STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING _____ B. WING _____	C 09/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the Complaint Investigations of 9/22/2017, NC 00129188 and NC00131141.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 157		10/20/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/13/2017

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F 157	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to notify the physician of an abnormal lab value for one of one residents reviewed, which was a potential contributing factor in the Resident's decline in condition and subsequent hospitalization (Resident #154). Findings included: A review of medical records revealed Resident #154 was admitted 1/11/2017 with diagnoses that included Congestive Heart Failure (CHF), iron deficiency anemia, Chronic Kidney Disease and Diabetes. The Admission Minimum Data Set (MDS) dated 1/18/2017 noted Resident #154 to be severely impaired for cognition and needed extensive assistance for all Activities of Daily Living (ADLs) with the physical assistance of one person. A review of orders in the medical record revealed an order written on 5/13/2017 for labs to be	F 157	DISCLAIMER Haymount Rehabilitation and Nursing Center acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Haymount Rehabilitation and Nursing. ALLEGATION OF COMPLIANCE The plan of correction is submitted as written allegation of compliance. F157 - 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) I. The plan of correcting the specific deficiency. The plan should address the	

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F 157	Continued From page 2 drawn on 5/15/2017. The labs were a Complete Blood Count (CBC), a Complete Metabolic Panel (CMP) and a Thyroid Stimulating Hormone (TSH). The lab results were reviewed and the result sheet noted the labs were reported to the facility on 5/15/2017 at 5:56 PM. The glucose value was 370 and the normal range listed on the lab sheet for a glucose was 70 - 105. The physician initials were on the lab sheet. There was no documentation of the lab result or the physician being notified. No new orders were noted. In an interview on 9/21/2017 at 12:15 PM, the Director of Nursing (DON) stated if there was a lab glucose reported of 300 +, the physician should be called. On 9/21/2017 at 3:15 PM, in an interview, Nurse #1 stated she did not remember Resident #154 or the abnormal lab, but if there was a lab value that high, she knew she would have notified the physician. There was no documentation in the medical record of the physician being notified. In a telephone interview on 9/21/2017 at 5:40 PM, the physician stated he had a stack of lab results to be signed each time he enters the facility, was unsure of who Resident #154 was, but did not remember being notified of a glucose of 370. The physician said if he had been notified of a glucose of 370 "something would be done, you just can't let that go." Further medical record progress notes review revealed Resident #154 had a temperature of 101.5 F. The physician was notified and Resident #154 was started on an antibiotic and received a	F 157	processes that lead to the deficiency cited; a. Resident 154 no longer resides in the facility. b. The non-compliance with policy was determined to be human error in not notifying the physician by phone, in addition to lapse in facility protocol for checking for compliance with lab process. II. The procedure for implementing the acceptable plan of correction for the specific deficiency cited a. Lab Log Sheets were reviewed by administrative nurses on 9/20/17 for completeness and checked for placement in the in each lab book. b. Licensed Staff will be re-inserviced by the facility DON/appropriate designee regarding entering labs onto the Lab Log when ordered and for each shift to check the lab book for upcoming labs, results received, and notification of results via proper method (phone, fax, physician box) on their shift based on the normality/abnormality of lab results c. This re-inservicing will occur on/before October 19th. Any licensed nurse not in attendance will be re-inserviced prior to the beginning of the shift. This information has also been added to the orientation of newly hired licensed staff. d. Physician Order sheet and Lab log will continue to be reviewed by the nursing administrative team 5xweek during Morning Clinical Meeting and any negative findings will be addressed by the DON/appropriate designee. DON/appropriate designee will notify MD	

