STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345421	A. BUILDING _____ B. WING _____	C 10/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHATHAM	72 CHATHAM BUSINESS PARK PITTSBORO, NC 27312

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to wait until 1 of 7 sampled residents (Resident #16) completed meal, before disinfecting dining area. The findings included: Resident #16 was admitted to the facility on 8/22/14 with Alzheimer's disease. On the admissions Minimum Data Set (MDS), dated 8/29/14, she was assessed as having severe cognitive impairments. On 10/29/14 at 1:30 pm, Resident #16 was observed with her lunch tray in front of her, eating a frozen nutritional supplement in the activity room, while five housekeepers, cleaned the floor and disinfected furnishings. On 10/29/14 at 1:31 pm, Administrative Staff #1, who was nearby, was summoned to the activity room, after this observation was made. She entered the room and asked the housekeepers to clean, after Resident #16 finished her meal. They immediately stopped cleaning. Administrative Staff #3 was interviewed on 10/29/14 at 4:35 pm. She shared that they educated the housekeepers to not clean while a	F 241	The Laurels of Chatham wishes to have this submitted plan of correction stand as its written allegation of compliance. Our date of compliance is November 26, 2014 Preparation and/or execution of this plan does not constitute admission to nor agreement with either the existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. F241 Resident #16 1. Upon becoming aware of the observation, immediate re-education was provided to the five housekeepers not to clean the floor and disinfect furnishings while residents are eating. 2. All residents who eat in common areas have the potential to be affected. 3. All housekeeping staff have been educated by the Director of Housekeeping services not to provide cleaning/disinfecting furniture while residents are eating to ensure each resident□s dignity and respect in full recognition of his or her individuality is maintained. This will occur prior to November 26th.	11/26/14

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

Electronically Signed | 11/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 1 resident was present.	F 241	4. Using an Audit tool, rounds will be conducted by Administrator 5 days a week for 2 weeks, then randomly each week for two months, to observe for compliance. Variances will be corrected at the time of observation and additional education will be provided as necessary. Audits will be reviewed by QA committee monthly for three months to assure substantial compliance. Additional action plans will be developed as necessary based on the results of the Audits. Administrator is responsible for overall monitoring and continued compliance.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 record reviews, observations and staff interviews, the facility failed to provide proper incontinent care for 2 of 2 sampled residents (Residents # 12 & # 8), who were dependent on staff for personal hygiene and failed to provide feeding assistance for 2 of 2 sampled residents (Residents #20 and #22) who needed extensive assistance at meal time. Findings included: 1. Resident #12 was admitted to the facility on 2/4/14 with multiple diagnoses including non Alzheimer's dementia. The annual Minimum	F 312	F312 1. CNA #2 was retrained in providing appropriate incontinence care for Resident #12 with return demonstration to confirm understanding. No negative outcomes occurred. Facility will continue to provide appropriate incontinence care for Resident #12 CNA #5 was retrained in providing appropriate incontinence care for Resident #8 with return demonstration to confirm understanding. No negative	11/26/14

