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	345126	A. BUILDING _____ B. WING _____	C 10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		10/30/18

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

Electronically Signed | 10/24/2018

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F 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff and physician interviews, and record reviews the facility failed to correctly implement a plan of care by not following appropriate hand hygiene during care to avoid contaminating a resident ' s bathing water with stool during a bed bath and using a contaminated, wet glove to adjust a pressure ulcer dressing for 1 of 3 resident reviewed for providing care according to resident care plans. (Resident #3) Findings included: Resident #3 was admitted to the facility on 1/25/18. Resident #3 ' s active diagnoses included cancer, hypertension, benign prostatic hyperplasia, arthritis, aphasia, cerebrovascular accident, functional quadriplegia, and abnormal posture. Review of Resident #3 ' s most recent minimum data set assessment dated 7/10/18 revealed the resident was assessed as severely cognitively impaired. Resident #3 had no moods or behaviors. Resident #3 was totally dependent on staff for bed mobility, dressing, eating, toilet use, and personal hygiene. The resident was always incontinent of bowel and bladder. Pain was not present during the assessment. Resident #3 had one stage II pressure ulcer and one stage III pressure ulcer at the time of the assessment. The resident was receiving pressure ulcer care. Review of Resident #3 ' s skin integrity report	F 656	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Mount Olive Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. F-656 Resident #3 was affected by this practice. Care Plan for Resident # 3 was reviewed for accuracy and Care Card updated to assure resident receives appropriate wound care. This practice has the ability to affect all residents. The Care Plan and Care Cards have been reviewed for all Current residents receiving PU wound care. Clinical staff received training by the CNE/NPE/Designee on the importance of reviewing and following the resident Care Plan to assure listed interventions are being followed. Training completed on 10/2/18, 10/22/18, 10/23/18, and 10/24/18. Unit Managers will continue to audit Pressure Ulcer care to assure care	

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F 656	Continued From page 2 revealed the resident returned from the hospital on 9/25/18 with a new unstageable wound to Resident #3 ' s left hip identified upon admission on 9/25/18. On 9/25/18 the wound was measured to be 4.5 centimeters long, 6.5 centimeters wide, and less than 0.1 centimeters deep. Review of Resident #3 ' s care plan dated 9/26/18 revealed the resident was care planned for actual skin breakdown related to pressure areas to bilateral hips and right ankle. The interventions included to assist him in turning and repositioning at regular and frequent intervals and provide peri care and incontinence care as needed. He was also care planned to require assistance with activities of daily living. During observation on 10/2/18 at 12:38 PM Nurse Aide #1 and Nurse Aide #2 were observed providing Resident #3 a bed bath and incontinent care. Resident #3 was on the right side. A fresh wound dressing was in place on Resident #3 ' s left ischium unstageable pressure ulcer. Approximately two inches of the dressing on the left ischium unstageable pressure ulcer had pulled away from Resident #3 ' s skin leaving a gap of approximately one inch. Nurse Aide #1 had one bin of warm water at the bedside, multiple wash cloths, and was using no-rinse soap. Nurse Aide #1 had cleaned Resident #3 ' s upper body and had begun to remove the resident ' s brief. Nurse Aide #2 observed that there was stool in Resident #3 ' s brief and removed the brief. Nurse Aide #1 then used a damp washcloth in her right hand to wipe the stool from the resident, folding the washcloth multiple times. A small amount of stool was observed to be on Nurse #1 ' s glove on her right hand. Nurse Aide #1 then reached for a new	F 656	is being provided in accordance with the care plan. All pressure ulcer care plans will be reviewed with the Unit Managers (UM) in the Clinical At Risk (CAR) meeting weekly to assure care is being provided as required and care plans will be modified as needed. Care Plan audits for residents with pressure ulcers will be completed by the(UM)3 times a week for 3 months, To ensure that interventions are carried out accordingly. Audits will be completed for residents who may develop new wounds. Results will be reviewed with the UM's and Center Nurse Executive (CNE) at the QAPI meeting for three months and may be extended or otherwise adjusted based on compliance and any additional findings.	

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F 656	Continued From page 3	F 656		

washcloth with her right hand still having the same glove on the hand and a small amount of stool was observed to be smeared on the new washcloth. Nurse Aide #1 placed this washcloth and her right hand with the glove in the bin of warm water and then wrung the washcloth out into the bin of water. At this point, Nurse Aide #1 observed the dressing on the unstageable ischium pressure ulcer had pulled away from the resident ' s skin. Nurse Aide #1 used her right hand with the same soiled glove to reattach the bandage to the skin. Her hand was still wet from the water she had been using. Nurse Aide #1 ' s index, middle and ring fingers were under the adhesive edge of the bandage and her thumb was on the outside of the adhesive edge of the bandage as she pulled it back to the skin and replaced it. The bandage was slightly damp where her fingers had touched the bandage.

