STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 10/17/2018

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AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		11/12/18

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

Electronically Signed | 11/05/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and staff and resident interviews the facility failed to ensure a resident's dignity for 1 of 5 residents when a housekeeper entered resident room without knocking prior to entering the rooms. (Residents #9) The Findings Included: Resident #9 was admitted to the facility on 05/15/18 with diagnoses that included history of stroke, dementia, depression and hyperlipidemia among others. A review of Resident #9's most recent Minimum Data Set Assessment (MDS) dated 07/22/18 revealed resident to be moderately impaired cognitively with no psychosis, behaviors or instances of rejection of care. An observation was made on 10/16/18 at 11:08 AM of Housekeeper #1 who pulled her cart up to room #410 without knocking at 11:10 AM. At this time, an observation was made of Resident #9 awake, alert and up in room #410 and appeared to be working on a craft or project. An interview on 10/17/18 at 3:57 PM with Resident #9 who was observed in room #410, revealed she felt the facility's staff should always knock on resident rooms before entering. Resident #9 reported she remembered the housekeeper coming in the previous day and remembered that she did not knock or speak to her when she entered the room. Resident #9 stated she did not want to make a big deal about	F 550	Plan of Correction For Complaint Survey 10/16/18 through 10/17/18 Autumn Care of Statesville This plan of correction is completed per North Carolina State Requirements. It is not an admission of guilt on behalf of Autumn Care of Statesville. F550: Resident Rights/Exercise of Rights Immediately, the specific housekeeper in violation of not providing the resident a dignified existence was educated by DON on knocking on resident doors upon entry. Every resident in the facility has the potential to be at risk. Therefore, designees completing quality rounds in the facility are reviewing staff upholding resident dignity by knocking on resident doors through the quality zone audit tool Monday through Friday. Staff education was provided to all departments regarding resident dignity and more specific, knocking on resident doors upon entry. In order to continue compliance, quality rounds will be completed by designees of the NHA daily for 4 weeks throughout weekdays. The quality zone audit tools will be collected and reviewed by the NHA or designee 3 times a week for 4 weeks to identify any trends. The trends will be	

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F 550	Continued From page 2 it but wished the housekeeper would have knocked and announced herself before entering the room. An interview with Housekeeper #1 on 10/17/18 at 2:51 PM revealed her daily routine consisted of cleaning rooms on the 400 and 600 halls. She reported she was supposed to knock before entering all resident rooms. She denied forgetting to knock on multiple resident rooms before entering the previous day. During an interview on 10/17/18 with the Director of Maintenance who reportedly oversaw the housekeeping staff as well revealed he expected his staff to always knock and introduce themselves to the residents in the room. He reported with some of the long term residents with whom the housekeeping staff have developed a relationship with, his expectation is that the housekeeping staff knock before entering but are not required to introduce themselves but he did expect the housekeeping staff to speak to the residents if they were in the room at the time. An interview with the Director of Nursing on 10/17/18 at 3:03 PM revealed is was her expectation that all staff knock before entering any resident rooms. She reported that Housekeeper #1 should have knocked on the resident's rooms before entering.	F 550	discussed and resolved ongoing by the QAPI Committee for 5 months. Any necessary further monitoring will be identified and implemented by the QAPI Committee. Completion Date: 11/12/18	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		11/12/18

