STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

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F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to assess 2 of 2 residents (Resident # 7 and Resident # 98) to safely self-administer medications. Findings included: During a review of a facility policy titled "Self-Administration of Medication", the policy read in part: * Each resident is offered the opportunity to self-administer his or her medication during the routine assessment by the facility's interdisciplinary team. *If the resident desires to self-administer medications, as assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility, during the care planning process. *The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment, which is placed in the resident's medical record. The Self-Administration of Medication policy provided for review was not dated. 1. Resident # 7 was admitted to the facility on 5/10/17 with diagnoses that included Chronic Obstructive Pulmonary Disease, Congestive Heart Failure and Hypertension. Review of resident's most recent comprehensive MDS dated 5/17/17 coded as an admission	F 176	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 176 Corrective Action for Resident Affected On 8/17/17, the nystatin was removed from resident #7's bathroom until a self administration of medication assessment could be completed and a physician's order obtained if indicated. On 8/17/2017, the nystatin was removed from resident #98 room until a self-administration of medication assessment could be completed and a physician order obtained if indicated.	9/14/17

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

Electronically Signed | 09/07/2017

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F 176	Continued From page 1 assessment, revealed the resident was cognitively intact, understands others as well as is understood by others. Her vision and hearing were assessed as adequate. During a review of the resident's active care plan, there was no care plan in place for resident to self-administer medication. A review of the interdisciplinary progress notes from 5/10/17 through 8/17/17 was completed. There were no notes written by any discipline related to self-administering medication. A review of a tab in the electronic medical record titled Self-Administer Medication Assessment revealed no Self-Administer Medication Assessment had been completed. On 8/14/17 at 11:59 a.m., a bottle of Nystatin powder was observed to be in resident's bathroom. The bottle of Nystatin powder was labeled by a local pharmacy with the resident's name and directions on the label were to apply twice a day. The date on the bottle as when the prescription was filled was 3/10/17. During an interview with the resident following the observation of her bathroom on 8/14/17 at 11:59 a.m., the resident stated she uses the Nystatin powder a couple of times a day when needed for a rash. Another observation of resident's bathroom was made on 8/15/17 at 3:05 p.m. The bottle of Nystatin powder was sitting on the hand rail to the right side of the toilet. The bottle was a 60 gm bottle. An observation of the resident's bathroom on 8/16/17 at 4:55 p.m. revealed the bottle of Nystatin powder on the hand rail to the right side of the toilet. The bottle felt to be half full. On 8/17/17 at 9:30 a.m., the Nystatin powder was observed again in the resident's bathroom. An interview was conducted with Nurse # 1 on	F 176	Corrective Action for Resident Potentially Affected On 8/17/17 all current resident rooms and bathrooms were assessed for any medications at bedside/ bathroom. Thirteen of seventy- four were identified to have medications at their bedside/in their bathrooms. The medications were immediately removed until self administration assessments by licensed nurses were initiated on 8/18/17. These self administration UDA assessments were completed on September 5, 2017 by licensed nurses. “Self-administration of medications UDA Assessment tool” in Point Click Care were completed on all thirteen residents and it was determined that seven can self-administer their own medications. The medications will be stored properly per Liberty policy at bedside for residents to self-administer. Systemic Changes The Director of Nursing provided education on August 28, 2017 and August 30, 2017 to all FT, PT and PRN nurses, nursing assistants, Med Tech and Med Aides on the following: ¿ Checking resident rooms and bathrooms for medications, eye drops, lotions, creams, any over the counter medications. These are to be removed from the bedside/bathroom until the resident is assessed to safely self administer ¿ Nursing assistants were educated on	

