 also changed the heel dressings. The resident's right heel had a black area on the entire bottom of the heel. The nurse applied a clean Mepilex (foam) dressing to the heel. The left heel had a reddened area on the bottom of the heel and the nurse applied a Mepilex (foam) dressing. Nurse #6 stated the wounds looked worse today.

Interview with Nurse #6 and Nurse #5 on 05/04/17 at 2:55 PM revealed that the orders for Resident #149's dressing changes were confusing. Nurse #6 stated that she discussed the wound care orders with the Wound Care nurse prior to changing the dressing and the wound care nurse told her to just wipe the area with gauze and apply a clean Mepilex (foam) dressing. Both Nurse #6 and Nurse #5 stated the orders were confusing with one order saying

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F 314	Continued From page 13 change daily and the other order saying change every 5 days. Nurse #6 stated that she did not follow the orders as written for Resident #149's dressings to his coccyx and bilateral heels. Review of a nurses note written by Nurse #6 on 05/04/17 at 7:50 PM revealed the wound to the coccyx continues to be open with quarter sized yellow area cleaned with gauze and santyl applied. Covered with Mepilex (foam dressing). New Mepilexes (foam dressings) applied to both heels; heels floated while in bed; low air loss mattress in place and functioning properly. Interview with the Wound Nurse on 05/05/17 at 2:19 PM revealed that she was in charge of the skin integrity program at the facility. She stated that she reviews all the skin assessments done weekly and stages and measures all wounds. The Wound Nurse stated that she provides education to residents, staff and family about wounds. She stated that any new skin concerns are discussed in the morning meetings. The Wound Nurse stated that she does send complicated cases out to the wound clinic or to 2 of the surgical practices in the area for debridement and treatment. The Wound Nurse stated that she expected the nurses providing wound care to follow the physician orders for dressing changes. Interview with the Director of Nursing (DON) on 05/05/17 at 4:45 PM revealed that her expectation was for the nurses to follow the physician orders for dressing changes.	F 314		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		5/31/17

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F 323	Continued From page 14 (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews the facility failed to maintain water temperatures at safe levels to avoid putting residents at risk at resident bathroom sinks in 8 of 69 occupied resident rooms (Room #604, #615, #621, #701, #516, #405, #409, and #105) and failed to ensure a system was in place to record water temperatures on the 500, 600, 700 hall and at the mixing valves in the Mechanical Room and to ensure mixing valves were not tampered with.	F 323	How the corrective action will be accomplished for the resident (s) affected Immediately on 5-4-17 the following actions were implemented to correct the deficient practice set forth by 483.25(d)(1)(2)(n)(1)-(3). The malfunctioning mixing valve that controls the hot water that serves patient rooms was located and isolated from the system. The original installer of the valve was notified that the valve was faulty and was in need of repair.	

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F 323	Continued From page 15 Findings included: A review of the facility Hot Water Temperature Logs were reviewed from January 2017 until May 2017 and revealed water temperatures were recorded on a weekly basis in a resident room on the 100, 200, 300 and 400 halls. There were no water temperatures recorded on the 500, 600 and 700 halls and there were no water temperatures recorded for the mixing valves located in the Mechanical Room. The logs revealed the most recent recorded water temperatures were documented on 05/03/17 as follows: Room #114 water temperature 116.8 degrees Fahrenheit (F) Room #218 water temperature 111 degrees F Room #321 water temperature 112.8 degrees F Room #417 water temperature 113 degrees F On 05/04/17 at 7:45 AM an observation of the hot water in the bathroom at the sink in resident room #615 revealed the hot water was barely warm when it was first turned on but after several minutes the water was too hot to touch, the faucet was hot to touch and steam was rising from the faucet. On 05/04/17 at 7:50 AM an observation of the hot water in the bathroom at the sink in resident room #604 revealed the hot water was barely warm when it was first turned on but after several minutes the water was too hot to touch, the faucet was hot to touch and steam was rising from the faucet. On 05/04/17 at 7:55 AM an observation of the hot water in the bathroom at the sink in resident room #518 revealed the hot water to be cool when it was first turned on but after several minutes the	F 323	On 5-5-17 a representative from the company who installed the system arrived to the facility and made the needed repairs and adjustments. The install representative left that same day. How the corrective action will be accomplished for those resident(s) with the potential to be affected by the same practice. On 5-5-17 Audits were taken of hot water temperatures at faucets that serve residents in other parts of The Foley Center at Chestnut Ridge and adjustments were made to the controlling system to accommodate the minimum and maximum values of water temperature Measures put in place to ensure practices will not occur On 5-8-17, plant operations staff were educated on the proper method of taking water temperature at resident faucets to include a longer test period to ensure no water temperatures are recorded out of regulatory range. In addition, the Plant Operations Manager made changes to the facility policy to include rooms; 100,200,300,400,500,520,600,623,700,703, and at the mixing valve during audits of hot water temperature to ensure the facility complies with North Carolina Health Code 10 A NCAC 132 D. 3404 (D) (1) UNDER SECTION 3400 OF MECHANICLE, ELECTRICAL, and PLUMBING stating that we will comply by providing a supply of hot water to resident of not more than 116 degrees and no less	