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F 157	Continued From page 3 chest x-ray. Resident #154 was transported to the hospital on 5/31/2017, according to the medical record.	F 157	of any outstanding lab values not addressed. III. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; a. Compliance with lab process will be brought to morning administrative meeting by the DON/appropriate designee and discussed with administrative team 5X week X 2 weeks b. Followed by weekly X 2 weeks, and as needed. c. Discussion to include actions taken for any non-compliance issues. Any discussion/revisions will be included in the morning meeting minutes. d. Compliance with lab process will be brought to the facility monthly QA meeting by the DON/appropriate designee monthly X 6 months, and as needed. e. Discussion by QAPI committee members to include actions taken for any non-compliance issues or revisions to lab process. Any discussion/revisions will be included in the QAPI meeting minutes. f. Discussion by QAPI committee members to include determination of root cause for non-compliance, actions taken for any non-compliance issues or revisions to lab process. Any discussion/revisions will be included in the QAPI meeting minutes. h. DON/appropriate designee will re-inservice licensed nurses as needed with any revisions to the lab process. i. Any revisions to lab process will require	

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F 157	Continued From page 4	F 157	monitoring to begin again at step III(a). IV. The title of the person responsible for implementing the acceptable plan of correction. a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program. b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence.	
F 247 SS=D	483.10(e)(6) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interview and record review, the facility failed to inform a resident (Resident #116) and the Responsible Party of a room change and the reason for the room change. Findings included: A review of medical records revealed Resident #116 was admitted on 7/8/2016 with diagnoses of dysphagia, glaucoma and dementia. The Annual Minimum Data Set (MDS) dated 7/1/2017, noted Resident #116 to be severely impaired for cognition and needed limited to extensive assistance for all Activities of Daily	F 247	F247 - 487.10e (6) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE I. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; a. The facility did notify the Resident Representative of a room change for Resident 116. The notification was completed by phone on (8/10/17). The reason for the room change was not given the Resident Representative for Resident 116 due to the confidentiality of the	10/20/17

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F 247	Continued From page 5 Living (ADLs) with the physical assistance of one person. In an interview on 9/18/2017 at 12:15 PM, the Responsible Party (RP) for Resident #116 stated Resident #116 had been in a room on another hall and had been moved, but the RP stated she was not told and did not know why Resident #116 had been moved. On 9/21/2017 at 4:10 PM, in an interview, the Social Worker (SW) stated Resident #116 was in a room on another hall and shared a bathroom with a resident who had an infectious disease. That was the reason for the move. Documentation was reviewed in the SW note that the RP was notified. The SW stated the RP was not told why Resident #116 was moved because the facility did not want to alarm the RP. On 9/21/2017 at 4:30 PM, the Administrator, 2 corporate consultants and an Administrator in Training were interviewed. The Administrator stated the RP was not told because it would be a HIPPA violation. The corporate consultant stated the regulation did not require it.	F 247	condition of Resident 116's roommate involving an infectious disease. b. Resident #116 had already completed the room change at the time of survey. c. The facility did not notify the Resident Representative for Resident 116 in writing of the room change due to the unawareness of the facility staff of this newly implemented addition to F247 to provide written notification of any change to a resident's room or roommate and the reason for said change. II. The procedure for implementing the acceptable plan of correction for the specific deficiency cited a. The facility policy was revised on 9/22/17 to reflect the newly implemented requirement for written notification to the resident or Resident Representative of a change in room or roommate. b. Applicable facility staff were inserviced by the facility Executive Director on/before 9/22/17 of the new requirement and revision to the facility policy. c. Any planned room/roommate change notification will be completed by the facility Social Worker/appropriate designee in compliance with all aspects of notifying the resident (if appropriate) or Resident Representative by phone, followed by written notification, and documentation of such actions in the resident's medical record. d. Details of reason for said change will be provided as allowable under HIPAA requirements. e. A copy of the written notification will be maintained in the resident's financial file. The administrative staff will review any	

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F 247	Continued From page 6	F 247	planned room/roommate change during morning administrative meeting prior to the event for completion of all aspects of required notification. III. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; a. Compliance with said program will be discussed in morning administrative meeting by the administrative team weekly X 4 weeks, and as needed. b. Discussion to include actions taken for any non-compliance issues. Any discussion/revisions will be included in the morning meeting minutes. c. Compliance will be brought to the facility monthly QA meeting by the facility Social Worker/appropriate designee monthly X 2 months, and as needed. d. Discussion by QAPI committee members to include actions taken for any non-compliance issues or revisions to lab process. Any discussion/revisions will be included in the QAPI meeting minutes. e. The Executive Director/appropriate designee will in-service applicable staff on any revisions to the said plan. f. Any revisions will require monitoring to begin again at step III (a). IV. The title of the person responsible for implementing the acceptable plan of correction. a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program.	