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F 684	Continued From page 3 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assess a resident's skin condition on admission to the facility for 1 of 3 residents sampled for pressure ulcers (Resident #4). The findings included: Resident #4 was admitted to the facility on 08/16/18 and discharged on 09/26/18. Resident #4's diagnoses included heart failure, orthostatic hypotension, end stage renal disease, anxiety, and depression. Review of the comprehensive minimum data set dated 08/23/18 revealed Resident #4 was cognitively intact and required extensive assistance with activities of daily living. The MDS further revealed that Resident #4 had no pressure ulcers but did have skin tears and moisture associated skin damage that required application of ointments or medication. Review of a weekly Skin Assessment dated 08/16/18 revealed that Resident #4 had a sacral wound. The assessment revealed nothing else about the wound except Resident #4 had a sacral wound. The assessment was completed and signed by the Unit Coordinator (UC). Review of a facility document titled Point of Care Audit dated 08/16/18 through 09/26/18 revealed Resident #4 received barrier cream to her sacral	F 684	F684: Quality of Care Resident #4 has discharged from our facility. Immediately, the nurse identified as responsible to complete the wound assessment was educated by DON on the necessary wound assessment required upon resident admission. All new admissions were identified as residents who are at risk. DON has verified that the electronic medical record is accurately triggering the wound assessment upon admission with no sign on deficiency. Nurse education was provided on the appropriate time frames to complete the wound assessments by the DON or designee. Education was provided on what is to be covered in nursing orientation. This is currently part of our orientation checklist as “Demonstrates Knowledge and skill in performing documentation of facility skin and wound care protocol for prevention and treatment.” As well as listed again under, “wound assessment and documentation”. For agency, we do not utilize agency services. However, if we should, this is covered on the agency orientation checklist as “Understanding facility policies relating to resident care.”	

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F 684	Continued From page 4 region after each incontinent episode every shift while present in the facility. Review of a Weekly Wound Assessment dated 08/23/18 revealed Resident #4 had Moisture Related Skin Damage (MRSD) to her sacrum that measured 1.0 centimeter (cm) x 0.4 cm x 0.2 cm and had a small amount of serous (bloody) drainage. The comments read, Resident #4 admitted with an open area to the sacrum related to moisture. The wound was cleaned and covered with calcium alginate and an absorbent foam. Will continue to monitor and adjust the treatment as needed. The assessment was signed by the Wound Nurse (WN) An interview was conducted with the WN on 10/16/18 at 3:47 PM. The WN indicated that she performed the daily dressing changes for most of wounds in the facility. She indicated that she routinely visited each new admission the morning after their admission to check their skin and make sure that any wounds or skin conditions were documented, and treatments had been initiated. The WN stated that the hall nurse generally admitted the resident to the facility which included the initial skin assessment. She added that the skin assessment contained an area for the nurse to place a description of the wound and the measurements of the wound. The WN stated that she was not the nurse that admitted Resident #4 to the facility and she had not completed the initial skin assessment. She added that she did attempt to see Resident #4 the day after her admission but due to her dialysis schedule kept missing her. The WN stated that she was able to visit with Resident #4 on 08/23/18 and assessed her skin. She added that she had an open area to her sacral area that appeared to be from moisture	F 684	Education was completed by 11/2/18. Moving forward, on weekdays, new admissions will be reviewed for accurate and completed wound assessments daily in morning clinical meeting for 4 weeks. On a monthly basis for 5 months, DON or designee will randomly select 5 admissions to ensure wound assessment and accurate response was completed timely. The DON or Designee will also audit any new licenses nurse team members as well as agency for 5 months to ensure orientation checklist is completed accurately. Any deficiencies will be identified and reported to the QAPI committee on an ongoing basis for 5 months. Any necessary further monitoring will be identified and implemented by the QAPI Committee. Completion Date: 11/12/18	

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F 684	Continued From page 5 and she initiated a dressing change to the area. The WN stated that the admission nurse who completed the skin assessment should have assessed the wound which included a description of the wound, measurements, and made sure a treatment was in place and that should have been done on admission and not a week later. An interview was conducted with the Director of Nursing (DON) on 10/16/18 at 5:32 PM. The DON stated that she expected the UC to assess the wound on admission including measuring the wound and a description of the wound. She added that the barrier cream was not the ideal treatment but it was an appropriate first line treatment to prevent further skin damage. An interview was conducted with the UC on 10/16/18 at 5:50 PM. The UC confirmed that she was assisting with the admission of Resident #4 and recalled completing the skin assessment on 08/16/18. The UC stated that Resident #4 had some edema to her arms, some skin tears, and had a wound on her sacral area. She described the area to the sacrum as moisture related but stated "I am not good with wounds." The UC stated that the wound was raw skin with the top layer of skin gone and she added that she made sure that there was barrier cream initiated. The WN confirmed that she did not formally assess the wound or measure the wound because "I am not comfortable with measuring wounds" and left for the WN to handle. .	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		11/12/18