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F 323	Continued From page 16 water was too hot to touch and the faucet was hot to touch. On 05/04/17 at 8:00 AM an observation of the hot water in the bathroom at the sink in resident room #405 revealed the hot water to be cool when it was first turned on but after several minutes the water was too hot to touch and the faucet was hot to touch. On 05/04/17 at 8:03 AM an observation of the hot water in the bathroom at the sink in resident room #408 revealed the hot water to be warm when it was first turned on but after several minutes the water was too hot to touch and the faucet was hot to touch. On 05/04/17 at 8:04 AM an observation of the hot water in the bathroom at the sink in resident room #417 revealed the hot water to be cool when it was first turned on but after several minutes the water was too hot to touch and the faucet was hot to touch. On 05/04/17 at 8:10 AM an observation of the hot water in the bathroom at the sink in resident room #204 revealed the hot water to be warm when it was first turned on but after several minutes the water was too hot to touch, the faucet was hot to touch and steam was rising from the faucet. On 05/04/17 at 8:13 AM an observation of the hot water in the bathroom at the sink in resident room #101 revealed the hot water to be cool when it was first turned on but after several minutes the water was too hot to touch and the faucet was hot to touch. During an interview on 05/04/17 at 8:30 AM with	F 323	than 100 degrees. On 5-31-17 a lock was installed on the mixing valve to prevent any unauthorized tampering. How the facility plans to monitor and ensure correction is achieved and sustained. On 5-19-17 the Plant Operations Manager purchased of a new digital thermometer solely for the purpose of resident room water temperature monitoring. On 5-24-17 the Plant Operations Manager/designee began taking water temperature audits in specific areas within the facility (2) X day(Monday thru Friday) for (6) weeks then (2) x week (Monday thru Friday) thereafter. The temperatures will be logged and maintained by the Plant Operations Manager. Findings will be submitted to the Administrator each morning for (6) weeks, then (2) X week thereafter. All temperature findings will be discussed in morning meeting as needed with leadership staff to discuss any trends that would potentially cause unsafe practices. Any unsafe findings will be corrected immediately thru adjustment(s) or replacement of the controlling system(s) that provide hot water to resident faucets. Any water temperatures not meeting the before mentioned value of not more than 116 degrees and no less than 100 degrees will result in the repair, adjustment or replacement of the controlling system(s) of that water temperature and those findings will be brought to the daily morning leadership meeting .	

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F 323	Continued From page 17 an Administrative Assistant she stated she had paged the Maintenance Director but he had not arrived at the facility yet this morning. During an interview on 05/04/17 at 9:07 AM the Administrator stated the Maintenance Director was out of the facility but was expected to arrive soon. During an interview on 05/04/17 at 9:43 AM the Maintenance Director stated his official title was Plant Operations Manager and the facility was new and they had moved into the building on 01/04/17. He stated he had 2 staff maintenance men who worked with him and they utilized a work order system and anybody could fill out a work order either in the computer system or on paper copies at the nurse's station when repairs needed to be made. He explained he or his staff checked water temperatures in resident rooms on a weekly basis usually in the middle of the week. He further explained they had 4 instant hot water boilers that were set at 140 degrees F and there was a large mixing valve for high volumes of water and a small mixing valve for low volumes of water and the mixing valves were set at 116 degrees F because he had to take into account for a little bit of temperature loss as the water traveled through the water lines. He further explained if the water temperatures were above 116 degrees F he adjusted the mixing valves to cool the water. He confirmed he had last checked water temperatures on 05/03/17 and he usually let the water run for a minute to a minute and a half and checked the temperature with a self-calibrating digital thermometer and then recorded the temperature on the log. He confirmed he had not checked water temperatures on the 500, 600 or 700 halls but felt	F 323	The Plant Operations Manager/designee will report findings to Quality Assurance Performance Improvement Committee (QAPI) monthly x (3) months to ensure compliance with changes is sustained, with a decision for continued monitoring if needed.	