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F 247	Continued From page 7	F 247	b. The facility Social Worker, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion	F 272		10/20/17

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F 272	Continued From page 8 of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to comprehensively assess behaviors for 1 of 4 residents reviewed (Resident #14). Findings included: Record review revealed Resident #14 was admitted to the facility on 1/27/2014 with diagnoses which included Alzheimer's disease with behavior disturbances, Heart Disease, and Hypertension. The most recent comprehensive Minimum Data Set (MDS) dated 6/1/2017 indicated the resident was severely cognitively impaired and required extensive to total assist with all activities of daily living (ADLs). Section E of the MDS indicated the resident exhibited no physical or verbal behaviors, and did not reject care. An interview was conducted with the MDS Nurse on 9/21/2017 at 9:07 AM. The MDS Nurse	F 272	F272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS I. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; a. Resident #14 behaviors were not noted on the resident's MDS or Care plan per review of resident record. b. Resident #14's plan of care and MDS were promptly updated by the MDS Coordinator to reflect behaviors exhibited by Resident #14. c. In review of the resident record by the facility administrative staff, it was noted that behaviors exhibited by Resident #14 were documented in the medical record but not coded as a result of human error. II. The procedure for implementing the acceptable plan of correction for the specific deficiency cited a. MDS Coordinators will be re-inserviced	

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F 272	Continued From page 9 indicated the information in the MDS assessment was gathered from the look back period of 7 days prior to the assessment date of 6/1/2017. The MDS Nurse indicated the documentation must not have revealed any behaviors during that time. Review of the nursing notes revealed Resident #14 displayed physical and verbal behaviors, and rejection of care during the period of 5/28/2017 through 6/1/2017. An interview was conducted on 9/21/2017 at 3:46 PM with the Cooperate Director of Clinical Operations who stated the facility expectation was for all assessments to be accurate.	F 272	on/before 10/19/17 by the Corporate Director of Clinical Reimbursement regarding expectation of doing direct observation and communication with the resident (as appropriate) and with direct care staff prior to completing the resident's MDS and updating the resident's Plan of Care as needed. b. Five MDS/plan of cares completed will be reviewed by the Corporate Director of Clinical Reimbursement/ appropriate designee per week X 4 weeks c. If compliance is maintained in the 4 week review period, the number of MDS/plan of cares reviewed will be reduced to 3 per week X 4 weeks d. Should compliance remain consistent, random MDS/plan of cares will be reviewed weekly X 4 weeks III. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; a. Compliance with said program will be brought to the facility monthly QA meeting by the MDS Coordinator/appropriate designee monthly X 3 months, and as needed. b. Discussion by QAPI committee members to include actions taken for any non-compliance issues or revisions to said program. Any discussion/revisions will be included in the QAPI meeting minutes. c. Discussion by QAPI committee members to include determination of root cause for any non-compliance, actions taken for any non-compliance issues or	

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F 272	Continued From page 10	F 272	revisions to said program. Any discussion/revisions will be included in the QAPI meeting minutes. d. Corporate Director of Clinical Reimbursement/appropriate designee will re-inservice MDS Coordinators and/or direct care staff as needed with any revisions. e. Any revisions will require monitoring to begin again at step III(a). IV. The title of the person responsible for implementing the acceptable plan of correction. a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring. b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence.	
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (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	F 323		10/20/17

