STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 04/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews the facility failed to notify the Responsible Party when a resident was sent to	F 157	Colony Ridge Nursing and Rehabilitation Center acknowledges receipt of the Statement of	5/15/15

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

Electronically Signed | 05/11/2015

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F 157	Continued From page 1 the hospital for 1 of 1 (Resident # 1) sampled residents. Findings included: Resident #1 was admitted to the facility on 08/25/13 with cumulative diagnoses of dementia, congestive heart failure (CHF), and Chronic Obstructive Pulmonary Disease (COPD). Review of the Minimum Data Set (MDS) dated 10/01/14 revealed Resident #1 was moderately cognitively aware. Review of the 24 Hour Summary from 10/09/14-10/14/14 did not show any record that Resident #1's Responsible Party (RP) had been notified of a change in condition resulting in hospitalization. Review of the Nursing Health Status Notes dated 10/10/14 at 9:00 PM revealed Resident #1 was having trouble breathing. Resident #1's heart rate became elevated and the oxygen saturation (a level used to determine the percentage of oxygen in the blood stream with 100% being the goal) was 95%. Resident #1 became anxious and the physician came to the facility to assess Resident #1. Resident #1 was then sent to the hospital by the physician. The nurse attempted to contact Resident #1's RP three times but was unable to make contact. Review of the Nursing Health Status Notes after 10/10/14 at 9:00 PM did not show any further attempts to notify the RP that Resident #1 had been sent to the hospital. In a telephone interview on 04/15/15 at 9:55 AM Resident #1's RP stated she was never notified by the facility that her family member had been sent to the hospital. She indicated she found out on 10/12/14 when the hospital called her questioning why no family members had come to the hospital. In an interview on 04/06/15 at 10:55 AM the Director of Nurses (DON) indicated Resident #1's	F 157	Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as written allegation of compliance. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Colony Ridge Nursing and Rehabilitation Center. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings. The family of resident # 1 will continue to be notified of any changes in condition to include being sent to the hospital by the licensed hall nurse. A 100% audit will be conducted by the Director of Nursing (DON), Quality Improvement (QI) Nurse and Treatment Nurse of progress notes, 24 hour reports, physician telephone orders for 4/6/15 through 5/6/15 for all residents, to include residents # 1 to ensure the RP had been notified of any significant change in resident□s condition, to include when resident is sent to the hospital, to be completed by 5/15/15. The Responsible Party (RP) will be notified of any identified	

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F 157	Continued From page 2 RP had not been notified that the facility had sent Resident #1 to the hospital. She indicated the hospital did not try to notify the RP when Resident #1 was admitted to the hospital and that it was a double breakdown. The DON stated the facility nurse did try to call the RP but kept getting a voicemail mailbox and did not leave a message. She indicated it was her expectation that the nurses would keep calling to notify the RP of any change in condition until they actually spoke to someone. In an interview on 04/16/15 at 11:50 AM Nurse #3 indicated when a resident had a change in condition and the nurse was unable to notify the RP it should be passed on to the next nurse. That nurse should keep attempting notification and if unsuccessful it should be passed on again until the RP was spoken to. If the RP was not notified the information should also by placed on the 24 Hour Report. In an interview on 04/16/15 at 12:22 PM Nurse #4 stated if she had been unable to reach a RP regarding a change in condition she would have attempted to call the second contact. If she was unable to speak with someone she would pass that information to the next nurse in shift report. She indicated she would also make sure the information was placed on the 24 Hour Report.	F 157	areas of concern during the audit by the DON, QI Nurse or Treatment Nurse by 5/15/15 with documentation in the medical record. All licensed nurses to include Nurse #3 and Nurse #4 were inserviced by 5/15/15 by the Staff facilitator of the requirements regarding notification of RP of significant change in resident□s condition to include when resident is sent to the hospital and the need for documentation of notification of the RP in the clinical record; If unable to reach the RP, the licensed nurse will indicate this on the 24 hour report and the oncoming licensed nurse will continue to try and contact the RP; nurses will check the 24 hour report when coming on duty for any changes in resident condition and the need to contact responsible party. All newly hired license nurses will be inserviced by the staff facilitator during orientation regarding notification of RP of significant change in resident□s condition to include when resident is sent to the hospital and the need for documentation of notification of the RP in the clinical record; if unable to reach the RP, the licensed nurse will indicate this on the 24 hour report and the oncoming licensed nurse will continue to try and contact the RP; nurses will check the 24 hour report when coming on duty for any changes in resident condition and the need to contact responsible party. When there is a significant change in a resident□s condition to include sending a resident to the hospital, the licensed nurse is responsible for notifying the RP and documenting in the medical records. If	