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F 689	Continued From page 6 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to provide supervision during toileting for a resident who was at risk for falls and fell during toileting while unsupervised for 1 of 3 residents sampled for falls (Resident #1). Findings included: Resident #1 was admitted to the facility on 08/06/18 with diagnoses which included muscle weakness, abnormal gait and mobility, depression, anxiety and Alzheimer's disease. A review of a nurse's admission note dated 08/06/18 at 5:41 PM revealed Resident #1 was admitted from the hospital and used a walker with stand by assist but preferred to use a wheelchair most of the time. A review of a care plan dated 08/07/18 indicated Resident #1 was at risk for falls and the goal was to minimize risks for falls and minimize injuries related to falls. The interventions were listed in part to implement preventative fall interventions and devices, maintain call light within reach and educate resident to use call light and maintain needed items within reach. A review of the admission Minimum Data Set	F 689	F689: Free of Accidents Hazards/Supervision/Devices Resident #1 has discharged from our facility. All residents who need assistance with toileting are at risk. Education will be provided to clinical staff including nurses, nurse aides, and therapy staff, specifying the importance of supervising residents while assisting with toileting activity We do not utilize agency staff. Education will be provided to agency prior to working in our facility if necessary through our agency staff orientation. Education was completed by 11/2/18. Weekly, a DON designee will shadow a CNA to provide an audit that the CNA staff are supervising residents while toileting. The documented results will be turned in to the DON or designee three times a week for 4 weeks. Monthly, the DON or designee will randomly select 3 residents to audit for 5 months. Any deficient return will be addressed in the next weekday morning clinical meeting and discussed at	

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F 689	Continued From page 7 (MDS) dated 08/10/18 indicated Resident #1 was severely impaired in cognition for daily decision making. The MDS also indicated Resident #1 required extensive assistance with bed mobility and transfers and was frequently incontinent of urine and always continent of bowel. A review of a Fall Risk Evaluation dated 08/13/18 at 5:41 PM completed by Nurse #4 revealed in part Resident #1 had no falls in the last 90 days. The evaluation also revealed Resident #1 ambulated with problems and devices, her gait was unsteady, slow and lurching, her balance was not steady and she was only able to stabilize with physical assistance. A review of an incident report dated 08/18/18 at 4:07 PM completed by Nurse #5 revealed a NA assisted Resident #1 to the bathroom and went back to check on her 2 times and she was not finished. The report indicated when the NA went back a third time Resident #1 was on the floor on her knees in front of the wheelchair. The report further indicated Resident #1 stated she slid on the floor and then got herself to her knees. The report revealed Resident #1 had pulled the call bell half way but not hard enough to set it off. The report indicated Resident #1 had fading bruises to her right outer calf that were 7 centimeters (cm) by 6 cm that looked like they were healing. A section labeled immediate action taken indicated Resident #1 was reminded to wait for assistance and she was reoriented to the use of the call bell. A review of a Fall Risk Evaluation dated 08/18/18 at 4:07 PM completed by Nurse #5 revealed in part Resident #1 had 1-2 falls in the last 90 days. The evaluation also revealed Resident #1	F 689	the QAPI committee meeting for 5 months. Further necessity for monitoring will be determined by the QAPI Committee. Completion Date: 11/12/2018	

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F 689	Continued From page 8	F 689		

ambulated with problems and devices and her gait was unsteady, slow and lurching. The evaluation further revealed Resident #1's balance was not steady and she was only able to stabilize with physical assistance.

A review of nurse's notes dated 08/18/18 revealed there was no documentation of Resident #1's fall.

A review of a note on the incident report dated 08/19/18 revealed NAs were to remain with Resident #1 as Resident #1 tolerated while in the bathroom.

A review of a change of condition form titled Situation, Background, Assessment/Appearance and Request (SBAR) dated 08/20/18 at 10:49 AM revealed Resident #1 was sent to the emergency room for chest pain.

During a telephone interview on 10/17/18 at 10:31 AM, Nurse #5 stated she did not recall Resident #1. She explained she should have documented Resident #1's fall in the nurse's notes but could not recall any details of Resident #1's fall or which NA had taken Resident #1 to the bathroom.