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F 312	Continued From page 2 Data Set (MDS) assessment dated 10/10/14 indicated that Resident #12 had memory and decision making problems, always incontinent of bowel and bladder and needed extensive assistance for personal hygiene. The care plan dated 10/22/14 was reviewed. One of the problems was potential for impaired skin integrity related to incontinence. The goal was for the skin to remain intact and the approaches included to provide incontinent care with each incontinent episode. On 10/29/14 at 11:15 AM, Nurse Aide (NA) #2 was observed to check Resident #12 for incontinence. Resident #12 was up in wheelchair. NA #2 was observed to transfer the resident to bed. In bed, the resident started to punch the NA. NA #2 proceeded to lower the resident's pants and her disposable brief was observed wet with urine. NA #2 was observed to wet the end of the bath towel with water and cleaned the outside of the perineal area and groin. The resident was not observed punching at this time. NA #2 was not observed to separate the labia to clean the inside of the perineum. Resident #12 was turned to her side and was observed to have a moderate amount of stool on her rectum. Using the same towel, NA #2 was observed to remove the stool from the rectal area. Then, a clean disposable brief was applied. NA #2 had used one wet bath towel with no soap during the incontinent care. NA #2 was not observed to pat dry the perineal and rectal areas before applying the clean disposable brief. After the incontinent care, NA #2 transferred the resident to the wheelchair and the resident had pinched the NA on her arm. On 10/29/14 at 11:20 AM, NA #2 was interviewed. She stated that she didn't provide proper incontinent care for Resident #12 because the	F 312	outcomes occurred. Facility will continue to provide appropriate incontinence care for Resident #8 All Residents identified as needing assistance with incontinence care will be provided with incontinence care as appropriate. All CNAs will be retrained by SDC/Unit Managers on expectations regarding providing appropriate incontinence care to male/female residents. This will occur prior to November 26. A QA monitoring tool will be utilized by the Unit Manager/SDC to monitor incontinence care with return demonstration q shift for 1 week and the random shifts (to include all shifts and on weekends) for 3 weeks and then weekly random shifts for 2 months. Variances will be corrected at the time of observations and additional education will be provided as necessary. 2.Feeding assistance will be provided for Resident #20 and # 22 in a timely manner. All residents assessed as needing eating assistance will be provided assistance in a timely manner. All Licensed staff will be re-trained by the SDC/Unit managers providing timely assistance with feeding and on scheduling assignments during meal times. This will occur prior to November 26. 3. Audits of residents need assistance	

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F 312	Continued From page 3 resident was pinching/punching her. She also stated that she always used a bath towel to do an incontinent care. On 10/29/14 at 1:30 PM, interview with the administrative staff #1 was conducted. She stated that she expected the nursing staff to follow the policy when providing incontinent care to a resident. 2. Resident #8 was readmitted to the facility on 10/10/14. A 5 day Minimum Data Set (MDS) dated 10/17/14 indicated Resident #8 had short term and long term memory impairment and was moderately impaired in decision-making. He required extensive assistance with toilet use and personal hygiene. Resident #8 was occasionally incontinent of bladder and bowel. Cumulative diagnoses included clostridium difficile. On 10/29/14 at 11:50AM, NA #5 was observed for provision of incontinent care for Resident #8. NA #5 washed resident's face, arms, chest and back. Then, NA#5 washed the perineal area, groin area and scrotum. Resident #5 was uncircumcised and NA#5 did not retract the foreskin to cleanse that area. She proceeded to apply the incontinent brief. Just before closing the brief, she noted some bowel movement on a dressing located on the left inner buttocks. She removed the dressing and continued to apply the incontinent brief without cleaning the area. When asked regarding [proper incontinent care for an uncircumcised male, NA#5 stated she knew she should have pulled back the foreskin to cleanse the area but got nervous. NA#5 stated she did not realize she did not wash the soiled area where the dressing was removed and should have washed the area with soap and water before she applied the incontinent brief.	F 312	with feeding will be conducted at least 10 times per week for 4 weeks to observe for compliance will be done by SDC or unit manager utilizing a QA monitoring tool, to include all shifts and on weekends). Variances will be corrected at the time of observations and additional education will be provided as necessary. Random audits will be conducted weekly for 2 months to monitor continuing compliance. Audits will be reviewed by QA committee monthly for three months to assure substantial compliance. Additional action plans will be developed and additional training will be given as necessary based on the results of the Audits. The DON is responsible for overall monitoring and continued compliance with additional education being given it.	