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like one of his staff had checked them but they had not documented them. He also confirmed there were no temperatures recorded of the temperatures at the mixing valves.

During an environmental tour on 05/04/17 at 10:20 AM with the Plant Operations Manager and the Administrator, the Plant Operations Manager utilized a self-calibrating digital thermometer to check water temperatures at the sink in resident bathrooms as follows:
Room #604 water temperature 121.0 degrees F at 10:22 AM
Room #615 water temperature 120.2 degrees F at 10:25 AM
Room #621 water temperature 129.7 degrees F at 10:30 AM
Room #701 water temperature 130.8 degrees F at 10:34 AM
Room #516 water temperature 128.6 degrees F at 10:37 AM
Room #405 water temperature 127.2 degrees F at 10:45 AM
Room #409 water temperature 126.6 degrees F at 10:51 AM
Room #105 water temperature 127.5 degrees F at 11:00 AM

During a follow up interview on 05/04/17 at 11:05 AM the Plant Operations Manager confirmed the hot water temperatures were too hot and the water needed to be cooled. He stated he did not realize when the water started getting hot it kept getting hotter and he and his staff had not been letting the hot water run long enough to get an accurate temperature reading.

During an observation and interview on 05/04/17 at 11:14 AM in the Mechanical Room where the

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mixing valves were located revealed a large thermometer mounted on the water pipe above the mixing valves and the temperature reading was verified by the Plant Operations Manager at 126 degrees F. The Plant Operations Manager stated the mixing valve temperature was supposed to be set at 116 degrees F but someone had turned off a valve on the water line so cold water was not mixing with hot water to resident rooms and explained the purpose of the valve was to temper the hot water. He stated he was not sure who had turned the valve off but it was the usual routine for maintenance staff to look at the thermometer during rounds each morning and make sure the thermometer read 116 degrees F. He stated he expected for maintenance staff to report to him if the temperature looked out of the ordinary so he could check it out. The Plant Operations Manager explained the installer of the water system had showed him after the system was installed where to keep the valve on the water line positioned. He then opened the valve partially and the temperature on the thermometer started to decrease and after several minutes the water temperature had dropped to 118 degrees F. He stated he would continue to monitor the water temperatures until they reached 116 degrees F. The Administrator stated he had not received any reports from residents, visitors or staff that water was too hot in resident bathrooms. He also stated he was not aware of any injuries that had occurred due to hot water. The Plant Operations Manager also stated he had not received any reports that water was too hot in resident bathrooms and he had not received any work orders that the water in resident bathrooms was too hot. He further stated he was not aware of any resident injuries related to hot water.

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During a follow up interview on 05/04/17 at 2:25 PM the Administrator stated the Plant Operations Manager was still working on the water system and now the water temperatures on the resident hallways and at the mixing valves was too cold at 90 degrees F. He explained they were trying to get the hot water back up to 116 degrees F and the System Director of Plant Operations who had oversight of the maintenance department was also in the facility to assist and they had called the company who had installed the water system to come to the facility to evaluate it.

During a follow up environmental tour on 05/04/17 at 3:04 PM with the Plant Operations Manager and the System Director of Plant Operations, the Plant Operations Manager utilized a self-calibrating digital thermometer to check water temperatures at the sink in resident bathrooms as follows:
Room # 200 water temperatures 89.6 degrees F at 3:04 PM
Room # 105 water temperatures 96.6 degrees F at 3:10 PM
Room # 405 water temperatures 97.1 degrees F at 3:22 PM
Room # 516 water temperatures 101.6 degrees F at 3:28 PM
Room # 604 water temperatures 104.3 degrees F at 3:38 PM
Room # 623 water temperatures 90.3 degrees F at 3:47 PM
Room # 701 water temperatures 103.4 degrees F at 3:50 PM

During a follow up interview on 05/04/17 at 3:55 PM the Plant Operations Manager explained he had determined there was a problem with the

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small mixing valve and he had turned it completely off. He stated the large mixing valve was working but he had been turning the hot water up slowly in order to keep temperatures from getting too hot. He further stated he would continue to monitor water temperatures until they were at 116 degrees F. He explained there had not been a problem with hot water in the showers in resident rooms because they had an anti-scald valve in them which prevented water from exceeding 116 degrees F. He also verified the facility used whirlpool tubs which had visual gauges to set the water temperature and they also had anti-scald valves so the temperature could not exceed 116 degrees F.