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F 176	Continued From page 2 8/17/17 at 9:35 a.m. She indicated she was resident #7's nurse. The nurse stated that resident # 7 does have an order for Nystatin powder and that nursing applies the powder as the resident requests. She further indicated that Nystatin is kept on the treatment cart and no medications are kept in the resident's room. She indicated she had no resident that self-administered medication. An observation of Nurse # 1 was made at 9:40a.m on 8/17/17. The nurse was observed removing the medication from the resident's bathroom. Once she removed the bottle of Nystatin powder from the bathroom, she placed it in the medication storage room to be returned to the pharmacy. 2. Resident # 98 was admitted to the facility on 12/20/16 with diagnoses that included End Stage Renal Disease and Chronic Obstructive Pulmonary Disease. Review of resident's most recent MDS dated 5/12/17, coded as a 14-Day PPS assessment, revealed the resident was cognitively intact, understands others as well as is understood by others. Her vision was assessed as impaired. During a review of the resident's active care plan, there was no care plan in place for resident to self-administer medication. A review the interdisciplinary progress notes written since 12/20/16 was completed. There were no notes written by any discipline related to resident self-administering medication. A review of a tab in the electronic medical record titled Self-Administer Medication Assessment revealed no Self-Administer Medication Assessment had been completed. On 8/15/17 at 11:06 a.m. a 60 gm bottle of Nystatin powder was observed to be lying on the	F 176	checking resident rooms, drawers, closets, bathrooms, etc for any medications, creams, over the counter medications, etc and to immediately give to staff nurse ¿ Nurses were educated on the self administration UDA and Liberty policy of medication storage at bedside Any clinical staff not completing this education by September 14, 2017 will not be permitted to work until completing this education. This education will be incorporated into the standard orientation for employees. Quality Assurance The Director of Nursing/licensed nurse will monitor for any medications at the bedside/any the bathrooms using the QA Medication Audit Tool. Any issues will be reported addressed immediately. This will be done weekly for four weeks and then monthly for 2 months. Reports will be presented to the weekly QA committee by the Director of Nursing or NHA to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Staff Development Coordinator, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 176	Continued From page 3 bottom of resident's bed within reach of the resident. The bottle of Nystatin powder was labeled by the facility's Pharmacy with the resident's name and directions to apply topically when needed. The bottle had a date of 4/28/17 indicating the prescription was filled 4/28/17. During an interview with the resident following the observation in her room on 8/15/17 at 11:06 a.m., the resident stated she uses the Nystatin powder herself after she uses the bathroom. Another observation of the resident's room was made on 8/15/17 at 4:55 p.m. The bottle of Nystatin powder was observed to be lying on top of resident's cover near the foot of her bed. An interview was conducted with Nurse # 1 on 8/17/17 at 9:35 a.m. The nurse stated she was the nurse responsible for Resident # 98. She further stated that Nystatin is kept on the treatment cart and no medications are kept in the resident's room. She indicated she had no resident that self-administered medication. On 8/17/17 at 9:45 a.m. the resident was observed taking the bottle of Nystatin powder out of her top bedside drawer. A second interview was conducted with the resident on 8/17/17 at 9:45 a.m. The resident indicated she dusts the Nystatin powder on her hands and then applies it after she uses the bathroom. The resident stated that staff used to apply the Nystatin powder for her, but they don't anymore. She further stated she needs to take the bottle of Nystatin powder to the nurse's station so the label can be pulled off for a refill because she is almost out. An observation was made on 8/17/17 at 9:50a.m of Nurse #1 removing the bottle of Nystatin Powder out of the room for resident #98. . During an interview on 8/17/17 at 9:55 a.m. with	F 176	Compliance date: Sept 14, 2017	

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F 176	Continued From page 4 the Director of Nursing, she indicated neither resident had been assessed to be able to self-administer medications. She further stated the facility would proceed with assessing the residents for self-administration of the Nystatin powder if that is what the resident wishes.	F 176		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to honor food choices by not providing requested cereal on meal trays for 1 of 1 residents (Resident #93). Findings included: Record review revealed Resident #93 was admitted to the facility on 6/1/2017 with diagnoses which included Hypertension, Diabetes and Anemia. The initial dietary review dated 6/5/2017 indicated	F 242	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates	9/14/17

