STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345264	A. BUILDING _____ B. WING _____	C 04/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEY TOTAL LIVING CENTER	514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164

(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 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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, record review, and staff interviews the facility failed to provide care to prevent urinary tract infections for 1 of 3 residents reviewed for urinary tract infections. (Resident #2) The findings included: Resident #2 was admitted to the facility 01/08/13 with diagnoses which included history of urinary tract infection, muscle weakness, anemia and diabetes. Review of Resident #2's most recent 14 day Minimum Data Set dated 03/19/13 revealed she had severe cognitive impairment, needed extensive assistance with toileting and hygiene and was frequently incontinent of bowel and bladder. In the medical record of Resident #2 was a laboratory result dated 02/06/13 which revealed a urine culture with greater than 100,000 colony-forming units per milliliter (CFU/ML) of Escherichia coli. Hand written, signed and dated	F 315	Preparation and submission of this written plan does not constitute an agreement of admission by Stanley Total Living Center of the truth to the facts alleged or conclusions set forth in the CMS-2567. This plan of correction is written in response to the Statement of Deficiencies and demonstrates our good faith effort and desire to improve quality care and services rendered to our residents—it is submitted as required by Federal and State law. **(A)** (1) Resident #2 was placed on prophylactic ABT for chronic UTI on 3/27/13 which continues to date per order. Stool cultures were obtained on 4/9/13 and verified as negative for C. Diff, VRE, and ova/parasites as of 4/16/13. NA #1 received	4/16/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer D Roseliew | TITLE: Administrator | (X6) DATE: 4/24/13

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 315	Continued From page 1 on the laboratory form was Macrobid (an antibiotic) 100 milligrams for 7 days. In the medical record of Resident #2 was a laboratory result dated 02/11/13 which revealed a urine culture with greater than 100,000 CFU/ML of Escherichia coli. Hand written, signed and dated on the laboratory form was to discontinue Macrobid and start Ceftin (an antibiotic) 500 mg twice per day for 10 days. Review of the facility's Infection Control Log for Residents revealed on 02/13/13 Resident #2 was having blood in her urine and she was started on Rocephin (an antibiotic) 1 Gram intramuscularly daily for 7 days. Review of Resident #2's medical record revealed she was hospitalized 02/14/13 - 02/19/13 with the diagnosis hemorrhagic cystitis with gross hematuria. A. On 04/08/13 at 11:20 AM Nursing Assistant (NA) #1 was observed providing incontinence care to Resident #2. NA #1 donned gloves then went to the sink to wet a towel. NA#1 sprayed non-rinse peri wash on the towel. NA #1 then pulled down the front of the resident's incontinence brief and brown stool was observed in the peri area of the brief. NA#1 rolled Resident #2 to her side, removed the soiled incontinence brief and discarded it into the trash can. With Resident #2 lying on her back NA #1 began to clean the resident's peri area, wiping repeatedly (approximately 7 times) with the same area of the towel. The towel had visible smears of stool. NA #1 then used a different area of the same towel to clean Resident #2's buttocks. NA #1 used a	F 315	a written disciplinary action on 4/11/13 for her failure to perform proper perineal care per facility policy/procedure and was re-educated and retrained through 1 on 1 with return demonstration by the SDC. (2) Random pericare audits/monitoring were conducted by unit nurses beginning on 4/9/13—these were daily audits on varying shifts/units to ensure proper pericare procedures were followed and that no other residents were affected by improper technique. Any concerns were immediately addressed and corrected by the nurse.	4/23/13

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F 315	Continued From page 2 different area of the towel each time she wiped the resident's buttocks as the towel became thick with pasty stool. NA #1 then applied a clean incontinence brief. An interview was conducted on 04/08/13 at 2:06 PM with Nurse #1. Nurse #1 stated Resident #2 used to tell staff when she needed to go to the bathroom. Nurse #1 stated staff had been taking Resident #2 to the bathroom but she had not seen them do this for approximately 2 weeks. Nurse #1 stated she was aware Resident #2 had frequent urinary tract infections but she was unaware of the results of her urine cultures. She stated the resident was currently taking an antibiotic prophylactically for treatment of urinary tract infections. Nurse #1 stated she was unaware Resident #2 was having frequent pasty stools and that stool was getting into the resident's peri area. Nurse #1 stated if the peri area was contaminated with stool she expected nursing assistants to use a clean area of a cloth with each wipe when providing incontnence care. On 04/08/13 at 2:38 PM NA #1 stated she worked with Resident #2 on a regular basis. NA #1 stated Resident #2 had frequent stools which got into her peri area. NA #1 stated she had been in a hurry when she provided incontinence care to Resident #2 at 11:20 AM and that she should have washed Resident #2 with a different part of the cloth with each wipe. On 04/08/13 at 3:37 PM the Director of Nursing (DON) stated when providing incontinence care it was her expectation for the nursing assistant to wipe with a clean part of the cloth for each wipe of the peri area. The DON stated she was	F 315	(3) All nursing assistants will be retrained and re-educated by the SDC through 1 on 1 with return demonstration on proper perineal care per facility policy/procedure. This training will be provided to all nurse aides upon hire/orientation and at least annually through skills reviews. (4) Unit/Floor nurses will conduct random audits/monitoring of pericare to ensure proper technique is being followed. This random audit will be done beginning on 4/24/13 on varying shifts/units weekly x 4 and then monthly x 3 with any concerns being addressed immediately. Reports will be provided to the QA&A Committee for further review and changes as necessary to the plan of correction to ensure continued compliance.	5/6/13 5/6/13