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F 323	Continued From page 11 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 observation, record review, and staff interviews, the facility failed to maintain a hazard free environment for 1 of 1 residents (Resident #14) by leaving the resident unattended in bed while the bed was raised in the high position for over 30 minutes and failed to maintain acceptable and safe water temperatures for 2 of 6 halls (200 and 300) in the facility. Findings included: 1-Record review revealed Resident #14 was admitted to the facility on 1/27/2014 with diagnoses which included Alzheimer's disease with behavior disturbances, Heart Disease, and Hypertension. The most recent comprehensive Minimum Data Set (MDS) dated 6/1/2017 indicated the resident was severely cognitively impaired and required extensive to total assist with all activities of daily living (ADLs). The Care Area Assessment dated 6/1/2017 indicated Resident #14 was at a risk for falls and the area of falls was carried to the care plan. Record review of the care plan revealed the most recent update was 8/28/2017. The care plan indicated the resident was at a risk for falls due to	F 323	F323 483.25(d)(1)(2)(n)(1)-(3) FOF ACCIDENT HAZARDS/ SUPERVISION/ DEVICES I. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; a. Resident #14's bed was placed in the lowest position by the direct care staff and without any negative outcome to the resident b. Identified CNA was suspended pending investigation with subsequent disciplinary action given by the facility Executive Director and DON. c. Through review by the administrative team of actions exhibited by the identified staff member, it was determined that the bed was left in a raised position through human error d. Hot Water temperature logs indicated the temps were all within range until 9/19/17. At this time the temperature was degrees above required range. The reason was due to the mixing valve in need of adjusting. Immediately adjusted	

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F 323	Continued From page 12 impaired cognition, increased behaviors, poor safety awareness, and a history of falls. The interventions for the risk for falls included a completed fall risk assessment, provided assistance when needed, observation for unsafe activity with safety interventions. Record review revealed a completed falls risk assessment evaluation dated 5/18/2017 and indicated the resident scored a 14. The evaluation revealed a resident with a score of 10 or above should be considered a high risk for falls and a fall prevention protocol should be initiated. An observation of Resident #14 was conducted on 9/19/2017 at 12:10 PM. The resident was observed in bed, and the bed was raised in the high position. The resident removed the sheet, moved her legs from side to side, and attempted to pull the fitted sheet off the bed. The resident was observed continually from 12:10 PM to 12:40 PM. The bed remained in the high position. At 12:40 PM, NA #5 entered the room and spoke to Resident #14. NA #5 lowered the bed prior to exiting the room. An interview was conducted with the MDS Nurse on 9/21/2017 at 9:07 AM. The MDS Nurse indicated all residents' beds in the facility should be kept in the low position for safety. The MDS Nurse indicated it was a "given" for beds to be in the low position for safety, and all staff was aware the beds were to be in the low position for residents at risk for falls. An interview was conducted with NA #5 on 9/21/2017 at 3:40 PM. NA #5 reported she worked with Resident #14 on 9/19/2017 for the day shift. NA #5 indicated she must have forgotten to lower the resident's bed after lunch. NA #5 also indicated she was aware the resident was a fall risk and the bed needed to be lowered after care was provided for the resident's safety.	F 323	by the Maintenance Director and hot water was within required range with no negative outcome to any resident. II. The procedure for implementing the acceptable plan of correction for the specific deficiency cited a. Direct care staff will re-inserviced on/before 10/19/17 by the DON/appropriate designee with regards to following established fall precautions for any resident deemed to be at risk for falls. b. Random direct care staff will be observed and documented on the Resident Room Audit by the licensed nursing and QM staff 5 times per week X 4 weeks, and as needed with any non-compliance promptly addressed to include staff counseling. c. Should compliance be maintained during the initial 4 weeks, random direct care staff will be observed by licensed nursing and QM staff 2 times per week X 4 weeks, and as needed, with any non-compliance promptly addressed. d. With regards to the temperature range. The Maintenance Director will check 4 random resident rooms on each hall daily X 4 weeks to determine required range of temperature for hot water and prompt action taken for temperatures outside the required range. Findings will be documented on the water temp log. Facility Executive Director will be notified immediately of out of range temps. e. Should audits show temperatures are sufficient, random testing will be reduced to 2 rooms per hall on a weekly basis on-going. III. The monitoring procedure to ensure	