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F 242	Continued From page 5 Resident #93 was assessed by the facility Dietary Manager (DM), and food preferences were noted on the resident's food tray card. The preference for breakfast included two bowls of cereal with the breakfast tray. The Admission Minimum Data Set (MDS) dated 6/8/2017 indicated Resident #93 was cognitively intact. The MDS indicated during the interview for preferences, the resident stated it was very important to have snacks available between meals. Review of the residents care plan dated 6/8/2017 included a problem with nutrition, and the interventions included to provide and serve diet as ordered. An interview was conducted with the resident on 8/14/2017 at 9:50 AM. The resident was seated in a wheelchair with a breakfast tray on the over bed table. The resident stated she was supposed to get two bowls of cereal with breakfast, because she saved one to have for a snack at 10:30 AM. The resident stated she used to get two bowls, but for the last couple of weeks there was either one bowl or none at all. The tray card on the breakfast tray indicated two bowls of cereal were to be included with breakfast. An interview was conducted with the resident on 8/15/2017 at 8:33 AM. The resident was up in the wheelchair eating breakfast. There was one bowl of cereal observed on the breakfast tray. The tray card indicated two bowls of cereal with breakfast. The resident stated a family member brought a box of cereal to her the evening before since dietary did not provide the two bowls. The resident indicated she would eat the cereal the	F 242	indicated. F 242 Corrective Action for Resident Affected- On August 17, 2017 Resident 93 was served two bowls of cereal per his/her recoice and by reviewing the residents tray card for accuracy of reflecting the residents preferences and serving two bowls of cereal to the resident at breakfast. Corrective Action for Resident Potentially Affected On August 17, 2017 the Dietary Manager assessed all current residents to ensure that choices and preferences were being honored for meals/food preferences and choices and that tray cards were accurate. 20 of 74 resident tray cards were updated to include resident specific choices and preferences by the dietary manager. Systemic Changes On August 17, 2017 all FT, PT and PRN Dietary staff received educational training from the Registered Dietician on the following topics: ¿ Self- Determination-Resident Rights	

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F 242	Continued From page 6 family member brought for her snack at 10:30 AM. An interview was conducted with the resident on 8/16/2017 at 8:35 AM. The resident stated someone from dietary talked with her on 8/15/2017. The resident stated her breakfast tray that morning included two bowls of cereal, and she hoped it would continue. An interview was conducted with the DM on 8/16/2017 at 9:45 AM. The DM indicated some time in the last few weeks, Resident #93 requested not to have cereal sent with breakfast. The DM stated it was not documented anywhere in the notes, and the tray card was not changed when the resident made the request. The DM indicated a dietary aide spoke with the resident on 8/15/2017, and the two bowls of cereal would be added to her breakfast tray again. An interview was conducted with the resident on 8/17/2017 at 8:44 AM. The resident was seated in bed with the breakfast tray on the over bed table. The resident indicated there was no cereal on the breakfast tray. An observation of the breakfast tray revealed no cereal, and the tray card indicated two bowls of cereal which was highlighted in yellow. An interview was conducted with the DM on 8/17/2017 at 8:55 AM. The DM reported the cereal was sent on the resident's tray for breakfast. The DM was informed there was no cereal on the resident's tray. The DM talked with the dietary staff and indicated she was not sure why the cereal wasn't on the tray. The DM reported the cereal would be delivered to the resident.	F 242	to Make Choices ¿ Follow practice of double-checking the trays for accuracy before loading them on a transport cart ¿ Notify the Dietary Director immediately if tray cards require an update This information has been integrated into the standard orientation training for all employees. Quality Assurance The Dietary Manager/ licensed nurse will complete the Meal Monitoring QA Tool to ensure that residents receive their preferred choices during meal times by selecting random residents based on their correct foods and preferences/choices and diet orders/tray cards. This audit will be completed weekly for 4 weeks, then monthly for 2 months. Corrective active action will be taken for any concerns immediately. Reports will be presented to the weekly QA committee by the Dietary Director or DON to ensure corrective action has been initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA meeting. The weekly QA meeting is attended by the Director of Nursing, NHA, MDS Coordinator, Support Nurses, Rehab Director, Dietary Manager, and HIM. Compliance Date: September 14, 2017	

