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	345008	A. BUILDING _____ B. WING _____	C 11/20/2012

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GOLDEN LIVINGCENTER - DARTMOUTH	300 PROVIDENCE RD CHARLOTTE, NC 28207

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	12-17-2012

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews, and medical record review the facility failed to provide incontinence care in a manner to prevent a urinary tract infection for one of one resident observed for incontinence care, Resident #2.

The findings are:

The facility's policy titled "Incontinence Care" dated 2006, read in part, "Wash all soiled skin areas, washing front to back."

Resident #2 was admitted to the facility on 06/06/12 with diagnoses that included diabetes and congestive heart failure. Review of her most recent Quarterly Minimum Data Set (MDS) dated 09/05/12 indicated she was cognitively intact and needed extensive assistance with toileting and personal hygiene.

Review of Resident #2's care plan updated on 09/12/12 revealed Resident #2 had the

F315 Urinary Incontinence

The facility will continue to provide residents incontinence care in a manner to prevent urinary tract infection.

Criteria I

Resident # 2 was re-admitted to the facility 06/06/12 with diagnosis that include diabetes and congestive heart failure.
The C.N.A.1 was re-educated on the Incontinence Care Policy by the DCE on the same day. The DCE has conducted observation audit of C.N.A performing Peri care.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 12/14/12

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.

DHSR/HFC Black Mountain Branch Received DEC 17 2012 by: PAM

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F 315	Continued From page 1 potential/actual urinary tract infection. The goal for Resident #2 was to remain free of urinary tract infections. Review of Resident #2's hospital records revealed she was hospitalized on 10/25/12 through 11/01/12 with symptoms of fever, nausea and vomiting. Further review of the hospital records revealed Resident #2 had a urinary tract infection in which the culture grew out Escherichia coli. On 11/20/12 at 1:35 PM an observation was made Resident #2 receiving incontinence care performed by Nursing Assistant (NA) #1. NA #1 was assisted by Nurse #1. NA #1 cleaned the resident's peri-area wiping front to back. Nurse #2 then assisted NA #1 to turn the resident onto her side. NA #1 cleaned the resident's anal area wiping from the top of the buttocks toward the perineal area. The resident had a small amount of loose stool in the anal area. NA #1 continued to wipe from the anal area toward the perineal area approximately eight times. NA #1 then put a clean incontinence brief on the resident. She adjusted the covers and removed her gloves. An interview was conducted on 11/20/12 at 1:46 PM with NA #1. She stated she wiped the resident from the top of the buttocks toward the peri-area. She further reported this was the way she always performed incontinence care. She then stated she should have wiped the other way. During an interview on 11/20/12 at 1:52 PM with Nurse #1 she stated NA #1 should have cleaned the resident wiping front to back.	F 315	***Criteria II*** The Unit Manager (UM), will complete a review of every resident on his or her unit that requires extensive assistance with toileting and personal hygiene. For any resident found to need extensive assistance with toileting and personal hygiene, the UM will list these resident on "the extensive assistance log". The resident care guides forms will updated for extensive assistance needed. The MDS nurse will update each care plan. ***Criteria III*** The DCE will in-service all of the Nursing staff on the policy titled "Incontinence Care. The DCE will randomly do observation audits observing staff C.N.A. giving personal hygiene care and using correct techniques. ***Criteria IV*** ADNS will monitor and observe the DCE perform (1) C.N.A. daily providing incontinence care for 3 months. The ADNS will sign the C.N.A observation report.	

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F 315	Continued From page 2 An interview was conducted on 11/20/12 at 2:00 PM with the Assistant Director of Nursing (ADON). The ADON stated it was her expectation that staff clean residents by wiping from the cleanest area to the dirtiest area. The ADON further stated NA #1 should have cleaned Resident #2's anal area by wiping away from the urethral area.	F 315	The DCE will be report results in the scheduled QAPI Meetings. Any issued identified will be addressed and the plan will be updated for continued compliance. The Executive Director is responsible for overall compliance.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329	**F329 Unnecessary Drugs** 12-17-2012. The facility will continue to ensure that each resident's drug regimen is free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences, which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. ***Criteria I*** Resident # 1 the Nurse Practitioner was notified and there was no new orders received. There was no negative outcome to the resident #1.	

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F 329	Continued From page 3	F 329		

by:
Based on record review and staff and resident interviews the facility failed to monitor a resident's blood pressure for 1 of three 3 sampled residents on antihypertensive medication (Resident #1).

The findings are:

Resident #1 was admitted to the facility on 06/06/12 with diagnoses that included hypertension. The most recent Minimum Data Set (MDS) dated 09/03/12 specified the resident's cognition was not impaired and that the resident received diuretic medication daily.