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F 312	Continued From page 4 On 10/29/14 at 1:30 PM, interview with the administrative staff #1 was conducted. She stated that she expected the nursing staff to follow the policy when providing incontinent care to a resident. 3. Resident #20 was admitted to the facility on 3/12/12 with the following cumulative diagnoses: dementia and hypertension. On the 10/14/14 quarterly MDS assessment, it indicated that she had severe cognitive impairments and needed extensive assistance with eating. On 10/28/14 at 10:00 am, Resident #20 was observed asleep, with a covered meal tray, containing untouched breakfast food, next to her bed. Nurse Aide #1 was interviewed on 10/28/14 at 10:09 am. She explained that she was the only aide on the unit and she was responsible for passing trays, answering call bells, offering feeding assistance on the 500, 600, 700 and 800 halls and was monitoring a resident who fell earlier that morning. She shared that the other aides were assigned to the dining room and had not returned to help pass the trays. On 10/29/14 at 4:30 pm, administrative staff #3 was interviewed. She commented that her expectations were for residents who were capable of feeding themselves to be offered their food trays first, and then staff should assist others who needed assistance with their meals. 4. Resident #22 was admitted to the facility on 1/13/14 with the following cumulative diagnoses: dementia, hypertension and diabetes mellitus,	F 312		

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F 312	Continued From page 5 type II. On the 10/16/14 quarterly MDS assessment, it indicated that she had severe cognitive impairments and needed extensive assistance with eating. On 10/28/14 at 10:02 am, Resident #22 was observed in bed with her breakfast tray, covered next to her, untouched. Nurse Aide #1 was interviewed on 10/28/14 at 10:09 am. She explained that she was the only aide on the unit and she was responsible for passing trays, answering call bells, offering feeding assistance on the 500, 600, 700 and 800 halls and was monitoring a resident who fell earlier that morning. She shared that the other aides were assigned to the dining room and had not returned to help pass the trays. On 10/29/14 at 4:30 pm, administrative staff #3 was interviewed. She commented that her expectations were for residents who were capable of feeding themselves to be offered their food trays first, and then staff should assist others who needed assistance with their meals.	F 312		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain medication error rate at 5% or below by not following the	F 332	F332 1. Resident #24□s meds are being administered as ordered. At the time of	11/26/14

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F 332	Continued From page 6 doctor's orders (Resident # 24) and not flushing the gastrostomy (G) tube with water before and in between medication administration (Resident # 23). There were four errors of twenty five opportunities for error resulting in a 16% error rate. Findings included: The facility's policy on enteral medication administration dated 03/05 was reviewed. The policy read in part " medications should be given one at a time followed by a 30 cubic centimeter (cc) water flush. When interrupting a continuous tube feeding, irrigate tube with 30 cc of water before administering medication. " 1. Resident #23 was admitted to the facility on 5/31/14 with multiple diagnoses including seizure disorder, hypokalemia and gastric reflux. The physician's orders revealed that Resident #23 had orders for Potassium Chloride (KCL) 20 milligrams/15 milliliter (ml) twice a day via tube for hypokalemia, keppra 1000 mgs/10 ml. via tube twice a day for seizure disorder and Carafate 1 gram (gm)/10 ml four times a day via tube for gastric reflux. These three medication were due at 8:00 AM. The order also indicated that Resident #23 was on tube feeding from 6:00 PM to 8:00 AM and on pleasure food every meals. On 10/29/14 at 9:30 AM, Nurse #2 was observed during the medication pass. Nurse #2 was observed to prepare and to administer the medications of Resident #23. Nurse # 2 was observed to administer the medications in tablet form by mouth and the liquid form via tube. Nurse # 2 was observed to administer the KCL, keppra and carafate one at a time via G tube without flushing the tube with water before and in between the medications.	F 332	survey the physician was notified of medication not being given as ordered by Nurse #4. No new orders were given except for nursing to monitor BP of resident. No adverse effects were noted during the time or after the time of monitoring was completed. Re-education was provided to Nurse #4 on correct Medication Administration and following Physicians orders. Resident # 23□s gastrostomy (G) tube is being flushed with water before and after medication administration. MD was notified and no new orders were received. Nurse #2 was re-educated on correct procedure for enteral medication administration. 2. An audit of current Residents who receive medications with parameters and Residents who receive medications via G tube was conducted to verify proper procedure was followed and the medications and medications were administered as ordered. 3. All Licensed staff (prior to working)will be re-educated on Professional Standards of Practice for the Administration of Medication by the SDC/Unit Manager, prior to November 26th. Medications pass audits of licensed staff will be conducted by Director of Nursing regarding compliance with Professional Standards of Practice for the administration of medications including medications with parameters and enteral medication administration.	