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F 323	Continued From page 13 An interview was conducted on 9/21/2017 at 3:46 PM with the Cooperate Director of Clinical Operations who stated the facility expectation was for residents who were identified a falls risk to have their beds in the lowest position. 2. On 9/19/2017 at 9:30 AM, the hot water was checked in the bathroom sink faucet in room 201. The hot water was very hot to touch. The remaining rooms on the 200 hall were also noted to have very hot water coming from the faucet. The 300 hall bathroom faucets were checked and also felt very hot. The 100 hall bathroom hot water did not feel as hot as the other halls. On 9/19/2017 at 10:30 AM, the Maintenance Director stated he checks the water temps in two rooms on each hall each week. He proceeded to check hot water temps in bathroom faucets on the 100, 200 and 300 halls. The hot water temperature in the sink in the bathroom shared by room 206 and 208 registered at 117.8 F. The temperature of the hot water in the sink in the bathroom shared by room 313 and 315 registered 119.6 F. The Maintenance Director stated his thermometer was an infrared "gun" which is aimed at the water and shows the temp. The Maintenance Director stated his thermometer is calibrated yearly by the manufacturer. At 11:45 AM, the Maintenance Director stated he was going to the mixing valve to adjust it. At 2:0 0 PM on 9/19/2017, the Maintenance Director checked the hot water temp in the sink of the bathroom between rooms 206 and 208. The temp was 111.0 F. The temperature of the hot water was also taken in the sink of the bathroom between room 313 and 315 and the temp was 111.0 F. The temperature logs were reviewed for August	F 323	that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; a. Results of audits will be brought to the morning administrative meeting by the DON/appropriate designee weekly X 4 weeks for discussion. The Maintenance Director/appropriate designee will bring results of temperature checks to the morning administrative meeting 4X week X 4 weeks. b. Results of audits/compliance rate will be brought to facility monthly QAPI and/or Safety meetings by the DON/appropriate designee and the Maintenance Director/appropriate designee X 6 months for review by committee members, determination of root cause for any non-compliance, revision of plan as needed. c. Discussion by QAPI committee members to include actions taken for any non-compliance issues or revisions to said program. Any discussion/revisions will be included in the QAPI meeting minutes. d. Facility DON/appropriate designee will re-inservice direct care staff as needed with any revisions to the said fall-risk program. f. Any revisions will require monitoring to begin again at step III(a). IV. The title of the person responsible for implementing the acceptable plan of correction. a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for	

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F 323	Continued From page 14 and September, 2017 and revealed all temps were within an acceptable range. On 9/22/2017 at 3:30 PM, the Administrator stated his expectation was the hot water temperatures would be within an acceptable range.	F 323	implementing, directing, and monitoring the above said program. b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence.	
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: (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;	F 441		10/20/17

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F 441	Continued From page 15 (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 annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility staff failed to remove gloves following incontinence care and opened the room door, disposed of the uncontained	F 441	F441 483.80(a)(1)(2)(4)e(f) INFECTION CONTROL, PREVENT SPREAD, LINENS I. The plan of correcting the specific deficiency. The plan should address the	