During an interview 10/2/18 at 12:50 PM Nurse Aide #1 stated she did remember not changing gloves after cleaning Resident #3 ' s bowel movement and then used the same hand to soak and wring out the water back into the basin. She further stated she did not notice the feces on her glove prior to getting the next rag. The nurse aide stated she did not remember which hand she used to replace the pressure ulcer bandage. Nurse Aide #1 further stated if it was her right hand she used to replace the wound dressing she should not have used that hand because of the risk for contamination and infection and it was not best practice.

During an interview on 10/2/18 at 12:58 PM the Director of Nursing stated it was her expectation staff members remove soiled gloves, wash their hands, and then don new gloves prior to

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F 656	Continued From page 4 continuing care. She further stated the reason she would expect staff to not touch bandages with soiled gloves was because of the risk for infection to the wound. During an interview on 10/2/18 at 2:29 PM Resident #3 ' s Physician stated it was best practice for staff to not touch wound dressings with soiled gloves. He further stated in the facility it was his expectation wound dressings not be touched by contaminated gloves.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to avoid contaminating a resident ' s bathing water with stool halfway through a resident ' s bed bath for 1 of 3 dependent residents reviewed for activities of daily living care. (Resident #3) Findings included: Resident #3 was admitted to the facility on 1/25/18. His active diagnoses included aphasia, cerebrovascular accident, functional quadriplegia, and abnormal posture. Review of Resident #3 ' s most recent minimum data set assessment dated 7/10/18 revealed he was assessed as severely cognitively impaired. He had no moods or behaviors. Resident #3 was	F 677	F-677 Resident #3 was affected by this practice. Wound was immediately cleansed and new dressing applied. Resident #3 was given a new bath to assure cleanliness. This practice has the ability to affect all residents. Dependent residents are receiving ADL care as required and as care planned. Clinical staff received training by the CNE/NPE/Designee on infection control practices, such as hand washing, donning and removing gloves, total bed baths, pericare, aseptic technique, dressing changes and care cards with return demonstration at time of in-servicing.	10/30/18

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F 677	Continued From page 5 totally dependent on staff for bed mobility, dressing, toilet use, and personal hygiene. He was always incontinent of bowel and bladder. Review of Resident #3 ' s care plan dated 9/26/18 revealed he was care planned to require assistance with activities of daily living care. The interventions included to provide total care to Resident #3 for toileting and bathing. During observation on 10/2/18 at 12:38 PM Nurse Aide #1 and Nurse Aide #2 were observed providing Resident #3 a bed bath and incontinent care. Resident #3 was on his right side. Nurse Aide #1 had one bin of warm water at the bedside, multiple wash cloths, and was using no-rinse soap. Nurse Aide #1 had cleaned Resident #3 ' s upper body and had begun to remove the resident ' s brief. Nurse Aide #2 observed that there was stool in Resident #3 ' s brief and removed the brief. Nurse Aide #1 then used a damp washcloth in her right hand to wipe the stool from the resident, folding the washcloth multiple times. A small amount of stool was observed to be on Nurse #1 ' s glove on her right hand. Nurse Aide #1 then reached for a new washcloth with her right hand still having the same glove on the hand and a small amount of stool was observed to be smeared on the new washcloth. Nurse Aide #1 placed this washcloth and her right hand with the glove in the bin of warm water and then wrung the washcloth out into the bin of water. Nurse Aide #1 used the same bin of warm water to complete the resident ' s bath for his legs and feet. She did not replace the water following incontinent care. During an interview 10/2/18 at 12:50 PM Nurse Aide #1 stated she did remember not changing	F 677	Training completed on 10/2/18, 10/22/18, 10/23/18, and 10/24/18. All pressure ulcers will be added to the care cards with interventions. Unit Managers will randomly check on care provided to assure proper procedures are being followed and report on results weekly at the CAR Meeting. Infection Control Audits to be completed by the Unit Managers 3 times a week for 3 months. Audits to include hand washing, total bed baths, pericare, donning and removing gloves, care card observation on their person, aseptic technique and verbalization of process with dressings. Results will be reviewed with the Unit Managers and Center Nurse Executive at the QAPI meeting for three months and may be extended or otherwise adjusted based on compliance and any additional findings.	

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F 677	Continued From page 6 gloves after cleaning the resident ' s bowel movement and then used the same hand to soak and wring out the water back into the same basin. She further stated she did not notice the feces on her glove prior to getting the next rag. She further stated she should have changed gloves and that she had contaminated the water and then continued giving his bath with water that was contaminated and she should have replaced the water following incontinent care as well as her gloves. During an interview on 10/2/18 at 12:58 PM the Director of Nursing stated it was her expectation staff members remove soiled gloves, wash their hands, and then don new gloves prior to continuing care. She further stated by continuing the bath with a soiled glove Nurse Aide #1 contaminated the water she used for the rest of the resident ' s bath and it was her expectation a new bin of water be retrieved prior to continuing the bath.	F 677		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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:	F 880		10/30/18

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F 880	Continued From page 7 §483.80(a)(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; §483.80(a)(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; (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.	F 880		