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F 332	Continued From page 7 On 10/29/14 at 10:05 AM, Nurse #2 was interviewed. She stated that she didn't flush the tube with water prior to medication administration because she already flushed it that morning around 8:00 AM. She added that if the medication was in liquid form she didn't have to flush the tube with water in between medications. At 11:09 AM, Nurse #2 provided additional information. She acknowledged that she should have flushed the tube with water before and in between medication administration but she did not. On 10/29/14 at 4:14PM, administrative staff #3 was interviewed. She stated that nurses were supposed to administer the medications one at a time and to flush the tube with water before and in between medications. 2. Resident #24 was admitted to the facility 7/4/14. Cumulative diagnoses included: hypertension (elevated blood pressure) and depression. The physician's orders revealed that Resident #24 had orders for Lexapro (antidepressant medication) 15 mg. (milligrams) daily. This medication was due at 8:00AM. On 10/29/14 at 9:00AM, Nurse #4 was observed during medication pass. Nurse #4 prepared Resident #24's medications. Medications prepared included Lexapro 10 mg. one tablet. Nurse #4 administered all medications to Resident #24 which included Lexapro 10 mg. On 10/29/14 at 9:10AM., Nurse #4 was interviewed. She reviewed the Medication Administration Record (MAR) for Resident #24 and stated she should have given Lexapro 5 mg. one tablet with the Lexapro 10 mg. tablet to equal 15 mg as it was indicated on the MAR and on the	F 332	4. Using an Audit tool, audits will be conducted by Director of Nursing 5 times a week for 2 weeks, then randomly each week for three months, to observe for compliance. Variances will be corrected at the time of observation and additional education will be provided as necessary. These audits will occur on all shifts and on weekends. Audits will be reviewed by QA committee monthly for three months to assure substantial compliance. Additional action plans will be developed as necessary based on the results of the Audits. Administrator/Designee is responsible for overall monitoring and continued compliance.	

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F 332	Continued From page 8 medication card. Nurse #4 stated she guessed she was just nervous and that was why she made the errors. On 10/29/14 at 4:14PM, Administrative staff #3 stated she expected nursing staff to follow the physician's orders and administer medications as noted per physician's orders. 3. Resident #24 was admitted to the facility 7/4/14. Cumulative diagnoses included: hypertension (elevated blood pressure) and depression. The physician's orders revealed that Resident #24 had orders for Diltiazem ER (extended release) 240 mg. capsule one capsule by mouth twice a day for hypertension. Hold for SBP (systolic blood pressure) < (less than) 120. This medication was due at 8:00AM. On 10/29/14 at 9:00AM, Nurse #4 was observed during medication pass. Nurse #4 prepared Resident #24's medications. Medications prepared included Diltiazem ER 240 mg. Nurse #4 stated she needed to take Resident #24's blood pressure. She obtained Resident #24's blood pressure in the left arm and indicated the blood pressure reading was 106/ 63 and pulse 60. Nurse #4 administered all medications to Resident #24 which included Diltiazem ER 240 mg. On 10/29/14 at 9:10AM., Nurse #4 was interviewed. She reviewed the Medication Administration Record (MAR) for Resident #24 and stated she should not have given the Clonidine HCL and Diltiazem ER because the systolic blood pressure was too low. Nurse #4 stated she guessed she was just nervous and that was why she made the errors. On 10/29/14 at 4:14PM, Administrative staff #3 stated she expected nursing staff to follow the	F 332		

