STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(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 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews, the facility failed to revise the care plan to include new interventions to prevent falls for one (1) of three (3) residents reviewed for accidents (Resident #164). The findings included: Resident #164 was admitted to the facility on 6/28/14. Cumulative diagnoses included CVA (cerebrovascular accident) with left sided paralysis. Accident and incident reports from past 6 months	F 280	Pine Ridge Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Pine Ridge Health and Rehabilitation Center'□s response to this Statement of	2/20/15

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

Electronically Signed | 02/10/2015

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F 280	Continued From page 1 were reviewed and revealed Resident # 164 had sustained 2 falls in last 6 months. On 9/22/14 at 2:38PM, Resident #164 was found lying on his left side with his left arm resting on the foot pedal of the wheelchair and left hip on the opposite foot pedal of wheelchair. Interventions noted that a therapy referral was made and a non-slip mat was added to his wheelchair. A fall risk evaluation dated 12/18/14 indicated a score of 9 (10 or higher is at risk for falls). A Quarterly Minimum Data Set (MDS) dated 12/18/14 indicated Resident #164 was moderately impaired in cognition. He required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. Functional limitation in range of motion was noted with impairment on one side for upper/ lower extremities. Resident #164 was frequently incontinent of bladder/ bowel. No falls were noted since the last assessment. An Incident report dated 1/15/15 at 11:00AM stated Resident #164 slid out of his wheelchair. He was wearing silky jogging pants and slid out of the wheelchair due to the pants and the slick surface of his wheelchair cushion. Interventions noted that he was currently in therapy caseload. A non-slip mat would be added to his wheelchair and he social worker would be notified to see if family would bring Resident #164 some fleece wear pants. A care plan dated 7/18/14 and last revised on 1/1/15 indicated Resident #164 was at risk for falls characterized by actual falls, injury (one fall since admit to facility). Interventions included: assist during transfer and mobility; bed in lowest	F 280	Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Pine Ridge Health and Rehabilitation Center reserves the right to refute any the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 280 Right to Participate Planning Care-Revise CP Resident #164'□s care plan was reviewed and revised, to include new interventions to prevent falls, on 1/22/15 by the QI nurse. A 100% audit was initiated on 1/26/15 of all residents, to include resident # 164, and updated as necessary by the MDS nurse, the Director of Nursing (DON), and/or the Assistant Director of Nursing (ADON). The MDS nurses were inserviced by the ADON on updating and revising the care plans for all residents with falls for the past 30 days. All incident/accident reports, to include resident # 164□s, will be reviewed in the daily meeting 5 x's week. The MDS nurse will be responsible for updating the resident care plan for residents who have fallen at completion of investigation of incident within 72 hours. The DON, ADON and/or QI nurse will review the resident care plans of all residents identified with falls two times per week x 4 weeks, then weekly x 4 weeks, then monthly x 2	

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F 280	Continued From page 2 position; rehab therapy referral; have commonly used articles in reach; keep call light within reach and answer timely and low bed. Resident should wear proper and non slip footwear. Use wheelchair when out of bed. There was no documentation regarding the fall on 9/22/14 or 1/15/15 and the interventions recommended during the investigation of the falls. On 1/22/15 at 8:00AM, NA #6 stated was unaware that Resident #164 had recently fallen. She was not aware of any fall precautions for Resident #164. On 1/22/15 at 8:10AM, Nurse #3 stated Resident #164 had on slick pants and was sitting on the slick cushion in his wheelchair when he fell on 1/15/15. She was not aware of any fall precautions for Resident #164. On 1/22/15 at 2:51PM, Administrative staff #6 stated she was responsible for determining what interventions would be instituted when a fall occurred. She said Resident #164 was currently receiving therapy. Administrative staff #6 stated Resident #164 had the non-slip mat on top of his cushion in his wheelchair as well as a non-slip mat under the cushion of his wheelchair. She stated the interventions would be placed on the care plan and care guide when the fall occurred or shortly thereafter (within a three day time frame). She reviewed the care plan and stated the non-slip mat should have been added to the care plan. Administrative staff #6 then reviewed the care guide that was posted in the closet of Resident # 164 and stated the non-slip mat should have been noted on the care guide also. On 1/22/15 at 3:33PM, Administrative staff #4	F 280	months to ensure care plans have been updated to reflect interventions that have been put in place. A Care Plan Review QI tool will be used for the audits. All identified areas of concern will be addressed immediately by the DON and/or ADON. The DON will be responsible for compiling audit results from the Care Plan Review QI tool. The DON will present the compiled results at the monthly Quality Improvement Committee meeting. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring.	

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F 280	Continued From page 3 stated the use of the non-slip mat should have been noted on the care plan and on the care guide.	F 280		
F 312 SS=D	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 observation, record review, resident and staff interviews, the facility failed to provide nail care for one (1) of two (2) residents who required extensive assistance with personal hygiene (Resident #164). The findings included: Resident #164 was admitted to the facility on 6/28/14. Cumulative diagnoses included cerebrovascular disease, CVA (cerebrovascular accident) with left sided paralysis. A Quarterly Minimum Data Set (MDS) dated 12/18/14 indicated Resident #164 was moderately impaired in cognition. He required extensive assistance with personal hygiene. Functional limitation in range of motion was noted with impairment on one side for upper/ lower extremities. Resident #164 ' s care plan was reviewed with no care plan indicated for ADL ' s (activity of daily living).	F 312	F 312 ADL Care Provided for Dependent Residents Resident #164 was provided with nail care to both hands. Resident #164□ fingernail beds on both hands were cleaned. Resident #164□s toenails were also trimmed and cleaned. A 100% audit of all resident□s fingernails and toenails were completed on 1/26/15 by the Assistant Director of Nursing (ADON), QI nurse (QI), and MDS nurses (MDS). Any resident requiring fingernail care was provided with fingernail care at time of audit. Any resident requiring toenail care was provided with toenail care at the time of audit or added to the podiatrist□s (foot doctor) list. CNAs are responsible for nail care two times weekly on designated shower days. Hall Nurses assess residents two times weekly on shower days for need of	2/20/15