During a telephone interview on 10/17/18 at 12:55 PM, Nurse #4 stated she remembered Resident #1 but could not remember details related to a fall. She further stated she could not recall which NA took Resident #1 to the bathroom on 08/18/18.

During an interview on 10/17/18 at 2:18 PM, the Staff Development Coordinator (SDC) stated after review of the incident report of Resident #1's fall, she would have expected for the NA to have

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F 689	Continued From page 9 provided Resident #1 privacy but should have stood outside the bathroom door until Resident #1 was finished. She stated then the NA could have provided the necessary supervision during toileting. During an interview on 10/17/18 at 4:22 PM, the Director of Nursing stated it was her expectation for staff to provide supervision to prevent accidents. She further stated it was her expectation for nurses to assess the resident after a fall which included a check of vital signs and a complete assessment from head to toe. She also stated residents should not be left unattended during toileting when they were at risk for falls.	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		11/12/18

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F 842	Continued From page 10 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842		

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F 842	Continued From page 11 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to document a nursing assessment and failed to complete documentation of neurological checks for a resident who had an unwitnessed fall for 1 of 3 residents sampled for falls (Resident #1). The facility also failed to document a treatment or refusal of care for a resident who required a dressing change on her right arm (Resident #4) for 2 of 7 residents sampled and reviewed for documentation. Findings included: Resident #1 was admitted to the facility on 08/06/18 with diagnoses which included muscle weakness, abnormal gait and mobility, depression, anxiety and Alzheimer's disease. A review of the admission Minimum Data Set (MDS) dated 08/10/18 indicated Resident #1 was severely impaired in cognition for daily decision making. The MDS also indicated Resident #1 required extensive assistance with bed mobility and transfers and was frequently incontinent of urine and always continent of bowel. A review of an incident report dated 08/18/18 at 4:07 PM completed by Nurse #5 revealed a NA assisted Resident #1 to the bathroom and went back to check on her 2 times and she was not finished. The report indicated when the NA went	F 842	F842: Resident Records- Identifiable Information Resident #1 has discharged from our facility. Resident #4 has also discharged from our facility. All residents have the potential to be at risk after a fall. DON verified the electronic medical record is triggering the proper assessment post fall. All residents have the right to refuse care. Education was provided to the nursing staff on proper assessment follow up required post fall. Education was provided on what is to be covered in nursing orientation. We do not have agency staff at this time to educate. This is currently part of our nursing orientation checklist as “After fall interventions, documentation, head to toe, and huddle.” We do not utilize agency services. However, in the event we should use agency, this is covered under “reviewed and understands facility policies related to resident care.” Education will also be provided to nurses, nurse aids, and therapy staff regarding the need to document any resident’s choice to refuse care. Education was completed by 11/2/18.	

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F 842	Continued From page 12 back a third time Resident #1 was on the floor on her knees in front of the wheelchair. The report further indicated Resident #1 stated she slid on the floor and then got herself to her knees. The report revealed Resident #1 had pulled the call bell half way but not hard enough to set it off. The report indicated Resident #1 had fading bruises to her right outer calf that were 7 centimeters (cm) by 6 cm that looked like they were healing. A section labeled immediate action taken indicated Resident #1 was reminded to wait for assistance and she was reoriented to the use of the call bell. A review of nurse's notes dated 08/18/18 revealed there was no documentation of Resident #1's fall. A review of facility documents titled Neuro (neurological) Checks revealed neuro checks began on 08/18/18 at 12:30 PM. There was no documentation of hourly neuro checks at 6:00 PM and neuro checks for every 8 hours were not documented on 08/20/18 after 4:00 AM for 5 remaining times neuro checks were due to be checked. During a telephone interview on 10/17/18 at 10:31 AM, Nurse #5 stated she did not recall Resident #1. She explained she should have documented Resident #1's fall in the nurse's notes but could not recall any details of Resident #1's fall. During an interview on 10/17/18 at 2:18 PM, the Staff Development Coordinator explained nurses were expected to document a resident fall in the nurse's notes if they don't fill out a change of condition form (SBAR). She further stated when staff created an incident report in the electronic	F 842	Moving forward, post fall assessments will be reviewed daily on weekdays by the DON or designee in the morning clinical meeting for 4 weeks. Also, daily in morning clinical meeting, holes in MARs and TARs will be audited to ensure any refusal of care is properly documented for the duration of 4 weeks. Monthly, the DON or designee will select 5 random falls or any available falls if less than 5 and audit for correct post fall assessment follow up for 5 months. The DON or designee will also monitor all new licensed nurse team members and agency staff for completion of the orientation checklist for 5 months. In addition to post fall assessments, holes in MAR and TAR will continue to be reviewed daily and documented monthly to ensure proper documentation of refusal of care for 5 months. Any discrepancies will be discussed in the QAPI meeting. Ongoing the QAPI committee will monitor findings for 5 months. Further need for monitoring will be determined by the QAPI Committee. Completion Date: 11/12/2018	