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F 880	Continued From page 8 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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 and physician interviews, and record reviews the facility failed to avoid contaminating a resident ' s bathing water with stool during a bed bath and failed to avoid the use of a contaminated, wet glove to adjust a pressure ulcer dressing for 1 of 3 resident reviewed for infection control. (Resident #3) Findings included: Resident #3 was admitted to the facility on 1/25/18. Resident #3 ' s active diagnoses included arthritis, aphasia, cerebrovascular accident, functional quadriplegia, and abnormal posture. Review of Resident #3 ' s skin integrity report revealed the resident returned from the hospital on 9/25/18 with a new unstageable wound to the resident ' s left hip identified upon admission on 9/25/18. On 9/25/18 the wound was measured to be 4.5 centimeters long, 6.5 centimeters wide, and less than 0.1 centimeters deep. During observation on 10/2/18 at 12:38 PM Nurse	F 880	F-880 Resident #3 was affected by this practice. Wound was immediately cleansed and new dressing applied. Resident #3 was given a new bath to assure cleanliness. This practice has the ability to affect all residents. Audits completed on all current residents with PU□s to see if any of them have infections in their wounds □ 10/23/18. Clinical staff received training by the CNE/NPE/Designee on infection control practices, such as hand washing, donning and removing gloves, total bed baths, pericare, aseptic technique, dressing changes and care cards with return demonstration at time of in-servicing. Training completed on 10/2/18, 10/22/18, 10/23/18, and 10/24/18. All pressure ulcers will be added to the care cards with interventions. Unit Managers will randomly check on care provided to assure proper procedures are being followed and report	

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F 880	Continued From page 9 Aide #1 and Nurse Aide #2 were observed providing Resident #3 a bed bath and incontinent care. Resident #3 was on the right side. A fresh wound dressing was in place on Resident #3 ' s left ischium unstageable pressure ulcer. Approximately two inches of the dressing on the left ischium unstageable pressure ulcer had pulled away from Resident #3 ' s skin leaving a gap of approximately one inch. Nurse Aide #1 had one bin of warm water at the bedside, multiple wash cloths, and was using no-rinse soap. Nurse Aide #1 had cleaned Resident #3 ' s upper body and had begun to remove the resident ' s brief. Nurse Aide #2 observed that there was stool in Resident #3 ' s brief and removed the brief. Nurse Aide #1 then used a damp washcloth in her right hand to wipe the stool from the resident, folding the washcloth multiple times. A small amount of stool was observed to be on Nurse #1 ' s glove on her right hand. Nurse Aide #1 then reached for a new washcloth with her right hand still having the same glove on the hand and a small amount of stool was observed to be smeared on the new washcloth. Nurse Aide #1 placed this washcloth and her right hand with the glove in the bin of warm water and then wrung the washcloth out into the bin of water. At this point, Nurse Aide #1 observed the dressing on the stage unstageable ischium pressure ulcer had pulled away from the resident ' s skin. Nurse Aide #1 used her right hand with the same soiled glove to reattach the bandage to the skin. Her hand was still wet from the water she had been using. Nurse Aide #1 ' s index, middle and ring fingers were under the adhesive edge of the bandage and her thumb was on the outside of the adhesive edge of the bandage as she pulled it back to the skin and replaced it. The bandage was slightly damp	F 880	on results weekly at the CAR Meeting. Infection Control Audits to be completed by the Unit Managers 3 times a week for 3 months. Audits to include hand washing, total bed baths, pericare, donning and removing gloves, care card observation on their person, aseptic technique and verbalization of process with dressings. Results will be reviewed with the Unit Managers and Center Nurse Executive at the QAPI meeting for three months and may be extended or otherwise adjusted based on compliance and any additional findings.	

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F 880	Continued From page 10	F 880		

where her fingers had touched the bandage. Nurse Aide #1 used the same bin of warm water to complete the resident ' s bath for his legs and feet. She did not replace the water following incontinent care.

During an interview 10/2/18 at 12:50 PM Nurse Aide #1 stated she did remember not changing gloves after cleaning Resident #3 ' s bowel movement and then used the same hand to soak and wring out the water back into the basin. She further stated she did not notice the feces on her glove prior to getting the next rag. The nurse aide stated she did not remember which hand she used to replace the pressure ulcer bandage. Nurse Aide #1 further stated if it was her right hand she used to replace the wound dressing she should not have used that hand because of the risk for contamination and infection.

During an interview on 10/2/18 at 12:58 PM the Director of Nursing stated it was her expectation staff members remove soiled gloves, wash their hands, and then don new gloves prior to continuing care. She further stated it was her expectation Nurse Aide #1 notify the nurse about a pressure ulcer bandage that was pulling away from the skin and it was her expectation the nurse aides never touch pressure ulcer bandages with dirty gloves and replace it. She further stated the reason she would expect staff to not touch bandages with soiled gloves was because of the risk for infection to the wound.

During an interview on 10/2/18 at 2:29 PM Resident #3 ' s Physician stated it was best practice for staff to not touch wound dressings with soiled gloves. He further stated it would be impossible to say if Nurse Aide #1 ' s actions

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F 880	Continued From page 11 would have caused an infection. He further stated in the facility it was his expectation wound dressings not be touched by contaminated gloves.	F 880		