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F 312	Continued From page 4 On 1/21/15 at 9:31AM, an observation of Resident #164 revealed Resident #164 had elongated fingernails on both hands. Brown material was noted under the nail beds of all the fingers on both hands. Resident #164 stated he liked to have his fingernails short and they needed to be trimmed. He stated his toenails also needed to be trimmed. On 1/22/15 at 8:00AM, Resident #164 was observed and continued to have brown material under all of his nails on both hands. An observation of his toenails was also conducted at that time and revealed long toenails with nails curled over the ends of his toes. On 1/22/15 at 8:00AM, NA (nursing assistant) #6 stated Resident #164 received his bath on night shift. When asked about nail care, she stated the nursing assistants did not cut toenails/ fingernails but would tell the restorative aide and/or the nurse if nails needed to be trimmed. NA #6 said she would also notify the social worker if a resident needed to be seen by the podiatrist (foot doctor). NA #6 observed Resident #164 ' s fingernails and toenails. She said the fingernails and toenails needed to be cut and she would notify the nurse. NA #6 stated she did not know if the nurse/ restorative aide had already been informed regarding the need for fingernail and toenail care. On 1/22/15 at 8:03 AM, the restorative aide stated no one had informed her that Resident #164 needed to have his fingernails cut. She said the podiatrist would cut his toenails. On 1/22/15 at 8:05AM, Nurse #3 stated no one had informed her that Resident #164 needed to	F 312	podiatry services. Hall nurses refer residents to the social worker who places residents on the list for podiatry services. 100% of nursing department staff were inserviced by the ADON on 2/1/2015 regarding fingernail and toenail care. A Nail Audit tool will be completed by the QI nurse and/ or Director of Nursing (DON). The Nail Audit tool will be used weekly x 4 weeks, twice monthly x 2 months, and monthly x 3 months. The QI nurse will bring results of the audits to the monthly QI meeting to identify trends and continued need for monitoring.	

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F 312	Continued From page 5	F 312		

have his fingernails or toenails cut. She stated nursing assistants usually would inform her if nail care needed to be done and if the resident needed to be put on the podiatry list.

On 1/22/15 at 8:10AM, Administrative staff #4 stated podiatry performed toenail care and licensed staff could also cut the toenails. She said a nursing assistant was assigned once a week to do nail care (fingernails). She expected nursing staff to keep the resident's nails clean and fingernails should be cleaned and cut unless refused by the resident. Administrative staff #4 stated Resident #164 had refused some care in the past. She reviewed the charting from January 1st through present and stated Resident #164 had no refusals/ resistance of ADL care. She stated it was standard of practice to provide proper nail care. She stated she had not been informed that Resident #164 had elongated toenails

On 1/22/15 at 8:20AM, the restorative aide stated she had cut/ trimmed Resident #164's fingernails and he had not refused/ resisted care at all.

On 1/22/15 at 9:10AM, Administrative staff #5 stated Resident #164 was on the schedule to be seen by the podiatrist on 2/5/15. She reviewed the podiatry list for 10/6/14 and Resident #164 had not been seen at that time. She stated staff informed the social worker when a resident needed to have his toenails done by the podiatrist and, if a resident needed to be seen before the routine podiatry visit, the facility would take that resident to a private podiatry clinic in the community. She indicated Resident #164 had not been referred to a private podiatrist.

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F 314	Continued From page 6	F 314		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to float the resident's heels while in bed for 1 (Resident #23) of 1 sampled resident reviewed with pressure ulcer. Findings included: Resident #23 was admitted to the facility on 12/5/14 and was readmitted on 12/15/14 with multiple diagnoses including diabetes mellitus, hypertension and schizophrenia. The admission MDS assessment dated 12/21/14 indicated that Resident #23 had moderate cognitive impairment, needed extensive assist with bed mobility and had two unstageable pressure ulcers. The care plan dated 1/14/15 was reviewed. The problem was " ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to two unstageable areas on right lateral foot and ankle. The goal was " resident will maintain intact skin as	F 314	F 314 Treatment /Services to Prevent/Heal Pressure Ulcers On 1/23/15, Resident #23 had heel floats placed on his/her feet. On 1/23/15, the air boots as per the wound care specialist evaluation were placed on the resident. On 1/23/15, the residents care plan and care guide were updated to reflect the air boots. On 1/27/15, the treatment nurse, completed an 100% audit of all residents with wounds to ensure all appropriate pressure relieving devices as identified by the Resident Care Guide and Care Plan were in place. On 2/4/15, the ADON, initiated an inservice to all licensed nursing staff and nurse aides to include: Appropriate pressure relieving devices for the resident will be documented on the residents care	2/20/15