During an interview on 05/04/17 at 3:25 PM with Nurse Aide (NA) #1 she stated the water in the sinks in resident bathrooms could get a little bit hot but she mixed cold water with it to cool it. She explained residents had not complained about the temperature of the water in bathroom sinks or showers or tubs.

During an interview on 05/04/17 at 3:35 PM with Restorative Aide #1 she stated she had noticed the water got a little warm in the sink of resident bathrooms but she just added cold water to it to cool it. She further stated no residents had complained to her that the water was too hot in their bathrooms.

During a follow up observation and interview on 05/04/17 at 3:55 PM in the Mechanical Room the Plant Operations Manager confirmed the thermometer mounted to the water pipe above the mixing valves indicated the water was 102 degrees F and a temperature gauge at the small mixing valve was 100 degrees F. He stated

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something was wrong with the small mixing valve because when he turned it on the water temperatures increased rapidly to unacceptable levels and he had to turn it off. He further stated he was not sure what was wrong but he planned to keep the small mixing valve turned off and would continue to monitor the water temperatures. He explained the installers of the water system would be there in the morning on 05/05/17 to check out the system.

During an interview on 05/04/17 at 4:00 PM with the System Director of Plant Operations he confirmed he had oversight of the maintenance department and staff in the facility. He stated it was his expectations for staff to check water temperatures daily and ensure water temperatures were not too hot. He further stated it was his expectation to check mixing valve water temperatures daily to ensure the water did not get too hot but he had received no reports that the water was too hot in resident bathrooms.

During a follow up interview on 05/04/17 at 5:11 PM the Administrator stated maintenance staff were still working on regulating the water temperatures and they continued to be too cold.

During an interview 05/05/17 at 9:01 AM with Nurse #1 she stated she had not noticed the water was hot in the sinks in resident bathrooms. She also stated no residents had complained to her the water was too hot and she was not aware of any resident who had burns or injuries because the water was too hot.

During an interview on 05/05/17 at 9:18 AM with the Plant Operations Manager and the System Director of Plant Operations, the System Director

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of Plant Operations stated the installers were evaluating the water system and were working on the mixing valves. He explained they had monitored water temperatures and had kept the water temperatures low to prevent from sending hot water that exceeded 116 degrees F to resident hallways.

During an interview on 05/05/17 at 9:41 AM with Nurse #2 she stated she had not had a problem with water being too hot in resident bathrooms. She stated if the water was too hot she would contact her team leader to report the problem but she had not had any residents complain the water was too hot.

During an interview on 05/05/17 at 10:16 AM with Nurse #3 she explained she always used hot and cold water to wash her hands at the sinks in resident bathrooms so she had not noticed the water was too hot. She stated she had never had a resident complain the water was too hot. She stated if a resident complained the water was too hot she would call maintenance staff and report it. She further stated she was not aware of any resident injuries or burns caused by hot water.

During an interview on 05/05/17 at 10:45 AM with Resident #16 she stated she had no problems with the water temperatures. She further stated the Nurse Aides (NAs) always adjusted the temperature of the water and got it nice and warm. She explained she had never had any problems with the water at the sink in her bathroom but it took the water a little while to get warm and then she turned on the cold water to keep the temperature just right. A review of the most recent 30 day Minimum Data Set dated 03/21/17 indicated Resident #16 was cognitively

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intact for daily decision making and required extensive assistance with hygiene and was totally dependent on staff for bathing.

During an interview on 05/05/17 at 11:13 AM with Resident #20 he stated he had never had an issue with the hot water. He explained he knew the water at the sink in the bathroom got hot if he left it running for a while but the NAs and Nurses checked the water for him and made sure it was comfortable. He stated he had not been burned or injured due to the water being too hot. A review of the most recent quarterly Minimum Data Set dated 11/03/16 indicated Resident #20 was cognitively intact for daily decision making and required limited staff assistance for personal hygiene and bathing.