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F 332	Continued From page 9 physician's orders and administer medications as noted per physician's orders. 4. Resident #24 was admitted to the facility 7/4/14. Cumulative diagnoses included: hypertension (elevated blood pressure) and depression. The physician's orders revealed that Resident #24 had orders for Clonidine HCL (hydrochloride) 0.2 mg. by mouth three times daily for hypertension. Hold for SBP< 130. This medication was due at 8:00AM. On 10/29/14 at 9:00AM, Nurse #4 was observed during medication pass. Nurse #4 prepared Resident #24's medications. Medications prepared included Clonidine HCL 0.2 mg. Nurse #4 stated she needed to take Resident #24's blood pressure. She obtained Resident #24's blood pressure in the left arm and indicated the blood pressure reading was 106/ 63 and pulse 60. Nurse #4 administered all medications to Resident #24 which included Clonidine HCL 0.2 mg. On 10/29/14 at 9:10AM., Nurse #4 was interviewed. She reviewed the Medication Administration Record (MAR) for Resident #24 and stated she should not have given the Clonidine HCL and Diltiazem ER because the systolic blood pressure was too low. Nurse #4 stated she guessed she was just nervous and that was why she made the errors. On 10/29/14 at 4:14PM, Administrative staff #3 stated she expected nursing staff to follow the physician's orders and administer medications as noted per physician's orders.	F 332		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353		11/26/14

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F 353	Continued From page 10 The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to deploy sufficient nursing staff resulting in 5 of 5 residents (Residents #6,#7, #10, #13 and #14), capable of feeding themselves, having to wait approximately 90 minutes after breakfast trays were delivered to the unit, for their meals, resulting in cold food that was not palatable. The findings included: Cross refer to tag 364. Based on observations, record review, resident and staff interviews, the facility failed to ensure that food was promptly delivered to 5 of 5 residents (Residents # 6, #7,	F 353	F353 The identified residents, #6, 7, 10, 13, and 14, will be served their meal timely. All resident will be served their meals in a timely manner. Timely is defined as food which would be acceptable to a reasonable person regarding temperature for the item and appearance of the items. CNAs and licensed staff will be in serviced by the SDC/Unit Managers on expectations regarding timeliness of tray delivery during meal time and on new	

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F 353	Continued From page 11 #10, #13 and #14) observed, once available to uphold proper food temps and maintain palpability. An interview with Nurse Aide #1 on 10/28/14 at 10:09 am revealed that she was left alone on the unit, which covered four halls, with one nurse, who was passing medication; to pass trays, answer call bells and assist with feeding. The facility did not ensure that three additional aides, who had completed their dining room assignment, returned to the unit to assist with breakfast activities. An interview with Nurse #1 on 10/29/14 at 12:00 pm revealed that there were staffing challenges at the facility. Nurse #1 stated "Today, I have 24 residents and the aides have about 15 residents each, which was higher than their normal workload." An interview with Administrative Staff #5 on 10/29/14 at 2:50 pm revealed the facility's goal was to staff 13 nurse aides on day shift (7am-3pm), 11 nurse aides on evening shift (3pm-11pm) and 8 nurse aides at night (11pm-7am). She shared that their daily assignments varied by their resident census. A copy of the nurse staffing sheet was reviewed for 10/28/14. On day shift, there were 5 nurses and 12 nurse aides working with a resident census of 133. An interview with Administrative Staff #3 on 10/29/14 at 4:30 pm revealed that she was very new in her position but acknowledged that the facility had vacancies on their management level. She shared that she was unaware that there were problems with meal tray delivery however, her expectation was for trays to be delivered in less than 15 minutes once arriving on the unit. She also expected for residents who could feed themselves to be offered their trays first. If food	F 353	scheduling assignments during meal time to ensure timely delivery of trays to ensure food is hot and palatable. This will occur prior to November 26. A QA auditing tool will be utilized by the SDC/Unit Manager to ensure that adequate staff are in each dining areas and that meals are received timely for each meal for one week, then random daily meals for 3 weeks and then monthly for two months to ensure compliance, to include weekends. Variances will be corrected at the time of occurrences. Audit tools will be reviewed monthly in QA committee for 3 months to ensure ongoing compliance. Additional action plans will be developed if necessary based on the results of the audits.	