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F 314	Continued From page 7 evidenced by no further breakdown and will show positive healing with reduction in size/stage of pressure ulcer at next review. The approaches included " ensure appropriate pressure relieving devices in place during repositioning. " The wound care specialist evaluation reports were reviewed. The report dated 12/11/14 indicated that Resident #23 had unstageable pressure ulcers on the right lateral ankle and right lateral foot. The wound size on the right lateral ankle was 2 x 2 centimeter (cm) and it was 100% necrotic. The wound size on the right lateral foot was 1 x 0.8 cm and it was 80% necrotic. The recommendation was to treat the pressure ulcers with santyl (a debriding ointment) and to float the heels in bed. The report dated 12/18/14 revealed that the pressure ulcer on the right lateral ankle was a stage III and it measured 2 x 1.8 cm and it was 100% yellow necrotic. The pressure ulcer on the right lateral foot was unstageable measuring 0.7 x 0.7 cm and it was 80% necrotic. The recommendation was to treat the pressure ulcers with santyl and to wear a boot in bed to float the heels. The report dated 1/15/15 indicated that the pressure ulcer on the right lateral ankle was a stage III measuring 1.6 x 1.5 x 0.2 cm and it was 80% necrotic. The pressure ulcer on the right lateral foot was a stage III measuring 0.3 x 0.4 cm and it was 100% granulation. The recommendation was to wear a boot to float the heels and to treat right ankle pressure ulcer with santyl and a foam dressing to the right foot pressure ulcer.	F 314	plan and care guide. During daily routine care, the nurse and nurse aides will be responsible to review the residents care guide and ensure that all pressure relieving devices are in place, to include the Treatment Nurse providing care. On 2/4/15, Nurse #2(Treatment Nurse), DON and MDS Nurses were inserviced by the Administrator: When pressure relieving devices are recommended by the wound care specialist, the DON must be notified. The DON will discuss/inform the Administrator of the device and ensure the device is obtained. Nurse #2(Treatment Nurse) is responsible to ensure that the device is received and placed appropriately for the resident. Nurse #2 (Treatment Nurse) will communicate the new device to the MDS Nurses who will ensure the Residents Care Plan and Care Guide are updated. All Wound Care Specialist Evaluations will be reviewed by treatment nurse and/or the Director of Nursing weekly x 4 weeks, then every 2 weeks x 4 weeks to ensure all recommended pressure relieving devices are in place. All residents with wounds will be reviewed by the ADON to ensure that all interventions are in place for each resident and listed on the care plan and care guide, The ADON will bring results of the audit to the monthly QI Meeting and the committee will review all audit information	

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F 314	Continued From page 8 The report dated 1/22/15 revealed that the pressure ulcer on the right lateral ankle was a stage 4 measuring 2 x 2.3 x 0.3 cm and it was 80% necrotic. The report indicated that the ulcer had deteriorated due to infection and it was deeper than last week. The pressure ulcer on the right lateral foot was a stage III measuring 0.3 x 0.4 cm and it was 70% necrotic. The recommendation was to treat the ulcers with santyl and an air boot to float the heels. The physician ' s orders were reviewed. On 12/16/14, there was an order to clean the pressure ulcers on right lateral ankle and foot with normal saline (ns) and apply santyl and cover with dry dressing. The treatment records were reviewed and treatment was provided as ordered. On 1/9/15, there was an order to discontinue santyl to the right lateral foot, change to clean it with ns and apply dry protective dressing. On 1/23/15, there was an order to clean right lateral ankle and foot with ns, apply santyl and cover with foam dressing daily. On 1/20/15 at 4:03 PM and on 1/22/15 at 9:18 AM and 2:22 PM, Resident #23 was observed in bed. Resident #23 ' s feet were not floated and were resting against the mattress. On 1/22/15 at 9:25 AM, NA # 2 was interviewed. She stated that Resident #23 was not on any boots/heel protector. She was wearing socks all the time. On 1/23/15 at 10:23 AM, Resident #23 was observed during the dressing change. The pressure ulcer on the right lateral ankle was a	F 314	for any recommendations, take appropriate action as needed and monitor continued compliance in this area.	

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F 314	Continued From page 9 nickel size, with serous drainage and yellow slough. The pressure ulcer on the right lateral foot had a small open area and with yellow slough. Nurse #2 cleaned the ulcers with ns, santyl was applied and covered the ulcers with foam dressing. On 1/23/15 at 10:25 AM, interview with Nurse # 2 was conducted. She stated that the ulcer on the right lateral foot had opened back up. She also indicated that NAs were supposed to ensure that bunny boots were on at all times when the resident was in bed. She also revealed that the air boots were on order. She didn't indicate as to when she ordered the boots.	F 314		
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 observation, record review and staff interview, the facility failed to have an indication for an indwelling urinary catheter and failed to document an assessment of the ongoing need for an indwelling urinary catheter for 1 of 3 resident's (Resident #26). The findings included:	F 315	F 315 No Catheter, Prevent UTI, Restore Bladder Resident #26□'s physician was notified and order was obtained to remove the indwelling urinary catheter. The indwelling	2/20/15

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F 315	Continued From page 10 Resident #26 was admitted on 12/24/14 with cumulative diagnoses including pneumonitis, congestive heart failure, hypertension, renal failure and urinary tract infection. The Admission Minimum Data Set (MDS) dated 12/31/14 revealed the resident was cognitively impaired, required extensive assistance for toileting and had an indwelling catheter. The Physician ' s Orders from 12/24/14 through 1/20/15 were reviewed. There were no orders for an indwelling urinary catheter. The History and Physical Admission Progress Note dated 1/2/15 was reviewed. There was no mention of an indwelling urinary catheter within this note. Review of the Care Plan dated 1/13/15 revealed a plan of care for " altered pattern of urinary elimination with indwelling catheter " . Interventions included: " catheter care per facility protocol " , " change catheter per physician orders and/or facility protocol " , " empty drainage bag at the end of each shift " , " monitor and record output " , " ensure that drainage tubing is secured with anchoring device " , " maintain a closed drainage system " , " keep drainage bag below the level of the bladder " , monitor s/s (signs and symptoms) of urinary tract infection. On 1/21/15 at 10:38 AM Nurse #4 stated that Resident #26 had an indwelling urinary catheter since admission. She said that she did not know what the indication for the catheter was but reviewed the resident ' s medical diagnoses in the chart at this time. She then indicated that she did	F 315	urinary catheter was removed as ordered on 1/23/15. A 100% audit was completed of all residents with indwelling and suprapubic urinary catheters. The audit verified indications for an indwelling urinary catheter. The audit also verified an assessment for ongoing need for an indwelling urinary catheter. A 100% inservice was completed by the ADON on 2/1/2015 with nursing staff, to include the MDS nurses, on the need for indications for indwelling urinary catheters and documentation of an assessment, to include the required MDS assessments of the ongoing need for an indwelling catheter. The ADON and/or DON will assess all new admissions on the need for indications for use of a urinary catheter and ensure proper documentation within 72 hours of admission. The ADON and/or DON will use the Cather Audit tool to document these assessments within 72 hours of admission. All admissions/re-admissions will be assessed by the ADON for the presence of and/or appropriate diagnosis for use of indwelling catheter, any negative finding will be addressed immediately. A Catheter Audit QI audit tool will be completed by the ADON and/or QI twice weekly x 4 weeks, then twice monthly x 2 months, then monthly x 3 months. Any negative findings or concerns will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 01/23/2015