During an interview on 05/05/17 at 11:24 AM with Resident #60 he stated he was aware the water in his bathroom sink was hot but had not received any injury because the NAs and Nurses mixed hot water with cold for him to get it to a comfortable temperature. A review most recent quarterly Minimum Data Set date 02/28/17 indicated Resident #60 was cognitively intact for daily decision making and required extensive staff assistance for personal hygiene and bathing.

During an interview on 05/05/17 at 11:35 AM with Resident #59 she reported the water in the sink in her bathroom was not too hot but she was concerned because currently she did not have any hot water. She stated she had never been injured or burned by the hot water at the sink in her bathroom and the water temperature had always been comfortable. A review of the most recent significant change Minimum Data Set dated 02/09/17 indicated Resident #59 was

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moderately impaired in cognition for daily decision making and required extensive assistance with hygiene and total assistance with bathing.

During a follow up interview on 05/05/17 at 12:00 PM with the Plant Operations Manager and the System Director of Plant Operations, the System Director of Plant Operations stated the installer had reset all the mixing valves and recalibrated everything and verified the thermometer on the pipe above the mixing valve now indicated 112 degrees F. He stated they were working on a plan to prevent anyone from making adjustments or tampering with the mixing valves.

During an interview on 05/05/17 at 2:35 PM with NA #3 she stated she had not had a problem with hot water in resident bathrooms. She explained she mixed cold water with the hot water to make the water temperature warm for the residents. She stated she had not had any complaints from residents or families that the water was too hot at the sinks in resident bathrooms and she was not aware of any injuries or burns to residents because of hot water.

During an interview on 05/05/17 at 4:14 PM with the Administrator and Director of Nursing, the Administrator stated it was his expectations for water temperatures to be monitored on a daily basis and the temperatures documented on a log from a resident room on every resident hallway. He stated it was his expectation for temperatures at the mixing valves to be monitored and documented and he expected the water temperatures to be maintained within safe ranges. He stated he was unaware the water temperatures were hot in the resident bathrooms until he had observed the temperatures that were

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F 323	Continued From page 26 checked during the environmental tour on 05/04/17. He further stated he had not received any complaints from residents or families that the water temperatures were too hot at the sinks in resident bathrooms. He confirmed there had been no incidents, burns or injuries to residents related to hot water. The Director of Nursing confirmed she had not received any complaints from residents or families that water temperatures at the sinks in resident bathrooms were too hot. She also confirmed she had not received any reports of burns or injuries to residents caused by hot water.	F 323		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections	F 441		6/2/17

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before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which 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; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an

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F 441	Continued From page 28 annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to disinfect a blood glucose meter according to manufacturer's guidelines before and after obtaining a finger stick blood sugar for 1 of 1 resident observation of blood glucose monitoring during medication pass (Resident #1). The facility also failed to post isolation signage on the resident's door and place the isolation cart outside the room for 2 of 2 residents on enteric precautions (Resident #147 and #148). Findings included: 1. A review of a facility policy for blood glucose maintenance dated 08/19/16 indicated in part the monitor needed to be cleaned with an Environmental Protection Agency (EPA) approved cleaning agent. A review of the manufacturer's directions for use for Germicidal Disposable Wipes indicated to unfold a clean wipe and thoroughly wet surface and allow treated surface to remain wet for a full 2 minutes and let air dry. An observation during medication pass on 05/03/17 at 4:07 PM revealed Nurse #4 removed a plastic box from inside a drawer on the medication cart and opened it and removed a blood glucose meter from inside the box. She then removed an individual packet of a germicidal disposable wipe and opened the package and wiped the front, sides and back of the blood glucose meter for approximately 15 seconds and	F 441	How the corrective action will be accomplished for the resident(s) affected. Immediate education on 5-5-2017 was provided to nurse #4 with regard to the disinfection process for blood glucose meters after each use to include ensuring the recommended wet contact time. Recommended wet contact time for the current EPA approved product is two (2) minutes. Wet contact time to be ensured by staff utilizing a timing device. On 5/5/2017, all isolation carts (resident #148) were cleared of items not necessary to the resident isolation status, the cart was relocated to outside the resident room and signage was cleared of anything obscuring the view. On 5/8/2017, the isolation signage was relocated to eye level on the outside of each resident(s) door if isolation was indicated. The new isolation signage clearly indicated the isolation precautions to follow, instructions for required personal protective equipment (PPE) and directing visitors, non-clinical staff and/or volunteers to see the nurse/care provider prior to entering. The isolation requirements for resident #147 were discontinued on 5-4-17 at 7:00pm and the room was terminally cleaned by environmental services. How the corrective action will be	

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discarded the wipe in the trash on the medication cart. She then laid the blood glucose meter on top of the medication cart while she gathered supplies and then carried the blood glucose meter and supplies into Resident #1's room and placed them on a bedside table. She performed a finger stick blood sugar and carried the blood glucose meter back to the medication cart. She then opened an individual packet of germicidal wipes and wiped the front, sides and back of the blood glucose meter for approximately 15 seconds, discarded the wipe in the trash can on the medication cart and placed it in the plastic storage box and placed the box inside a drawer on the medication cart.