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F 315	Continued From page 3 unaware Resident #2 was having frequent pasty stools and that should have been communicated to a nurse because it could have contributed to the urinary tract infections. B. Facility policy entitled Infection Control Program dated 10/20/11 read in part, "Surveillance. The facility uses different elements of surveillance to plan, organize, implement, operate, monitor, and maintain the Infection Control Program: 1. Process Surveillance - reviews practices that are directly related to resident care such as proper hand hygiene, sterile technique with procedures, appropriate use of personal protective equipment, and proper cleaning or reusable equipment. 2. Outcome Surveillance - Used to identify and report evidence of infection, involving collecting data, comparing to standards and detecting trends." On 04/08/13 at 2:06 PM Nurse #1 stated that Resident #2 used to tell staff when she had to go to the bathroom. Nurse #1 stated she had not seen staff assist Resident #2 to the toilet for approximately 2 weeks. She stated she was aware of Resident #2's frequent urinary tract infections but was not aware that Resident #2's urine cultures had resulted in Escherichia coli nor was she aware the resident was having frequent pasty stools that would get into her peri area. An interview was conducted on 04/08/13 at 3:08 PM with the Infection Control (IC) Nurse. The IC Nurse stated with the tracking of urinary tract infections he would look on a monthly basis to see if there was a cluster of residents with the same bacteria and/or that worked with the same nursing assistant. He stated he did not track	F 315	**(B)** (1) Resident #2 was placed on prophylactic ABT for chronic UTI on 3/27/13 which continues to date per order. Stool cultures were obtained on 4/9/13 and verified as negative for C. Diff, VRE, and ova/parasites as of 4/16/13. (2) The Infection Control log beginning from 4/9/12 to 4/22/13 was reviewed by the Infection Control Committee with no evidence of any trends or patterns with current infections. (3) The Infection Control Policy/Procedure was updated on 4/19/13 to include specific guidelines for tracking/trending of infections—a trend/pattern will be evidence by roommates or 3+ residents on the same staffing assignment with the same pathogen between a 5 day period.	4/16/13 4/23/13

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F 315	Continued From page 4 infections for individual residents to determine if they were having repeat infections. The IC Nurse stated though Resident #2's roommate had an Escherichia coli infection, (at the same time Resident #2 did) there would have to be more than just a roommate to consider tracking and trending an Escherichia coli infection. The IC Nurse stated no one had looked at incontinence care nursing assistants were providng specific to Resident #2. On 04/08/13 at 3.37 PM the Director of Nursing (DON) stated she had not recognized a need to observe staff perform peri care for residents who had recurrent Escherichia coli infections in their urine. The DON stated the only concern she had with Resident #2 was when she was having the abnormal bleeding prior to hospitalization 2/14/13. The DON stated she recently completed nursing assistant competencies in which peri care was performed. She stated if there was a problem it would warrant watching but she had not been aware of any problems with Resident #2. The DON stated she was not aware Resident #2 was having frequent pasty stools that were collecting in the peri area. . The DON stated that information should have been communicated to nursing staff because the frequent pasty stools could have contributed to the resident's urinary tract infections.	F 315	A mini infection control committee meeting will be held daily to review any newly diagnosed infections to determine any trends or patterns. All infections will be logged into the new AHT electronic health record system to assist with tracking/trending. Any trends observed by the IP or the Infection Control Committee will have the necessary interventions put in place as soon as possible including staff re-education. Nursing staff will be educated on this policy update involving tracking and trending on 5/2/13. (4) The AHT infection log will be reviewed by the QA&A Committee on a monthly basis including any interventions put into place for observed trends. The QA&A Committee will provide any further recommendations at that time.	5/2/13 5/6/13