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F 315	Continued From page 11 not see a specific reason for the resident to have a catheter. On 1/21/15 at 12:11 PM Resident #26 was observed in bed with her eyes closed. A urinary catheter bag was attached to the bedframe and the tubing, which ran up under the resident's covers, contained clear amber urine. On 1/23/15 at 2:39 PM Nurse #5 was observed checking to see if the resident ' s indwelling urinary catheter was secured with a lag strap, which it was at this time. Interview with Nurse #5 on 1/23/15 at 2:40 PM revealed that she did not know why the resident still had an indwelling urinary catheter. On 1/23/15 at 2:45 PM Nurse # 5 indicated she had checked with Administrative Staff #4 and was told that the physician was going to have the Nurse Practitioner assess the resident for the ongoing need for an indwelling urinary catheter the next time she was in the facility.	F 315	addressed by the DON. The ADON will bring results of audits to the monthly QI meeting to identify possible trends and continued need for monitoring.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		2/20/15

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F 323	Continued From page 12 Based on observation, medical record review and staff interviews, the facility failed to follow fall prevention interventions for one (1) of three (3) residents reviewed for falls as evidenced by Resident #164 not having a non-slip mat on the top of his wheelchair cushion. The findings included: Resident #164 was admitted to the facility on 6/28/14. Cumulative diagnoses included CVA (cerebrovascular accident) with left sided paralysis. Accident and incident reports from past 6 months were reviewed and revealed Resident # 164 had sustained 2 falls in last 6 months. On 9/22/14 at 2:38PM, Resident #164 was found lying on his left side with his left arm resting on the foot pedal of the wheelchair and left hip on the opposite foot pedal of wheelchair. Interventions noted that a therapy referral was made and a non-slip mat was added to his wheelchair. A fall risk evaluation dated 12/18/14 indicated a score of 9 (10 or higher is at risk for falls). A Quarterly Minimum Data Set (MDS) dated 12/18/14 indicated Resident #164 was moderately impaired in cognition. He required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. Functional limitation in range of motion was noted with impairment on one side for upper/ lower extremities. Resident #164 was frequently incontinent of bladder/ bowel. No falls were noted since the last assessment. An Incident report dated 1/15/15 at 11:00AM stated Resident #164 slid out of his wheelchair.	F 323	F 323 Free of Accident Hazards/Supervision/Devices On 1/23/15, a non-slip mat was placed on top of the wheelchair cushion for resident #164. An updated Fall Risk Assessment was completed for resident #164. A 100% audit was completed for all residents who had a fall within the past 30 days to ensure fall prevention interventions are in place by the QI Nurse on 1/26/2015. 100% audit was completed by the QI nurse on 1/26/2015 for all remaining residents with a history of falls to ensure interventions are in place and appropriate. 100% of nursing staff and department heads were inserviced on following fall prevention interventions to include resident #164 having a non-slip mat on top of his wheelchair cushion by the ADON on 2/1/15. An Incident/Accident QI audit tool will be completed by the QI nurse or ADON twice weekly x 4 weeks, twice monthly x 2 month, then once a month x 3 months. Any negative findings will be addressed by the DON. The ADON will bring results of the audit to the monthly QI meeting to identify trends and continued need for monitoring.	

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F 323	Continued From page 13	F 323		

He was wearing silky jogging pants and slid out of the wheelchair due to the pants and the slick surface of his wheelchair cushion. Interventions noted that he was currently in therapy caseload. A non-slip mat would be added to his wheelchair and he social worker would be notified to see if family would bring Resident #164 some fleece wear pants.

A care plan dated 7/18/14 and last revised on 1/1/15 indicated Resident #164 was at risk for falls characterized by actual falls, injury (one fall since admit to facility). Interventions included: assist during transfer and mobility; bed in lowest position; rehab therapy referral; have commonly used articles in reach; keep call light within reach and answer timely and low bed. Resident should wear proper and non slip footwear. Use wheelchair when out of bed. There was no documentation regarding the fall on 9/22/14 or 1/15/15 and the interventions recommended during the investigation of the fall.

On 1/22/15 at 8:00AM, an observation of Resident #164 ' s wheelchair revealed there was not a non-slip mat on the top of his wheelchair cushion.

On 1/22/15 at 8:10AM, Nurse #3 stated Resident #164 had on slick pants and was sitting on the slick cushion in his wheelchair when he fell on 1/15/15. She was not aware of any fall precautions for Resident #164.