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F 242	Continued From page 7 An interview was conducted with the Administrator on 8/17/2017 at 9:14 AM. The Administrator stated residents should be served specific foods requested if the facility could provide the food. The Administrator further stated the expectation was to honor resident's choices when possible.	F 242		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic	F 329		9/14/17

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F 329	Continued From page 8 drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to obtain lab work as ordered by the physician for 3 of 5 residents reviewed for unnecessary medication use (Resident #24, #163 and # 7). Findings included: 1-Record review revealed Resident #24 was admitted to the facility on 8/2/2016 with diagnoses which included Anemia, Chronic Kidney Disease and Insomnia. A review of the Quarterly Minimum Data Set (MDS) dated 6/15/2017 revealed the resident had an active diagnosis of Anemia and was severely cognitively impaired. A review of the monthly Physician orders for August 2017 revealed an order for a Complete Blood Count (CBC) to be obtained every 6 months. Review of the medical record revealed the most recent CBC was obtained on 1/30/2017. An interview with the Director of Nursing (DON) was conducted on 8/16/2017 at 3:12 PM. The DON stated the lab orders are entered by the	F 329	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F329 Corrective Action for Resident Affected The facility failed to obtain lab work for 3 of 5 residents (#24, #163, #7) as ordered by physician. • Resident #24 (HT) had a physician's order for CBC to be completed every 6 months. The last CBC completed was 1/30/2017. On 8/16/17, the provider was notified of routine lab missed by the DON and orders were obtained to collect CBC	

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F 329	Continued From page 9 nursing staff when the monthly orders were reviewed for the first of the month changeover. The DON indicated the CBC should have been obtained in July 2017. The DON further indicated the CBC was somehow missed and not carried over for the month of July. 2-Record review revealed Resident # 163 was admitted to the facility on 7/28/2017 with diagnoses which included Chronic Kidney Disease, Osteoarthritis and Heart Disease. A review of the Admission MDS dated 8/1/2017 revealed the resident was cognitively intact and had an active diagnosis of Chronic Kidney Disease. A review of the Physician Orders revealed an order dated 8/1/2017 for a Basic Metabolic Profile (BMP) to be obtained on 8/7/2016. The results for the BMP were in the medical record with a hand written note on the results sheet to recheck in 1 week on 8/14/2017 with the physician's initials written next to the order. On the bottom of the results sheet was a hand written note (with no signature) which indicated the resident was going home. A review of the Physician orders for August 2017 revealed no order for a BMP to be obtained on 8/14/2017. An interview was conducted with the Administrator on 8/17/2017 at 10:11 AM. The Administrator stated the facility had two residents with the same name on 8/7/2017 when the lab results were reviewed. The Administrator revealed the note at the bottom of the lab results page indicating the resident was going home was	F 329	on 8/16/17. CBC was collected as ordered on 8/16/17 by staff nurse and picked up by solstas carrier on 8/16/17. CBC results were obtained on 8/17/17 and provider was notified of results on 8/17/17. • Resident #163 (DL) had a physician's order for BMP to be completed 8/14/2017. On 8/16/17, the provider was notified of routine lab missed by the DON and orders were obtained to collect BMP on 8/17/17. BMP was collected as ordered on 8/17/17 by staff nurse and transported to Betsy Johnson lab on 8/17/17. BMP results were obtained on 8/17/17 and provider was notified of results on 8/17/17. • Resident #7 (WP) had a physician's order for UA C&S, CBC, and CMP to be completed on 7/20/17. On 8/16/17, the provider was notified of routine lab missed by the DON and orders were obtained to collect CBC and CMP on 8/17/17 and D/C order for UA C&S. CBC and CMP was collected as ordered on 8/17/17 by solstas phlebotomist and transported to solstas lab by phlebotomist on 8/17/17. CBC and CMP results were obtained on 8/17/17 and provider was notified of results on 8/17/17. Corrective Action for Resident Potentially Affected • On 8/16/17, the Lead Support Nurses and DON reviewed all residents to ensure all ordered routine labs were completed as ordered. 6 of 72 residents were identified to have this same concern as outlined above. All identified lab orders were clarified by the prescribing provider	