During an interview on 05/03/17 at 4:22 PM with Nurse #4 she stated she had received education regarding cleaning blood glucose meters during orientation. She stated she was expected to clean the blood glucose meter with the germicidal wipes before she took the blood glucose meter to the resident's room and she was supposed to clean it again when she brought it back to the medication cart because she didn't know if the person who had used it before had cleaned it. She stated it was her usual practice to wipe the front, sides and back of the blood glucose meter with the germicidal wipe. She further stated she did not time the length of time when she wiped off the blood glucose meter because she had been taught to focus on letting the meter dry before she used it and by the time she got to the resident's room the blood glucose meter had usually dried.

During an interview on 05/04/17 at 5:24 PM with the Infection Control Nurse she stated she did not do education and training for staff regarding blood glucose meter cleaning but the Staff

accomplished for those resident(s) with the potential to be affected by the same practice.
All residents on Isolation Precautions had the Isolation signage placed on the resident(s) door at eye level. The signage indicated the type of isolation precautions, instructions for required PPE and directing visitors, non-clinical staff and/or volunteers to see the nurse prior to entering. This signage was in addition to the isolation magnet adhered to the metal doorframe, identifying the isolation type.

Measures put in place to ensure practices will not occur.
Timing devices will be in place on each medication cart for the purpose of timing the wet contact time during the disinfection process for the glucose meters. Timing devices will be in place by 5-29-17.
Nursing staff received education regarding the use of the timing devices to ensure compliance with the product recommended wet time of 2 minutes on 5-29-17.

Nursing staff will receive initial education on glucose meter disinfection care on hire and an annual validation of competencies will be performed by all staff responsible for the disinfection of glucose meters. Education will include but is not limited to the disinfection process (including the disinfectant wet contact time) after each use.

The facility Value Analysis Committee will

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F 441	Continued From page 30 Development Coordinator (SDC) did the training in orientation for new nurses and it was also part of their required annual competency training and education. She confirmed the SDC had already left the facility for the rest of the day but staff were supposed to use the germicidal wipes the facility provided to clean blood glucose meters. During an interview on 05/05/17 at 11:12 AM with the SDC she confirmed she did the education and training for blood glucose meters for nurses during orientation and during the annual competency training. She stated she instructed nurses to use the germicidal wipes because they were supposed to kill most of the germs and blood pathogens. She explained she did not know if there was an exact time the blood glucose meter was supposed to remain wet but it was usually dry by the time by the time it was placed in a charging station or in the plastic storage box. After review of the manufacturer's recommendations to allow the surface to remain wet for a full 2 minutes she stated she was not aware of the recommendation and had not covered that as part of her education and training. She stated now she was aware of the recommendations she would expect for nurse's to clean the blood glucose meters to make sure they followed the manufacturer's recommendations for the surface to remain wet for a full 2 minutes. She further stated a wipe down of the blood glucose meter surfaces would not meet the expectation of the blood glucose monitor to remain wet for a full 2 minutes. She explained it had been their routine practice in the facility to stress cleaning of blood glucose meters but not how long the germicidal wipe should remain wet on them.	F 441	evaluate EPA approved disinfection agents with shorter wet contact times to ease the transition between resident blood glucose checks. Effective 5-18-17, the facility adopted isolations signage downloaded from the Statewide Program for Isolation Control and Epidemiology (SPICE), part of The University of North Carolina at Chapel Hill. Signs will be placed on the resident(s) door at eye level. Isolation carts will be placed outside the resident doors. All staff has been educated on the isolation process to include donning of required PPE before entering residents room and doffing prior to exiting room, isolation signage, isolation carts, etc. Visitors, non-clinical staff and/or volunteers will be directed to see the nurse/care provider prior to entering the room for instructions on donning/doffing PPE and proper hand hygiene. Isolation procedures will be reviewed and revised to include the above and facility wide education on these changes will be completed by June 2, 2017. How the facility plans to monitor and ensure correction is achieved and sustained. The Infection Preventionist/designee will conduct random blood glucose meter disinfection audits for at least one routine testing time (ac meals) each day (Monday-Friday) daily x (2) weeks; then weekly x (2) months; then monthly to	