On 1/22/15 at 2:51PM, an observation of Resident #164 ' s wheelchair was conducted with Administrative staff #6. A non-slip mat was noted under the cushion but there was not a non-slip mat on top of the cushion. Administrative staff #6

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F 323	Continued From page 14 stated there should have been a non-slip mat on top of the cushion as well as under the cushion to prevent further falls. On 1/22/15 at 3:33PM, Administrative staff #4 stated Resident #164 should have had a non-slip mat on top of the cushion after the fall on 1/15/15.	F 323		
F 329 SS=E	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 by:	F 329		2/20/15

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F 329	Continued From page 15 Based on record review, and staff interview, the facility failed to document the indication for the use of Robitussin (expectorant) and Gabapantin (anticonvulsant/analgesic) and failed to discontinue the Robitussin as ordered for 2 (Residents # 115 & # 123) of 5 sampled residents reviewed for unnecessary medications. Findings included: 1. Resident #115 was admitted to the facility on 1/18/13 and was readmitted on 3/4/14 with multiple diagnoses including Alzheimer's disease, paralysis agitans, diabetes mellitus, hypertension and depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated 10/23/14 indicated that Resident #115 had severe cognitive impairment. The admission orders (3/4/14) included Robitussin 10 milliliter (ml), 200 milligrams (mgs) every 6 hours. The Medication Administration Records (MARs) for March, 2014 revealed that Robitussin was administered as ordered. On 3/25/14, the pharmacist had requested for a stop date or diagnosis for the use of the Robitussin. On 4/4/14, the attending physician had ordered to discontinue the Robitussin. The MARS from August through November, 2014 were reviewed. Robitussin 10 ml was documented as administered every 6 hours round the clock. On 12/2/14, there was a telephone order to decrease Robitussin to 10 ml three times a day. The December and January, 2015 MARs revealed that Robitussin was administered 10 ml three times a day.	F 329	F 329 Drug Regimen is Free From Unnecessary Drugs Resident # 115□'s physician was contacted regarding an indication for the continued use of Robitussin. An order was received for Resident # 115□s Robitussin to be discontinued on 1/23/15. Resident #123□'s physician was contacted regarding an indication for use of gabapentin. The physician indicated that the gabapentin is to be used for Diabetic Neuropathy on 1/24/15. 100% audit of pharmacy review recommendations for the past three months were reviewed to ensure stop-dates for medications, discontinuation of medications and indications for usage of medications were completed by the DON and ADON on 1/26/15. A 100% inservice of the nursing staff was completed by the ADON on 2/1/2015, on documenting the indication for medications ordered by the physician, discontinuing unnecessary medications. A Medication Review QI audit tool will be completed by ADON or DON twice weekly x 4 weeks, twice monthly x 2 month, then once a month x 3 months. Any negative findings will be addressed by the DON. The ADON will bring results of the audits to the monthly QI meeting to identify trends and continued need for monitoring.	

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F 329	Continued From page 16 Review of the doctor's progress notes and diagnoses list revealed no diagnosis for the continued use of the Robitussin. On 1/23/15 at 9:20 AM, administrative staff #1 was interviewed. She stated that she could not find a diagnosis for the use of the Robitussin. On 1/23/15 at 11:55 AM, administrative staff #3 was interviewed. She stated that she had reviewed the chart and could not find a diagnosis for the use of the Robitussin. She also stated that she was aware that it was discontinued in April, 2014 but she could not find any order to restart it. On 1/23/15 at 4:30 PM, a telephone order was provided and the attending physician had ordered to discontinue the Robitussin. 2. Resident #123 was admitted to the facility on 12/5/14 with multiple diagnoses including Alzheimer's disease, diabetes mellitus, congestive heart failure and depressive disorder. The admission MDS assessment dated 12/11/14 indicated that Resident #123 had severe cognitive impairment. The admission orders (12/5/14) included gabapantin 300 mgs by mouth every evening. On 12/10/14, the pharmacist had requested for the diagnosis of gabapantin. On 1/20/15, the pharmacist had again requested for the diagnosis of gabapantin.	F 329		

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F 329	Continued From page 17 Review of the doctor's progress notes and the diagnoses list revealed no diagnosis for the use of gabapantin. On 1/22/15 at 5:45 PM, administrative staff #1 was interviewed. She stated that she did not receive a request from the pharmacist regarding the need for the diagnosis of gabapantin.	F 329		
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 observation, record review and staff interview, the facility failed to have a medication error rate of 5 percent or less by not flushing a gastrostomy tube (G-tube) between medications (Resident #68) and by giving a medication when it was not due to be given (Resident #68). There were 2 errors in 26 opportunities, for a medication error rate of 7.69 percent. The findings included: 1a. Resident #68 was admitted on 5/2/14 with cumulative diagnoses including hypertension, diabetes, cardio vascular disease and dementia. On 1/22/15 at 9:30 AM Resident #68 was observed during medication pass. Nurse #6 was observed to prepare and administer the resident ' s morning medications per the resident's gastrostomy tube (G-tube). Nurse #6 was observed giving Resident #48 a total of 13 medications (crushed with water or in liquid form) per G-tube during this medication pass. Each of	F 332	F 332 Free of Medication Errors Rate of 5% or More Resident # 68'□s nurse, Nurse #6, received immediate education on flushing a gastrostomy tube (G-tube) between medications. Resident #48□'s physician was notified on 1/22/15 by ADON regarding Resident #48 receiving gabapentin solution 250mg/ml, 8mls per G-tube @ 930am, when it was scheduled to be given at 6am, 12noon, 6pm, and 12 midnight. No new orders were received by the physician. 100 % of all other residents who receive medication via G-tubes were audited by the ADON on 1/26/2015 to ensure nursing	2/20/15