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F 441	Continued From page 16 soiled linen in the dirty linen bin, retrieved clean linen from the linen cart, reentered the room, and applied the clean linen to a resident's bed, which resulted in a risk of cross contamination for 1 of 1 residents reviewed for incontinence care (Resident #52). Findings included: Record review revealed Resident #52 was admitted to the facility on 3/6/2012 with diagnoses which included Pressure Ulcers, Heart Failure and Diabetes. The quarterly Minimum Data Set (MDS) dated 7/13/2017 revealed the resident was cognitively intact and required extensive to total assist with all activities of daily living. An observation of incontinent care by Nursing Assistant #5 (NA#5) was conducted on 9/20/2017 at 11:46 AM. NA #5 washed her hands, donned gloves, removed the resident's soiled brief and cleaned the resident. There was some stool observed on the linens and NA#5 removed the linens and placed the soiled linens and brief on top of the trash can which was lined with a plastic bag. NA #5 covered the resident and retrieved the soiled brief and linens from the top of the trash can, opened the room door by the door handle with her right hand and carried the soiled items un-bagged and placed in the soiled linen bin which was located in the hall directly outside of the room. NA#5 went to the clean linen cart which was also located in the hall outside of the room and obtained clean linen from the cart. The NA opened the door with the door handle and carried the clean linen into the room. NA #5 put the clean linens on the resident's bed, removed her gloves and exited the room.	F 441	processes that lead to the deficiency cited; a. The CNA cited as not following Infection Control practices with regards to handling linens, glove usage, and handwashing had received one-on-one training 2 days prior to cited occurrence. b. CNA was suspended pending investigation with subsequent disciplinary action given by the Executive Director and DON. Determined cause was human error. II. The procedure for implementing the acceptable plan of correction for the specific deficiency cited a. All licensed and non-nursing will be re-inserviced on the facility's policy for handling linens, glove usage and handwashing by the DON/appropriate designee on/before 10/19/17. Any staff not in-serviced by 10/19/17 will be removed from the schedule. All new staff will be trained during orientation. b. The DON/appropriate designee will complete random compliance audits and document on the Observation of Care audit with CNAs 4 X weekly X 4 weeks. Any non-compliance will be promptly addressed by the reviewer, and additional re-training provided as needed. c. If compliance is maintained, random audits will be reduced to bi-weekly X 2 months, and as needed. Followed by monthly x 3 months. Again, any non-compliance will be promptly addressed by reviewer and additional re-training provided as needed. III. The monitoring procedure to ensure that the plan of correction is effective and	

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F 441	Continued From page 17 An interview was conducted with NA #5 on 9/20/2017 at 3:23 PM. NA #5 indicated she did not think about bagging dirty linen if the dirty linen cart is right outside the room. NA #5 reported she did not take her dirty gloves off when she exited the room of Resident #52 because she just didn't think about it. NA #5 indicated she didn't think about taking the dirty gloves off when she retrieved the clean linen. NA #5 stated she did not wash her hands after she took off the dirty gloves but she did wash them prior to working with another resident. NA #5 stated she always washed her hands before working with residents. NA #5 also indicated she was in-serviced on infection control in the last couple of weeks. An interview was conducted with the Director of Nursing (DON) on 9/20/2017 at 4:39 PM. The DON indicated all staff were educated on infection control during classroom orientation and were in-serviced throughout the year on infection control practices. The DON reported NA #5 was recently educated on infection control fundamentals and practices. The DON stated the expectation was for infection control practices to be followed by all staff which included the proper way to transport dirty linen, removal of dirty gloves prior to using a door handle or touching clean linen, and appropriate hand washing.	F 441	that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; a. Results of random audits for the infection control said program will be brought to the morning administrative meeting by the DON/appropriate designee weekly X 4 weeks for review by administrative team. b. Results of random audits will be brought to the facility QAPI month meetings by the DON/appropriate designee monthly X 6 months for review of plan and outcomes by QAPI committee members. c. Facility DON/appropriate designee will re-inservice direct care staff as needed with any revisions to the said infection control program. f. Any revisions to said programs will require monitoring to begin again at step III(a). IV. The title of the person responsible for implementing the acceptable plan of correction. a. The facility Executive Director, in conjunction with the facility QAPI committee, will be responsible for implementing, directing, and monitoring the above said program. b. The facility DON, in conjunction with the facility QAPI committee, will serve as the alternate responsible person in the Executive Director's absence.	