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F 441	Continued From page 31 During an interview on 05/05/17 at 11:31 AM the Director of Nursing stated it was her expectation for staff to clean blood glucose meters between each resident use. She also stated she expected for staff to follow manufacturer's recommendations to clean the blood glucose meters and they should use a timer on their cell phone or on the computer on the medication cart to ensure the length of time the blood glucose meter remained wet met the manufacturer's recommendations. During an interview on 05/05/17 at 4:14 PM the Administrator stated his expectations for cleaning of blood glucose meters was the same as the Director of Nursing. 2. Resident #147 was admitted from the hospital with Clostridium difficile and placed on enteric isolation. There was a magnet observed on the door facing of his room on 05/02/17 at 10:48 AM that was approximately 2 inches wide by 6 inches long with enteric written on it. The sign was almost the same color as the door facing and this was the only signage outside of the room. Inside the room to the right was a cart with gloves and masks on it, a gait belt and wipes. Underneath the items on the top of the cart was a sign describing the personal protective equipment required for entering the room. There was no signage on the door that said enteric precautions or isolation directing visitors, staff or volunteers to see the nurse prior to entering the room. The signage was observed on 05/03/17 at 8:32 AM, 05/03/17 at 4:14 PM, 05/04/17 at 12:06 PM and 05/04/17 at 3:36 PM. The resident was taken off isolation at 7:00 PM on 050/4/17 according to the nurses notes. An interview with the wound ostomy certified	F 441	ensure the 2 minute wet time is achieved per the product manufactures recommendation. Failure of compliance with the expectation will result in immediate action including additional education and/or disciplinary action. The Infection Preventionist/designee will conduct random audits of resident(s) requiring isolation precaution(s) with focus on signage location, isolation cart location, and visitor/non-clinical staff/volunteer compliance with PPE and hand hygiene (Monday-Friday) daily x 2 weeks; then weekly x 2 months; then monthly as resident□s clinical conditions indicate. Failure of compliance with the expectation will result in immediate action to include additional education and/or disciplinary action. Visitors and volunteers will be educated as needed with regard to the importance of infection prevention and their role when visiting resident(s). The Infection Preventionist/designee will present/discuss the audit findings in the weekly risk meeting at least monthly. The DON/designee will report findings to Quality Assurance Performance Improvement Committee (QAPI) monthly x (3) months to ensure compliance with changes is sustained, with a decision for continued monitoring if needed. Failure to achieve compliance will result in education and/or disciplinary action and/or continuation of monitoring.	

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nurse (WOCN) who was also responsible for the Infection Control program on 05/05/17 at 2:19 PM revealed Infection Control was a new role for her and she had attended SPICE (Statewide Program for Infection Control and Epidemiology) training in February of this year. The Infection Control nurse stated the residents on isolation should have a sticker on the door with the type of isolation on it and a cart with supplies inside the door. The nurse stated a sign should be on the cart visible for anyone entering the room instructing them on the proper protective equipment to wear inside the room. The nurse stated that she was not sure if the sign directed staff, visitors, volunteers or anyone entering the room to see the nurse before entering. The sign was 8 ½ by 11 and the nurse stated her expectation was the sign to be on top of the cart and visible with no other items on the cart.

An interview with the Director of Nursing (DON) on 05/005/17 at 4:45 PM revealed that her expectation was for the sign on the cart to be visible to family, staff, visitors and volunteers entering the room.

3. Resident #148 was admitted from the hospital with Clostridium difficile (C diff) and placed on enteric isolation. There was a magnet observed on the door facing of her room on 050/2/17 at 2:36 PM that was approximately 2 inches wide by 6 inches long with enteric written on it. The sign was almost the same color as the door facing and this was the only signage outside of the room. Inside the room to the left was a cart with gloves, masks and wipes on it. Underneath the items on the top of the cart was a sign describing the personal protective equipment required for entering the room. There was no signage on the