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F 353	Continued From page 12 appeared to not be hot, she expected her staff to reheat it.	F 353		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to ensure that food was promptly delivered to 5 of 5 residents (Residents # 6, #7, #10, #13 and #14) observed, once available to uphold proper food temps and maintain palpability. Findings included: 1. Resident # 6 was admitted to the facility on 9/16/14 with multiple diagnoses Parkinson's Disease and Failure to Thrive. The admission Minimum Data Set (MDS) assessment dated 9/23/14 indicated that Resident # 6 had memory and decision making problems and needed extensive assistance with eating. The current physician's orders of Resident #6 were reviewed. The orders included Jevity 1.2 (tube feeding formula) at 60 ml per hour via tube from 7:00 PM to 7:00 AM and regular diet with honey thick liquids. The orders also indicated that the resident needed 1:1 assistance with eating. On 10/28/14, a continuous lunch meal observation was conducted from 12:05 PM to 1:30 PM on station one (100, 200, 300 and 400	F 364	F364 The identified residents, #6, 7, 10, 13, and 14, will be served their meals promptly with eating assistance given as indicated by their plan of care. All residents will be served their meals promptly with eating assistance given as indicated by their plan of care. CNAs and licensed staff will be in serviced by the SDC/Unit Manager on providing assistance with meals, on expectations regarding timeliness of tray delivery during meal time and on new scheduling assignments during meal time to ensure timely (defined as: delivery of trays to ensure food is hot and palatable considering the items). This occurred prior to November 26. A QA auditing tool will be utilized by the SDC/Unit Managers to ensure that adequate staff are in each dining area to ensure feeding assistance is giving as indicated and meals are received timely for each meal for one week and then	11/26/14

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F 364	Continued From page 13 halls). Resident #6 resided on 400 hall. The cart arrived on 400 hall at 12:15 PM. Nursing aides were observed passing trays to resident's rooms. Resident #6 was observed in bed from 12:05 PM until 1:10 PM and no staff member was observed to enter the room to serve his lunch tray. At 1:15 PM, Nurse Aide (NA) # 3 was observed to open the 400 hall cart and removed the resident's tray. She proceeded to the resident's room and started to feed him. She acknowledged that the food was a little bit warm and not hot. On 10/28/14 at 12:18 PM, Nurse #3 was interviewed. She indicated that Resident #6 received tube feeding at night and received a tray during meals. She revealed that the resident was unable to feed self and the staff had to feed him. She further added that the staff had to deliver the trays of residents who did not need assistance with eating and then feed the residents who needed assistance. On 10/28/14 at 1:20 PM, NA #3 was interviewed. She stated that she was assigned to Resident #6. During meal times, the NAs had assignments, either in the dining room or on the hall. She was assigned to feed residents in the dining room. She indicated that the NAs assigned on the hall should have fed Resident #6 but did not. She added that it would take her 45 minutes or more to feed residents in the dining room. She revealed that every time she was assigned in the dining room, she came back on the hall and the resident had not been fed. 2. On 10/28/14 at 4:38 PM, Resident # 7 was interviewed. Resident # 7's cognitive status was intact. He stated that the food was always cold at all meals. He added that cold food was always brought up in the resident council meeting as a concern and nothing had been done to correct it. He had observed carts sitting on the halls for long	F 364	random daily meals for 3 weeks and then monthly for two months, to include weekends. Variances will be corrected at the time of occurrences. Findings from these Audit tools with be reviewed monthly for 3 months in the QA committee meeting for ongoing compliance with additional training given if indicated.	

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period of time before the staff delivered them to the residents.
On 10/29/14 at 12:45 AM, dietary staff #1 was interviewed. She stated that the cart would hold the food temperature (hot and cold) up to 8 minutes and after 8-10 minutes, the food temperature started to drop.
10/29/14 at , administrative staff #3 was interviewed. She stated that she expected the staff to deliver the trays to the residents once the cart arrived on the hall.
3. Resident # 14 was admitted to the facility on 5/30/14 with multiple diagnoses including Diabetes Mellitus, cerebro vascular accident (CVA) and dementia. The quarterly MDS assessment dated 9/3/14 indicated that Resident #14 had memory and decision making problems and needed extensive assistance with eating.
On 10/28/14, a continuous lunch meal observation was conducted from 12:05 PM to 1:30 PM on station one (100, 200, 300 and 400 halls). Resident #14 resided on 200 hall. The cart arrived on 200 hall at 12:10 PM. Nursing aides were observed passing trays to resident's rooms. Resident #14 was observed in bed from 12:05 PM until 1:15 PM and no staff member was observed to enter the room to serve his lunch tray At 1:23 PM, Nurse Aide (NA) # 4 was observed pushing a cart to 200 hall. When she opened the cart, there were 5 trays that were untouched and 2 trays that were dirty. She removed the tray of Resident #14 and brought it in the room. She was observed setting up the tray on top of the bedside table and then left the room. She indicated that she didn't know these residents (if dependent with eating or not) because she was a floater. She returned back to the resident's room at 1:25 PM and she was observed to set up the bedside table with the lunch tray in front of the