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F 329	Continued From page 10 intended for the resident with the same name who was discharged from the facility prior to 8/14/2017. The Administrator stated the order for the BMP requested on 8/14/2017 was never written due to the error. Therefore, the lab was not ordered or obtained on the date requested. The Administrator stated the expectation was labs would be obtained as ordered. 3. Resident # 7 was admitted to the facility on 5/10/17 with diagnoses that included: Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), and Hypertension (HTN). A review of the resident's most recent MDS dated 5/17/17, coded as an admission assessment had documentation of the resident being cognitively intact, had an active diagnosis of CHF, and had received diuretics 7 of 7 days of the look back period. A review of the physician orders revealed a telephone order dated 7/9/17 for a U/A (Urine Analysis), C & S (Culture and Sensitivity), CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Panel) to be drawn on 7/20/17. The order was signed by the physician. The telephone order was a triplicate form. The order was noted to have all three copies intact and the signature space for the nurse receiving the order was blank indicating the order had not been received by nursing. All lab results on the medical record were reviewed. There were no lab results for a U/A, C & S, CBC, or CMP for the month of July 2017. During an interview with the DON (Director of Nursing) on 8/16/17, the DON stated the physician usually folds the order sheet itself in the medical record to flag the page so the nursing staff will know a new order has been written. She	F 329	and obtained on 8/17/17 by solstas phlebotomist. • On 8/17/17, the SDC began review of all residents labs filed on the chart to ensure any orders hand written on the lab had been carried out. 4 of 72 residents were identified with lab order concerns. 2 of 4 residents had lab schedule clarified and completed prior to review. 2 of 4 identified lab orders were clarified with the prescribing provider and obtained on 9/1/17. • On 8/16/17, night shift staff nurses completed chart checks to ensure all handwritten orders had been received and taken off. No concerns were identified during this review. Systematic Changes On 8/17/17, the DON and Support Nurses implemented a new process for routine lab orders. The following steps were completed for all long term residents: Review of all current medications and diagnosis to verify current routine labs orders. An order for the necessary routine lab work was clarified with physician. The order for routine lab work and the related diagnosis was entered into Point Click Care. Another order was also entered into PCC that states: “Prep lab sheet for standing lab orders”. This order includes labs ordered, diagnosis codes for labs, and specified schedule for completion. These orders are scheduled for nightshift to complete on the last day of the month for upcoming month next lab day. The DON or Lead Support will run	

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F 329	Continued From page 11 further stated the order was missed and the lab work was not obtained.	F 329	order listing report in PCC for any labs due for the current month by the 15th to ensure all labs were completed as ordered. This process will be completed on all residents anticipated to remain in the facility greater than three months. On 8/17/17, the SDC began in servicing all nurses, including all FT, PT and PRN LPNs and RNs. Topics included: ensuring that new orders written by provider are not missed, preventing transcription errors for newly received orders, and ensuring that all orders for labs are carried out timely. Any clinical staff not completing this education by September 14, 2017 will not be permitted to work until completing this education. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The DON or Lead Support will monitor this issue using the QA Lab Audit Survey Tools. This will be completed by reviewing 5 residents to ensure that lab work was obtained as MD ordered. This will be completed by reviewing current routine lab orders and reviewing any new orders entered directly in PCC, hand written on chart, or hand written on labs. Any issues will be reported to the Administrator. This will be done weekly for one month, then	

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F 329	Continued From page 12	F 329	monthly for two months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager, and the Administrator. Compliance Date: September 14, 2017	
F 441 SS=D	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:	F 441		9/14/17

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F 441	Continued From page 13 (i) A system of surveillance designed to identify possible communicable diseases or infections 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	F 441		