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F 441	Continued From page 33 door stating enteric precautions or isolation. The signage was observed on 05/03/17 at 8:30 AM,005/3/17 at 4:20 PM, 05/04/17 at 12:03 PM, 05/04/17 at 4:23 PM and 05/05/17 at 9:22 AM. The resident remained on isolation throughout the survey. A review of the physician progress note written on 05/04/17 revealed the physician was going to continue her C diff treatment for another week. An interview with the wound ostomy certified nurse (WOCN) who is also responsible for the Infection Control program on 050/5/17 at 2:19 PM revealed Infection Control was a new role for her and she had attended SPICE training in February of this year. The Infection Control nurse stated the residents on isolation should have a sticker on the door with the type of isolation on it and a cart with supplies inside the door. The nurse stated a sign should be on the cart visible for anyone entering the room instructing them on the proper protective equipment to wear inside the room. The nurse stated that she was not sure if the sign directed staff, visitors, volunteers or anyone entering the room to see the nurse before entering. The sign was 8 ½ by 11 and the nurse stated her expectation was the sign to be on top of the cart and visible with no other items on the cart. An interview with the Director of Nursing (DON) on 05/05/17 at 4:45 PM revealed that her expectation was for the sign on the cart to be visible to family, staff, visitors and volunteers entering the room.	F 441		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET	F 520		5/31/17

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F 520	Continued From page 34 QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING _____ B. WING _____	C 05/05/2017

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F 520	Continued From page 35 deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in April of 2016. This was for one recited deficiency which was originally cited in March of 2016 on a Rectification survey and subsequently recited on the current recertification survey. The deficiency was in the area to provide supervision to prevent accidents. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F323: Provide Supervision to Prevent Accidents: Based on observations, record reviews and resident and staff interviews the facility failed to maintain water temperatures at safe levels to avoid putting residents at risk at resident bathroom sinks in 8 of 69 occupied resident rooms (Room #604, #615, #621, #701, #516, #405, #409, and #105) and failed to ensure a system was in place to record water temperatures on the 500, 600, 700 hall and at the mixing valves in the Mechanical Room and to ensure mixing valves were not tampered with. During the recertification survey of 03/11/16 the facility was cited for failure to analyze the root cause of a fall, coordinate interventions with the	F 520	How the corrective action will be accomplished for the resident(s) affected. All residents have the potential be affected by Quality Assurance determinations Measures put in place to ensure practices will not occur. The Quality Assurance Committee have put in place new focus areas for standing agenda items including tracking of all current deficiencies cited in the annual survey and the actionable items associated with each plan of correction item. Survey deficiencies and audit results associated with monitoring plan of correction items will be discussed in daily leadership meetings and any trends or patterns will be directed to the appropriate parties monitoring compliance and reported to the Quality Assurance Committee. The Quality Assurance Committee has also has identified the need for monitoring items within the existing categories of current deficiency citing and will place monitoring processes and reporting on the items that have can be identified with the highest risk. How the facility plans to monitor and ensure correction is achieved and sustained. The Administrator/designee will report all audit findings related to survey	

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F 520	Continued From page 36 cause and evaluate the planned interventions for effectiveness to prevent recurrent falls for 1 of 2 residents sampled for falls (Resident # 111). On the current recertification survey F323 was again recited for failing to maintain water temperatures at safe levels to avoid putting residents at risk at resident bathroom sinks in 8 of 69 occupied resident rooms (Room #604, #615, #621, #701, #516, #405, #409, and #105) and failed to ensure a system was in place to record water temperatures on the 500, 600, 700 hall and at the mixing valves in the Mechanical Room and to ensure mixing valves were not tampered with. During an interview on 05/05/17 at 4:14 PM with the Administrator he explained they had focused on the last survey on falls and early identification of fall risk. He stated this week was the first week he had heard anything about the water being too hot so they had not considered that as a problem related to supervision to prevent accidents. He stated they were in a new building and they had tried to address issues to make sure it was a safe environment for residents. He further stated he was aware there was some logging of water temperatures so he didn't feel the need to question whether there was a problem with hot water in resident rooms. He explained he thought the expectation was not just the monitoring but to change the process to identify what the problem was and build in a new work processes to prevent a problem from reoccurring.	F 520	compliance and other key clinical initiatives to the system□s Performance Improvement Committee on a monthly x (12) month basis. The Process Improvement Committee meeting will include processes at outlined by the State and Federal regulations to review systems, improvement plans, structures, and updates. Monitoring of each deficiency finding in most recent survey will be monthly X (12) months and ongoing as needed to sustain results.	