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F 364	Continued From page 15 resident. The resident immediately grabbed the fork and fed self. The food was luke warm at this time. On 10/28/14 at 1:30 PM, NA #4 was interviewed. She stated that she was a floater and didn't know the residents well. She indicated that she was picking up trays from the resident' s rooms. She had picked up two trays when she noticed that there were 5-6 trays left in the cart that were untouched. One of the trays was for Resident #14. She added that she didn't know why those trays were not served to the residents. On 10/28/14 at 4:38 PM, Resident # 7 was interviewed. Resident #7 's cognitive status was intact. He stated that the food was always cold at all meals. He added that cold food was always brought up in the resident council meeting as a concern and nothing had been done to correct it. He had observed carts sitting on the halls for long period of time before the staff delivered them to the residents. On 10/29/14 at 12:45 AM, dietary staff #1 was interviewed. She stated that the cart would hold the food temperature (hot and cold) up to 8 minutes and after 8-10 minutes, the food temperature started to drop. 10/29/14 at , administrative staff #3 was interviewed. She stated that she expected the staff to deliver the trays to the residents once the cart arrived on the hall. 4. Resident #10 was admitted to the facility on 12/6/13 with the following diagnoses: cerebral vascular disease with hemiplegia. The quarterly MDS assessment dated 10/15/14 indicated that Resident #10 had moderate cognitive impairments. He was able to eat with limited assistance.	F 364		

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On 10/28/14 at 10:05 am, Resident #10 was interviewed. His breakfast tray had recently been delivered. He indicated that the breakfast trays were usually passed on the halls between 9:00-9:30 am, but they were just a little bit today. He was served oatmeal and took a few bites of his food. He commented that his food was kind of warm. He then left the tray and went outside.

Nurse Aide #1 was interviewed on 10/28/14 at 10:09 am. She explained that she was the only aide on the unit and she was responsible for passing trays, answering call bells, offering feeding assistance on the 500, 600, 700 and 800 halls and was monitoring a resident who fell earlier that morning. She shared that the other aides were assigned to the dining room and had not returned to help pass the trays.

The 8/5/14 Resident Council Minutes were reviewed. Residents in attendance voiced that the food wasn't always hot.

Dietary Staff #1 was interviewed on 10/19/14 at 12:45 pm. She stated that the meal cart would hold hot food temperature (hot and cold) up to 8 minutes and after 8-10 minutes, the food temperatures started to drop.

On 10/29/14 at 4:30 pm, administrative staff #3 was interviewed. She commented that she wanted to see the meal trays delivered within 10-15 minutes of arriving on the floor. Her expectations were for residents who were capable of feeding themselves to be offered their food trays first, and then staff should assist others who needed assistance with their meals. If the food didn't appear to be hot, she wanted staff to reheat the food.

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5. Resident #13 was admitted to the facility on 5/2/14 with the following diagnoses: diabetes mellitus type II, dysphagia and chronic renal disease. The quarterly MDS assessment dated 10/15/14 indicated that Resident #13 had moderate cognitive impairments. He was able to eat with limited assistance.

On 10/28/14 at 10:07 am, Resident #7 was interviewed. In front of him was a plate of scrambled eggs, grits and bacon. He said that his food was cold but that he was trying to eat it. He mentioned that on the days when he doesn't have to be out of the building around 8:00 am, his breakfast tray arrived between 9:00-9:30am.