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F 441	Continued From page 14 spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to prevent possible cross contamination when one of two staff were observed dragging bagged, soiled linen in the hallway and not following proper handwashing protocol after disposing of soiled linen. Findings included: On 8/16/2017 at 10:45 AM, an observation was made of Nursing Assistant (NA) #1 dragging a bag of soiled linen on the floor of the hall she was assigned to. NA #1 put the bag of soiled linen into the soiled linen room. NA #1 did not wash her hands or use hand sanitizer, came out of the soiled linen room, walked around the nurse's station and proceeded to answer a call bell on the 500 hall. When NA #1 came out of the room, she stated "I know I was supposed to wash my hands and carry that bag of linen, but we are so busy and there are only two of us working." In an interview on 8/17/2017 at 10:39 AM, the Staff Development Coordinator (SDC) stated the NAs were oriented to hand washing when they were hired. The SDC stated the NAs were oriented to handwashing between each resident. The SDC stated it was not acceptable to drag a bag of soiled linen on the floor. In an interview with the Director of Nursing (DON) on 8/17/2017 at 11:24 AM, the DON stated her	F 441	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F441 Corrective Action for Resident Affected The aide observed dragging a soiled linen in the hallway and not following proper handwashing protocol after disposing of the soiled linen was immediately in-serviced by Director of Nursing on 8/17/17 as to the expectation and requirement of proper protocol of handling soiled linen and handwashing to prevent cross contamination between residents. Corrective Action for Resident Potentially Affected On 8/17/17 the Director of Nursing and	

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F 441	Continued From page 15 expectation was NAs would wash their hands between residents and the soiled linen containers would be taken to a spot on the hall that the linen could be placed in them and not have to be carried.	F 441	Staff Development Coordinator began assessing and in servicing all staff on duty on the following topics: ¿ Hand Hygiene ¿ Transporting linens ¿ Disposing soiled linens ¿ Cross Contamination ¿ Infection control processes when handling resident soiled linens and proper handwashing Systematic Changes On 8/17/17, the DON and Staff Development Coordinator (SDC) began in servicing all nurses, including all FT, PT and PRN LPNs and RNs. Topics included: hand hygiene and transporting linens. This education will be completed by 9/14/17. The DON/Nurse Manager will ensure that any staff member who did not receive the in-service training by 9/14/17 will not be allowed to work until this is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The DON or SDC will monitor this issue using the QA Infection Control Tool. This will be completed by observing 5 direct care workers to ensure that infection control prevention techniques are being	

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F 441	Continued From page 16	F 441	utilized. Any issues will be reported to the Administrator. This will be done weekly for one month, then monthly for two months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager, and the Administrator. Compliance Date: September 14, 2017	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET 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 :	F 520		9/14/17

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F 520	Continued From page 17 (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 deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions the committee put into place in August 17, 2017. This was for two deficiencies which were originally cited in September 9, 2016 on a recertification and complaint investigation and was recited on the current recertification survey. The deficiencies were in the areas of infection control and unnecessary medications. The continued failure of the facility during two surveys of record show a pattern of the facility's inability to sustain an effective QAA program. Findings included:	F 520	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 520	

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F 520	Continued From page 18 These tags are cross-referenced to: 1.F441: Based on observation, staff interviews and record review, the facility failed to prevent possible cross contamination when one of two staff were observed dragging bagged, soiled linen in the hallway and not following proper handwashing protocol after disposing of soiled linen. During the recertification survey and complaint investigation of September 9, 2016, the facility was cited at F 441 for failure to post signage indicating the type of precautions observed on residents with isolation. During the current recertification survey of August 17, 2017, the facility was cited at F 441 for failing to prevent cross-contamination by dragging bagged soiled linens and not following proper handwashing procedures. 2. F329: Based on record reviews and staff interviews the facility failed to obtain lab work as ordered by the physician for 3 of 5 residents reviewed for unnecessary medication use. During the recertification survey and complaint investigation of September 9, 2016 the facility was cited at F 329 for failure to discontinue an antibiotic after two urine sensitivity reports showed it was resistant to the cultured bacterium for 1 of 6 residents reviewed for unnecessary medications. During the current recertification survey of August 17, 2017, the facility was cited for failure to obtain lab work as ordered by the physician for 3 of 5 residents that were reviewed for unnecessary medications.	F 520	Corrective Action for Residents Affected: (cross reference F 441) The aide observed dragging a soiled linen in the hallway and not following proper handwashing protocol after disposing of the soiled linen was immediately in-serviced by Director of Nursing on 8/17/17 as to the expectation and requirement of proper protocol of handling soiled linen and handwashing to prevent cross contamination between residents. (cross reference F 329) The facility failed to obtain lab work for 3 of 5 residents (#24, #163, #7) as ordered by physician. • Resident #24 (HT) had a physician's order for CBC to be completed every 6 months. The last CBC completed was 1/30/2017. On 8/16/17, the provider was notified of routine lab missed by the DON and orders were obtained to collect CBC on 8/16/17. CBC was collected as ordered on 8/16/17 by staff nurse and picked up by solstas carrier on 8/16/17. CBC results were obtained on 8/17/17 and provider was notified of results on 8/17/17. • Resident #163 (DL) had a physician's order for BMP to be completed 8/14/2017. On 8/16/17, the provider was notified of routine lab missed by the DON and orders were obtained to collect BMP on 8/17/17. BMP was collected as ordered on 8/17/17 by staff nurse and transported to Betsy Johnson lab on 8/17/17. BMP results were obtained on 8/17/17 and provider was	