Review of Resident #1's medical record revealed a physician's order dated 06/07/12 that specified the resident was to receive Catapres (antihypertensive medication) twice daily and to give an additional Catapres tablet if the resident's blood pressure was over 160 systolic or over 100 diastolic. The resident was also ordered to have his blood pressure checked twice daily at 6:30 AM and 6:30 PM.

Further review of Resident #1's medical record revealed the Medication Administration Record (MAR) for the month of 10/12 specified the resident's blood pressure was documented 8 out of 31 times as having been checked at 6:30 PM. Nurses' notes were reviewed for the days the blood pressure was not documented on the MAR and revealed no additional information.

On 11/20/12 at 10:45 AM the nurse practitioner (NP) was interviewed. She reported that Resident #1 self administered his own medications but stated that she expected the

Criteria II

All residents who receive Catapres (antihypertensive medication) therapy will be audited to ensure that b/p is being taken and recorded as ordered.

The unit managers will generate a audit tool of residents on Catapres, B/P parameters and randomly check MARs that B/P is being taken.

Criteria III

The Director of Clinical Education (DCE) has in-serviced Nursing staff on taking and recording blood pressures for all residents taking Catapres. This will be included in the orientation of new nursing personnel.

Criteria IV

The Assistant Director of Nursing will report the results of the audit in the monthly Quality Assurance QAIP meeting for 3 months. Any issued identified will be addressed and the plan will be updated for continued compliance. The Executive Director is responsible for overall compliance.

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nursing staff to check the resident's blood pressure prior to the resident taking his Catapres medication. She stated that the resident had expressed concern to her that the nursing staff was not checking his blood pressure at 6:30 PM regularly. She added she had reviewed the resident's MAR and confirmed that his blood pressure was not being checked as ordered. She stated she clarified the order with the nursing staff.

On 11/20/12 at 12:00 PM Resident #1 was interviewed and stated that he depended on the nurses to check his blood pressure prior to him taking his antihypertensive medication. He stated that the nurses did not always check his blood pressure in the evening.

On 11/20/12 at 2:15 PM Nurse #1 was interviewed and reported that she had been the resident's nurse on the 3 PM to 11 PM shift and was aware the resident was ordered to have his blood pressure checked at 6:30 PM before the resident took his antihypertensive medication at 7:30 PM. She stated that she documented the resident's blood pressure on the MAR or in the nurses' notes and was unaware that the resident's blood pressure was not being checked twice daily as ordered.

On 11/20/12 at 4:00 PM the Assistance Director of Nursing (ADNS) was interviewed and reported that she thought there was confusion among the nursing staff whether the resident or the nurse was responsible for checking the resident's blood pressure. She stated the nurses were responsible for checking the resident's blood pressure twice daily as ordered and to document

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F 329	Continued From page 5 the results on the MAR before the resident took his antihypertensive medication. She stated she was aware that the 3-11 PM shift nurses had not been checking the resident's blood pressure.	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	**F 441 Infection Control, Prevent Spread, Linens** The facility will continue to establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. ***Criteria I*** Resident # 2 was provided incontinence care by C.N.A.1 has been re-educated by DCE on hand washing skills. ***Criteria II*** All residents may be affected by this practice. The DCE/ Infection Control nurse will re-educate all staff caregivers. ***Criteria III*** The Director of Clinical Education will conduct observation audits using the "Peri Care hand washing Audit Tool" will be completed on all C.N.A. by the DCE/ Infection Control nurse.	12-17-2012

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F 441	Continued From page 6 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and a facility document the facility failed to observe infection control practice by not washing their hands after performing incontinence care for 1 of 2 observations of staff proving care. The findings are: The facility's audit tool entitled "Peri Care Hand washing Audit Tool" read in part, "Hands must be washed every time gloves are removed." An observation was made on 11/20/12 at 1:35 PM of incontinence care performed by Nursing Assistant (NA) #1. NA #1 performed incontinence care for Resident #2. After providing the care NA #1 removed her gloves and tied up the trash bag containing the dirty linens. NA #1 put a clean pillow case on Resident #2's roommate's pillow and straitened the linens. NA #1 then picked up the dirty linens and exited the resident's room without washing her hands. An interview was conducted on 11/20/12 at 1:46 PM with NA #1. NA #1 stated she did not wash her hands after removing her gloves and exiting the room but stated she should have. During an interview on 11/20/12 at 1:52 PM, Nurse #1 stated NA #1 should have washed her	F 441	***Criteria IV*** The Director of Education will report results in the monthly QAIP for 3 months. Any issued identified will be addressed and the plan will be updated for continued compliance. The Executive Director is responsible for overall compliance.	12-12-2012

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hands after she removed her gloves and prior to leaving the room.

An interview was conducted on 11/20/12 at 2:00 PM with the Assitant Director of Nursing (ADON). The ADON stated it was her expectation that staff wash their hands after proving care and removing their gloves.