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medical record it generated the neuro checks forms along with assessment forms for staff to complete. She stated nurses were expected to do neuro checks after Resident #1's fall and they should have document them in the electronic medical record as indicated immediately after the fall every 15 minutes, then every 30 minutes, then every hour, then every 4 hours and then every 8 hours as the forms indicated.

During an interview on 10/17/18 at 4:22 PM, the Director of Nursing explained after review of Resident #1's medical record she would have expected to have seen nurse's notes about Resident #1's fall. She stated she also would have expected to see head to toe assessments of Resident #1 after her fall but they were not there. After review of the neuro check documents she verified they had not been completed and she would have expected to see all neuro checks documented after Resident #1's fall.

2. Resident #4 was admitted to the facility on 08/16/18 and discharged on 09/26/18. Resident #4's diagnoses included heart failure, orthostatic hypotension, end stage renal disease, anxiety, and depression.

Review of the comprehensive minimum data set dated 08/23/18 revealed that Resident #4 was cognitively intact and required extensive assistance with activities of daily living. The MDS further revealed that Resident #4 had no pressure ulcers but did have skin tears that required application of non-surgical dressing and application of ointments or medication. The MDS indicated that Resident #4 had no refusal of care during the assessment reference period.

Review of a physician order dated 08/24/18 read,

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clean right arm skin tears x 2 with wound cleanser and pat dry, then apply thin layer of Bactroban and cover with gauze change every other day and as needed.

Review of the treatment administration record (TAR) dated 09/01/18 through 09/30/18 revealed the dressing change to Resident #4's right arm was completed as ordered except on 09/17/18 and 09/21/18.

Review of Resident #4's medical record revealed no entry's indicating Resident #4 had refused the treatment or why the treatment had not been completed on 09/17/18 or 09/21/18.

Review of the facility's daily assignment sheet revealed that Nurse #1 was responsible for Resident #4 on 09/17/18 and Nurse #2 was responsible for Resident #4 on 09/21/18.

An interview was conducted with Nurse #2 on 10/16/18 at 12:31 PM. Nurse #2 confirmed that she had cared for Resident #4 on 09/21/18. Nurse #2 stated that she was fairly certain she had completed Resident #4's treatment to her right arm because she "always completed her treatments as ordered." Nurse #2 stated that she may have forgotten to initial the TAR and that was just an oversight on her part and she should have documented the dressing change in Resident #4's medical record.

An interview was conducted with Nurse #1 on 10/16/18 at 5:35 PM. Nurse #1 confirmed that she was responsible for taking care of Resident #4 on 09/17/18. She stated that she could not recall for sure that she changed the dressing to Resident #4's right arm or not but added that if

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F 842	Continued From page 15 she did not change it or if Resident #4 refused the dressing change she would have documented the refusal on the TAR and made a progress note. Nurse #1 stated that Resident #4 was at dialysis 3 days a week, so it was very difficult to catch her long enough to change the dressings and Nurse #1 stated that if she did not document the refusal on the TAR or in the progress note she should have and may have just been an oversight. An interview was conducted with the Director of Nursing (DON) on 10/17/18 at 4:55 PM. The DON stated that she expected the dressing change or refusal of care to be documented in the medical record.	F 842		
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: §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	F 880		11/12/18

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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.