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F 332	Continued From page 18 the 13 medications was in its own medication cup and poured into the resident ' s G-tube individually, however, while giving the medications she did not flush the g-tube with water between each medication given. On 1/22/15 at 10 AM Nurse #6 was interviewed. She acknowledged that she did not flush Resident #68 ' s G-tube with water between each medication that she was observed to give that morning. She indicated that she was aware that she should have flushed the G-tube with water between each medication but said that she had never given this resident his medications before so she forgot to do it. On 1/23/15 at 9:30 AM Administrative Staff #1 was interviewed. She acknowledged that the standard of practice and facility policy was to flush the G-tube between each medication and indicated that she expected staff to follow the policy. 1b. Resident #68 was admitted on 5/2/14 with cumulative diagnoses including hypertension, diabetes, cardio vascular disease and dementia. On 1/22/15 at 9:30 AM Resident #68 was observed during medication pass. Nurse #6 was observed to prepare and administer the resident ' s morning medications, including gabapentin (an anticonvulsant medication used to treat seizures and used to treat nerve pain), per the resident ' s gastrostomy tube (G-tube). Review of the Physician's Orders summary for 1/1/15 through 1/31/15 revealed an order for Gabapentin solution 250 mg (milligrams) per ml (milliliter), administer 8 ml (400 mg) per G-tube. The medication administration times were listed as 6 AM, 12 noon, 6 PM and 12 midnight. On 1/22/15 at 10 AM Nurse #6 was interviewed. She acknowledged that she gave a dose of gabapentin to Resident #68 with his morning	F 332	staff are flushing G-tubes between medications. Any negative findings were addressed immediately. 100% of all residents receiving gabapentin were audited by the ADON on 1/26/2015 to ensure gabapentin is being given when it is due to be given. Any negative findings were addressed immediately. 100% of licensed nursing staff was educated by the DON and ADON on 2/1/2015 regarding the facility must ensure that it is free of medication error rates of five percent or greater. This education included flushing a G-tube between medications and giving a medication when it is due to be given. A Medication Pass Audit QI tool will be used by the ADON, QI nurse, and/or MDS nurses to ensure that G-tubes are being flushed in between medications and that all medications, including gabapentin, are being administered when it is due to be given. The audit will be completed twice weekly x four weeks, twice monthly x 2 months, then monthly x 3 months to include audits of nights and weekend nurses. The ADON will bring results of the audits to the monthly QI committee meeting to identify possible trends and continued need for monitoring.	

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 332	Continued From page 19 medication pass that morning. The Medication Administration Record (MAR) for Resident #68 was reviewed with Nurse #6 at this time. She acknowledged that for 1/22/15 she had signed off the gabapentin under the 12 noon time slot but indicated that the medication had not been due with the resident ' s morning medications that she already gave. Further review of the MAR for Resident #68 on 1/22/15 revealed the 6 AM dosage was not signed off. Nurse #6 stated she had not been told whether the 6 AM dose was or was not given by the nurse on the previous shift. Review of the Physician's Orders for 1/21/15 through 1/22/15 revealed no orders regarding the administration of gabapentin. Review of the Nurses Notes for 1/21/15 through 1/22/15 revealed no charting regarding administration of the resident's gabapentin. On 1/23/15 at 9:30 AM Administrative Staff #1 was interviewed. She indicated that giving a medication at 9:30 AM, when it was scheduled to be given at 6 AM, 12 noon, 6 PM and 12 midnight was outside the acceptable timeframe and therefore a medication error.	F 332		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		2/20/15

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F 431	Continued From page 20 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to date Advair and Prostat when opened on 3 of 5 carts (100 hall cart, 300 hall cart, and 500 hall carts) and failed to discard expired fleets enema from 1 of 2 medication rooms (central medication room). Findings Included: Review of facility policy dated 1/1/14 for the administration of Advair Diskus Oral Inhaler (example 1) revealed staff were to write the pouch opened and use by dates on the label on top of the Diskus. The use by date is one month from the date the pouch was opened. Review of the manufacturer's medication	F 431	F 431 Drug Records, Label/Store Drugs & Biologicals The Advair Diskus Oral Inhaler (example 1) from 100 hall was immediately discarded. The Fleets Enema (example 2) which expired August 2014 was immediately discarded from the central medication room. The opened bottle of Prostat observed in the medication cart on 500 hall was immediately discarded. A 100% audit was completed on 1/24/15 by the ADON, QI Nurse, and MDS nurses	

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	345144	A. BUILDING _____ B. WING _____	C 01/23/2015

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PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

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F 431	Continued From page 21 guidelines on storage and handling revealed Advair Diskus (example 1) should be discarded 1 month after opened or after the counter reads " 0 " (after all blisters have been used), whichever comes first. Observation on 1/22/15 at 10:58 AM of the central medication room revealed a fleets enema (example 2) which expired August 2014. Observation on 1/22/15 at 11:10 AM of the 100 hall medication cart revealed an Advair Diskus (example 1) had been used, however, had no open date. Interview on 1/22/15 at 11:37 AM with Nurse #8 revealed that Nurse #1 works the 100 hall medication cart approximately 4 days a week. Nurse #1 reported that whoever opened the Advair Diskus (example 1) had not dated it when they opened it like they should have. Interview on 1/22/15 at 12:00 AM with Administrative Staff #4 revealed that it was her expectation for whoever opened the medication to have dated the medication and that if a date could not be verified, then the medication be discarded. The DON reported that Administrative nurses checked the medication carts and the medication room on a weekly basis for appropriately labeled, and expired medications. On 1/23/15 at 3:13 PM an opened bottle of prostat was observed in the medication cart on 500 hall. The opened date was not written on the bottle. Nurse #7 was interviewed at this time. She acknowledged the prostat was opened and used already, but did not have the date it was opened on it. She stated that she had been told prostat did not need to be dated but upon reading the instructions on the bottle (discard 3 months after opening, put date opened on the bottom of	F 431	of all medication carts and medication rooms to ensure all medications properly labeled with dates and no medications were expired. Any negative findings were immediately addressed by the DON or ADON. An inservice was initiated for 100% of all licensed nursing staff by the ADON on 2/1/2015. The inservice included: (1) Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (2) Advair and Prostat must be labeled with opening dates and discarded in one month (Advair) and three months after opening (Prostat). (3) Fleets enemas will be discarded per manufacturer□s expiration date. The ADON, QI nurse, and MDS nurses will complete a medication audit weekly to ensure compliance with labeling and dating of medications and that medication carts and medication rooms are free of expired medications. Any negative findings will be addressed immediately. An Initial When Complete Calendar QI monitoring tool will be used to ensure that medication rooms and medication carts are compliant with labeling and dating of medication and that medication carts and medication rooms are free of expired	