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F 520	Continued From page 19 During interview with the facility director of nursing on August 17, 2017 at 1:30pm, she revealed the current deficiencies were a result of human error. She also revealed the audits from last year's deficiencies were completed and they were unaware of any further issues.	F 520	notified of results on 8/17/17. • Resident #7 (WP) had a physician's order for UA C&S, CBC, and CMP to be completed on 7/20/17. On 8/16/17, the provider was notified of routine lab missed by the DON and orders were obtained to collect CBC and CMP on 8/17/17 and D/C order for UA C&S. CBC and CMP was collected as ordered on 8/17/17 by solstas phlebotomist and transported to solstas lab by phlebotomist on 8/17/17. CBC and CMP results were obtained on 8/17/17 and provider was notified of results on 8/17/17. Corrective Action for Residents Potentially Affected (cross reference F 441) On 8/17/17 the Director of Nursing and Staff Development Coordinator began assessing and in servicing all staff on duty on the following topics: ¿ Hand Hygiene ¿ Transporting linens ¿ Disposing soiled linens ¿ Cross Contamination ¿ Infection control processes when handling resident soiled linens and proper handwashing (cross reference F 329) ¿ On 8/16/17, the Lead Support Nurses and DON reviewed all residents to ensure all ordered routine labs were completed	

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F 520	Continued From page 20	F 520	as ordered. 6 of 72 residents were identified to have this same concern as outlined above. All identified lab orders were clarified by the prescribing provider and obtained on 8/17/17 by solstas phlebotomist. ¿ On 8/17/17, the SDC began review of all residents labs filed on the chart to ensure any orders hand written on the lab had been carried out. 4 of 72 residents were identified with lab order concerns. 2 of 4 residents had lab schedule clarified and completed prior to review. 2 of 4 identified lab orders were clarified with the prescribing provider and obtained on 9/1/17. ¿ On 8/16/17, night shift staff nurses completed chart checks to ensure all handwritten orders had been received and taken off. No concerns were identified during this review. Systemic changes: On August 30, 2017 the Administrator, Director of Nursing, and Interim Administrator was in-serviced by Nurse Consultant on the following areas: Topics included: -Review of all areas under F441 (Infection Control, Prevention, Linens) and F329 (Drug Regimen is free from unnecessary drugs) -Evaluation of services and processes with identification of deficient areas by the quality assurance team for improvement and monitoring.	

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F 520	Continued From page 21	F 520	-How to develop and implement plans of action to correct identified quality deficiencies. -How to monitor on-going quality assurance compliance, communicate areas identified to be concern with changes to the action plans Quality Assurance: The Administrator or Director of Nursing will monitor this issue by ensuring the QA meetings and audits are being held and conducted as instructed by reviewing and attending the weekly QA committee meeting. NHA/DON will ensure compliance of monitoring the completion of the audits performed. This will be done weekly x 4 weeks. Then this will be done on a monthly basis for 2 months by the Administrator, DON, or designee. Reports will be presented to the QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Quarterly Quality of Life Committee. QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. (Cross reference Tag F 329 and F 441) Compliance Date: September 14, 2017	

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