Nurse Aide #1 was interviewed on 10/28/14 at 10:09 am. She explained that she was the only aide on the unit and she was responsible for passing trays, answering call bells, feeding assistance on the 500, 600, 700 and 800 halls and was monitoring a resident who fell earlier that morning. She shared that the other aides were assigned to the dining room and had not returned to help pass the trays.

The 8/5/14 Resident Council Minutes were reviewed. Residents in attendance voiced that the food wasn't always hot.

Dietary Staff #1 was interviewed on 10/19/14 at 12:45 pm. She stated that the meal cart would hold hot food temperature (hot and cold) up to 8 minutes and after 8-10 minutes, the food temperatures started to drop.

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F 364	Continued From page 18 wanted to see the meal trays delivered within 10-15 minutes of arriving on the floor. Her expectations were for residents who were capable of feeding themselves to be offered their food trays first, and then staff should assist others who needed assistance with their meals. If the food didn't appear to be hot, she wanted staff to reheat the food.	F 364		
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	F 441		11/26/14

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F 441	Continued From page 19 hand washing is indicated by accepted professional practice. (c) Linens 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 observation, record review and staff interviews, the facility failed to follow infection control procedures for hand washing/ hand hygiene prior to exiting the room of Resident #8 who was on contact precautions for C-Diff (clostridium difficile). The findings included: A facility policy titled Transmission-based Precautions Contact Precautions" revised 01/13 stated, in part, "Gloves and hand washing: 3. Remove gloves before leaving the room and wash hands immediately with an antimicrobial agent or a waterless antiseptic agent " CDC (Centers for Disease Control) guidelines updated Fall 2011 stated, in part,"Clinical Practice guidelines for CDI (Clostridium difficile infection) recommend preferential use of soap and water for hand hygiene over alcohol-based hand hygiene products." Resident #8 was readmitted to the facility on 10/10/14. Resident had a diagnosis of clostridium difficile. Clostridium difficile is an infectious bacterium that causes diarrhea and more serious intestinal conditions.	F 441	F441 The identified resident #8 was not affected by this practice. CNA #5 was reeducated regarding infection control expectations when giving care to a resident who has C-Diff All Direct care staff , prior to working, will be trained by SDC/Unit Manager on infection control practices for hand washing/hand hygiene for residents with diagnosis of clostricium difficile. This occurred prior to November 26. A QA auditing tool will be utilized by SDC/Unit Manager to monitor care of residents with C Diff precautions q shift for 1 week and then random daily monitoring for 3 weeks and then random weekly monitoring for 2 months to ensure compliance with infection control practices for hand washing/hand hygiene Findings from these Audit tools will be reviewed monthly for 3 months in the QA committee meeting for ongoing compliance with additional training given if indicated.	

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F 441	Continued From page 20 On 10/29/14 at 11:50AM, an observation of incontinent care was conducted. A contact isolation sign was noted on Resident #8's door. Nursing assistant (NA) #5 stated Resident #8 was on contact precautions for C-Diff. NA #5 donned a disposable gown, gloves and mask. She entered the room and performed incontinent care for Resident #8. She completed care and placed linens and disposable items in two trash bags and placed them at Resident #8's doorway. NA #5 proceeded to remove her mask, gown and gloves and placed them in the trash container. She exited the room, obtained the linen and trash containers. NA #5 did not wash her hands prior to exiting the room. NA #5 reapplied disposable gloves that she had obtained from the cart that was outside of Resident #8's room and removed the bags of linen and trash from the room placing them in the containers which were located in the hallway. Then, she stood in the hallway, took alcohol hand gel from her pocket and cleansed her hands with the gel. When asked regarding hand washing when caring for a resident with C-Diff, she stated she used the alcohol gel and was going to go down the hall and wash her hands with soap and water. She stated she knew she should have washed her hands with soap and water prior to exiting the room and after handling the linens and trash but was nervous. On 10/29/14 at 1:27PM, Administrative staff #1 stated she expected facility staff to follow the policy and guidelines for contact precautions and to use soap and water when caring for a resident diagnosed with C-Diff.	F 441		