§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

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F 880	Continued From page 17 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 observations, record reviews and staff interviews the facility failed to post a contact isolation sign that was visible at a resident's room who was ordered by a physician to have contact isolation for a urinary tract infection for 1 of 2 residents on isolation precautions (Resident #7). Findings included: Resident #7 was re-admitted to the facility on 10/02/18 with diagnoses which included diabetes, heart disease, high blood pressure, urinary tract infection and dementia. A review of the most recent quarterly Minimum Data Set (MDS) dated 10/09/18 indicated Resident #7 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #7 required extensive assistance with activities of daily living and was always incontinent of urine and frequently incontinent of bowel. A review of a physician's order dated 10/11/18 indicated contact isolation per facility policy every shift for Vancomycin Resistant Enterococci (VRE). During an observation on 10/16/18 at 11:19 AM an isolation supply cabinet with 3 drawers that contained isolation supplies was located in the	F 880	F880: Infection Prevention and Control Immediately, an isolation sign was moved from the cart and posted on the resident #7's door. Any resident requiring isolation is considered to be at risk. 100% audit completed of all residents on isolation with no deficient practice of posting isolation signs on resident door. Education provided to all provided to all departments on requirements of posting isolation signs on resident door. We currently do not have any agency staff to educate. It is part of our orientation checklist that all new hires are trained on appropriate infection control policies including isolation precautions. Education was completed on 11/2/18. Residents identified as in need of isolation will be audited 3 times a week for 4 weeks by DON or designee. Monthly, DON or designee will review weekly audits for any deficient reports. Ongoing the QAPI Committee will review the findings for 5 months. HR or designee will also monitor all new team members and agency staff for completion of the appropriate orientation checklist for 5 months in efforts to ensure infection control policies	

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F 880	Continued From page 18 hallway approximately 3 feet away from Resident #7's doorway toward an adjacent room. A contact isolation sign was observed underneath a box of gloves on top of the isolation supply cabinet and there was no contact isolation sign posted on Resident #7's door. During an observation on 10/16/18 at 4:57 PM an isolation supply cabinet with isolation supplies was located approximately 3 feet away from Resident #7's room and was partially facing toward an adjacent resident room. A contact isolation sign was observed on top of the isolation supply cabinet but was covered by a box of gloves and there was no contact isolation sign on Resident #7's door. During an observation on 10/17/18 at 8:22 AM an isolation supply cabinet was located next to Resident #7's door. A contact isolation sign was on top of the isolation supply cabinet and partially covered with a box of gloves and there was no contact isolation sign on Resident #7's door. During an interview on 10/17/18 at 2:18 PM, the Staff Development Coordinator who was also in charge of infection control explained when a resident had physician's orders for isolation, staff were expected to place an isolation sign on the resident's door with an isolation supply cabinet next to the resident's door in the hallway. She further explained all staff were expected to follow the protocol for isolation and the isolation sign should be placed on the resident's door. She stated staff were not supposed to place anything on top of the isolation supply cabinet and the box of gloves should have been stored in a drawer of the isolation supply cabinet. She further stated the isolation sign should not have been placed on	F 880	are being followed. Further necessity for monitoring will determined by the QAPI Committee. Completion Date: 11/12/2018	

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top of the isolation supply cabinet and should not have been covered with a box of gloves but should have been placed on the resident's door so that it was visible.

During a telephone interview on 10/17/18 at 2:35 PM, Nurse #3 stated isolation signs were supposed to be posted on the resident's door. He further stated gloves, gowns and supplies should be stored in the drawers of the isolation supply cabinet and the isolation sign was not supposed to be left on top of the isolation supply cabinet.

During an interview on 10/17/18 at 4:22 PM, the Director of Nursing stated isolation supplies should be located right outside of the resident's door so they were ready for use. She further stated contact isolation signs were supposed to be placed on the resident's door. She explained a lot of times a box of gloves was placed on top of the isolation supply cabinet for convenience but the isolation sign was not supposed to be on top of the isolation supply cabinet. She stated she was not aware Resident #7 was on contact isolation but after review of physician's orders confirmed Resident #7 was ordered for contact isolation and stated the contact isolation sign should have been placed on Resident #7's door.