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	345144	A. BUILDING _____ B. WING _____	C 01/23/2015

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F 431	Continued From page 22 the bottle) agreed that it did require dating after all. Nurse #7 said she would discard the bottle of prostat. Interview on 1/22/15 at 12:00 AM with the Director of Nursing (DON) revealed that it was her expectation for whoever opened the medication to have dated the medication and that if a date could not be verified, then the medication be discarded.	F 431	medications. The hall nurses, ADON, QI nurse, and ADON/DON will complete the audit tool weekly x 4 weeks, twice monthly x 2 months, then monthly x 3 months. Any negative findings will be addressed immediately. The ADON will bring results of the audits to the monthly QI committee meeting to identify possible trends and to review for continued need of monitoring.	
F 441 SS=H	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	F 441		2/20/15

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F 441	Continued From page 23 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 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 record review, observation and staff interview, the facility failed to maintain an effective infection prevention and control program in order to prevent and control to the extent possible, the spread of scabies to residents and staff. Facility failed to educate all direct care staff immediately after a confirmed case was identified and failed to contain staff members who were exposed or had direct contact with Resident #78. Three (500, 100 and 200 halls) of five halls had residents with suspected scabies and were treated and two staff members (nurse's aides #4 & # 5) were diagnosed with scabies and were treated. Findings included: The facility's policy on scabies (a parasitic infestation of the skin caused by a mite that burrows in the top layer to the skin where it feeds and lays eggs) dated 9/2014 was reviewed. The policy under education read in part " educate your staff on early detection and reporting of rashes in residents to nurse or for staff to his/her immediate supervisor, active surveillance program to detect infestation as soon as possible	F 441	F 441 Infection Control, Prevent Spread, Linens On 1/30/15 an order was obtained from the medical director to treat all residents on 100 and 200 halls not previously treated for scabies with Ivermectin. The Ivermectin was administered to the 100 and 200 hall residents on 1/31/15 by the hall nurse(s). The medical director was contacted on 1/30/15. An order was obtained on 1/30/15 that all facility employees be offered treatment with Ivermectin. All facility employees including direct care staff were offered treatment with Ivermectin on 2/3/15. On 2/3/15, a 100% inservice was initiated to all staff by ADON and QI nurse on Scabies. A 100% inservice was initiated on 1/7/15	

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F 441	Continued From page 24 and suspect that any undiagnosed pruritic skin condition might be scabies. " The policy under control read in part " consider prophylactic treatment for resident ' s roommate and or staff that had direct skin to skin contact with infected resident, for infected staff, exclude from work until the day after treatment, and encourage infested staff to contact personal physician for possible prophylactic intervention for family members. " The dermatology consult reports for Resident #78 (room 512A) were reviewed. The reports indicated that Resident #78 was seen by a dermatologist due to the rashes on her hands, feet and arms on 8/22/14, 8/26/14, 9/26/14, and 12/2/14 and on 1/7/15. She was treated with periactin (used for itching) and eucerin cream with 1% triamcinolone for dry skin dermatitis. On 1/7/15, a scraping was done and Resident #78 was diagnosed with scabies and was treated with elimite cream (used to treat scabies) on 1/8/15. The facility's infection control report and Medication Administration Records (MARs) for January, 2015 were reviewed. The report/records indicated the following: 500 hall 1/7/15 - residents in rooms 510 B, 511, 512 A and B were observed to have rashes and were treated with elimite cream on 1/8/15. 1/14/15 - residents in rooms 503, 506 A and 516 A were observed to have rashes and 516 B was noted to be scratching on chest. Residents in rooms 503 and 506 A were treated with elimite cream on 1/14/15 while residents in room 516 A and B were treated on 1/15/15. 1/15/15 - residents in room 506 B and 519 were noted to have a suspected rash and were treated	F 441	by the DON for the nursing, housekeeping and laundry departments on Infection Control: Scabies Education. The inservice included (1) clinical presentation (2) transmission, (3) treatment, (4) prevention, (5) control, (6) reporting any skin abnormality to nurse for assessment and follow-up, (7) contact precautions, and (8) cleaning of re-usable equipment between residents such as blood pressure cuffs, thermometers and lifts with virex or alcohol. Another 100% inservice was initiated on 2/3/15 by the ADON for direct care staff on (1) Maintaining an effective infection prevention and control program in order to prevent and control to the extent possible, the spread of scabies to residents and staff, (2) Educating all direct care staff immediately after a suspected case is identified,(3) Containing staff members who were exposed or have direct contact with residents with suspected scabies, (4) Cleaning reusable equipment such as blood pressure cuffs, thermometers, lifts and belts which included a demonstration on cleaning equipment. On 1/26/15, a 100% inservice was initiated by the ADON for all direct care staff on Standard Precautions, Breaking the Infection Cycle, Infection Control of Our Employees, and Handling of Linen.	

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F 441	Continued From page 25 with elimite cream on 1/15/15. 1/16/15 - a resident in room 500 A had a rash and was treated with elimite cream on 1/16/15. Sixteen other residents on the 500 hall were treated with elimite cream as a prophylactic measures. 100 hall 1/15/15 - resident in room 109 B was noted to have a rash and was treated with elimite cream on 1/17/15 1/19/15 - a resident in room 108 B was noted to have a rash and was treated with elimite cream on 1/21/15 1/20/15 - a resident in room 108 A was noted to have a rash and was treated with elimite cream on 1/20/15. Three other residents in rooms 109 A, and 112 A and B were treated prophylactically. 200 hall 1/17/15 - residents in room 200 A and 208 B were observed to have rashes. Resident in room 208 B was treated on 1/17/15 and resident in room 200 A was treated on /18/15. The room mates were not treated. The staffing schedule for nursing from January 5 - 9, 2015 was reviewed. NA (nurse aide) #1 was assigned on 500 hall on 1/5/15, 400 and 500 halls on 1/6/15, 400 and 100 halls on 1/7/15 and 200 hall on 1/8/15. NA #2 was assigned on 500 hall on 1/5/15, 100 hall on 1/7/15 and 500 hall on 1/8/15. NA #3 was assigned on 500 hall on 1/5/15, 100 hall on 1/8/15 and 500 hall on 1/9/15. NA #4 was a medication aide and was assigned as a treatment nurse on 1/6/15 and 1/7/15, and as a NA on 100 hall on 1/8/15. Nurse # 1 was	F 441	An Outbreak Line Listing Log for employees and residents was initiated on 1/17/15 and will be maintained by the assistant director of nursing for the current scabies infection. Any trends will be identified and addressed immediately to prevent and control to the extent possible, the spread of scabies to staff and residents. The medical director and/or resident□s physician will be notified immediately for negative findings. Any staff members who are exposed or have direct contact with residents with suspected scabies will be contained to that area. An Infection Control QI monitoring tool was initiated on 2/9/2015 to monitor the Outbreak Line Listing Log. The director of nursing and/or administrator will use the Infection Control QI monitoring tool to audit the Outbreak Line Listing Log twice weekly x 4 weeks, twice monthly x 2 months, then monthly x 3 months. Any negative findings will be addressed immediately by the DON and/or administrator. The ADON will bring results of audits to the monthly QI Committee meeting to identify any trends and continued need for monitoring.	

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F 441	Continued From page 26 assigned on the 200 hall on 1/6/15 and 1/7/15, 500 hall on 1/8/15 and 200 hall on 1/9/15. The in service records were reviewed. The records indicated that 14 nursing staff members on the 500 hall were educated on 1/7/15 regarding scabies and the cleaning of reusable equipments (blood pressure cuffs, thermometers and lifts) with virex (a disinfectant) or alcohol. The rest of the staff members (nursing, housekeeping, dietary, activity, maintenance, administration, laundry, and social services) were educated on 1/15/15. The therapy department staff members were educated on 1/21/15. On 1/20/15 at 10:45 AM, rooms 108, 109, 506, 510, 511, 512 and 516 were observed to have an isolation sign to the doors. Upon interview with administrative staff #1, she indicated that residents in these rooms were on contact isolation due to rashes and had been treated for scabies. On 1/20/15 at 11:33 AM, administrative staff #1 was interviewed. She stated that the facility had one confirmed case of scabies (Resident #78). Resident #78 went to the dermatology clinic on 1/7/15 due to her rashes and was diagnosed with scabies and was treated. She added that she was out of work and when she came back she heard that other residents had developed rashes. The local health department and the medical director were notified. The medical director had at first ordered to treat only residents with rashes with elimite cream and on 1/16/15, he ordered to treat all residents on the 500 hall as a prophylactic measures. Clothing and linens were washed and rooms were deep cleaned including	F 441		

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F 441	Continued From page 27	F 441		

the curtains before and after treatments. Family members and staff were educated regarding scabies. She added that on 1/17/15, two staff members were diagnosed with scabies including NA # 4.

On 1/20/15 at 4:10 PM, NA #1 was interviewed. She stated that she had been in serviced regarding scabies. NA #1 indicated that her normal assignment was on 500 hall but she also had worked on different halls (100 and 200 halls). She also stated that as a nurse's aide, she had always direct contact with all the residents on the hall by answering call lights, delivering trays and assisting with feeding. She added that she was not trained on how to clean the reusable equipments such as blood pressure cuff, thermometers, lifts and belts.

On 1/21/15 at 11:45 AM, NA #5 was interviewed. She stated that on 1/16/15 she was assigned to a resident in room 109 B who had rashes and on 1/17/15 (Saturday) she had spots all over her body and she was itching. She left the facility and went to the doctor and was diagnosed with scabies and was treated with elimite cream. She added that she was not trained on how to clean the reusable equipments such as blood pressure cuff, thermometers, lifts and belts.

On 1/21/15 at 12:27 PM, NA #4 was interviewed. She stated that she worked as a medication aide, treatment nurse or as a nurse's aide. She indicated that as a medication aide, treatment nurse or a nurse's aide, she had a direct contact with the residents on each hall. She added that on 1/16/15, she worked as a medication aide on the 100 hall. On 1/17/15 (Saturday) she started itching and with rashes all over her body. She left

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F 441	Continued From page 28	F 441		

the facility and went to a doctor and was diagnosed with scabies. She added that she was not trained on how to clean the reusable equipments such as blood pressure cuff, thermometers, lifts and belts.

On 1/22/15 at 9:25 AM, NA # 2 was interviewed. She stated that she was assigned and had worked on a different hall (100 hall). She added that as a nurse's aide, she had direct contact with the residents on the hall. NA #2 further indicated that she had received education on scabies but not on how to clean the reusable equipment.

On 1/22/15 at 11:01 AM, administrative staff #1 was interviewed. She indicated that because 500 hall residents were mobile and hard to contain, all residents were treated with elimite cream. She stated that 100 and 200 hall residents were not mobile (bed bound), so only residents with rashes were treated. Administrative staff #1 acknowledged that direct care staff had been assigned on different halls. She stated that staff members were informed to see their doctor when they had symptoms of scabies. Administrative staff #1 indicated that on 1/7/15, education regarding scabies was provided to 500 hall staff members only. On 1/15/15, all staff members were educated and on 1/21/15, all therapy staff members were educated. She added that cleaning the reusable equipments with virex and alcohol was added on the education.

On 1/23/15 at 8:40 AM, administrative staff #2 was interviewed. He stated that he deep cleaned the room and washed all the soiled clothes and linens twice (initial treatment and after 7 days). He also stated that he had to depend on nursing as to when to clean the room and wash the

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F 441	Continued From page 29 clothing. He also stated that he didn't keep a record as to when and what room he had deep cleaned and washed the clothing/linens.	F 441		