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F 157	Continued From page 3	F 157	unable to reach the RP, the licensed nurse will indicate this on the 24 hour report and the oncoming licensed nurse will continue to try and contact the RP. The licensed nurses will continue to try and contact the RP until he or she is reached and notified of the resident□s change in condition, to include sending resident to the hospital, with each attempt at notification documented in the clinical record. The DON, QI Nurse, and Treatment Nurse will review progress notes, 24 hour reports, and physician telephone orders for all residents, to include resident #1, Monday-Friday, x 4 weeks then weekly x 4 weeks then monthly x 2 months to ensure notification of the RP for all significant changes in resident□s condition to include sending the resident to the hospital utilizing a RP notification QI Audit Tool. The DON, Treatment Nurse, and QI Nurse will immediately notify the RP for any identified areas of concern, document notification in the clinical record and provide retraining with the licensed nurse on an inservice sheet. The Administrator or DON will review and initial the RP notification QI Audit Tool weekly x 8 weeks then monthly x 2 months for completion and to ensure all areas of concern were addressed and documented in the medical records and retraining provided with the responsible staff member. The DON will compile results from the RP notification QI Audit Tools and present to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further	

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F 157	Continued From page 4	F 157	action and/or change in frequency of required monitoring.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		5/15/15

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F 225	Continued From page 5 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to fully investigate an allegation of abuse prior to submitting a report that the allegation had been unsubstantiated for 1 of 1 sampled residents (Resident #2). Findings included: Resident #2 was admitted to the facility on 06/28/14 with cumulative diagnoses of chronic pain, insomnia and stomach problems. Resident #2's Quarterly Minimum Data Set (MDS) dated 03/31/15 indicated Resident #2 was cognitively aware. Resident #2 was able to move around the facility with the use of a wheelchair. Review of the facility Grievance Log for 03/31/15 showed a concern had been raised regarding alleged sexual abuse by Resident #2. Review of the facility investigation into the alleged abuse revealed that a 24 hour report and a 5 working day report were completed. A police report was filed with the Nags Head Police Department by the facility. Review of the 5 working day investigation dated 04/08/15 showed the allegation of abuse had been unsubstantiated by the facility. Interviews with Resident #2 and a statement from the perpetrator were included in the investigation. Review of the Physician Telephone Orders dated 04/09/15 showed Resident #2 was sent to the hospital for confusion and an altered mental status. Review of the interviews from alert and oriented residents in regards to the allegation of abuse revealed they had not been done until 04/13/15.	F 225	Resident # 2 is no longer a resident of the facility. A 100% audit was conducted by the facility consultant on 5/7/15 for all allegations of abuse, neglect, or misappropriation of resident property from 3/31/15 thru 5/7/15 to ensure all allegation of abuse, neglect, or misappropriation of property, had been fully investigated prior to submitting a report to the Health Care Registry that the allegation had been substantiated and unsubstantiated. No further allegations of abuse, misappropriation of property, or neglect have been reported since 3/31/15. An inservice was conducted with the Administrator, DON, Quality Improvement (QI) Nurse, Staff Facilitator, Minimum Data Set (MDS) Coordinator, Activities Director, Social Worker, and Dietary Manager on 5/ 15 /15 by the facility consultant regarding the procedure for fully investigating allegations of abuse, misappropriation of property, or neglect per policy prior to submitting a report to the Health Care Registry that the allegation is substantiated or unsubstantiated. All newly hired department heads will be inserviced by the staff facilitator during orientation regarding the procedure for fully investigating allegations of abuse, misappropriation of property, or neglect,	

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F 225	Continued From page 6 Although the alleged abuse had not been witnessed, interviews with alert and oriented residents may have uncovered concerns these residents had regarding this person in authority at that time. In an interview on 04/15/15 at 12:00 PM the Interim Administrator confirmed that interviews with alert and oriented residents were not done until 04/13/15 and that would be the true date of the completion of the investigation.	F 225	per policy, prior to submitting a report that the allegation is substantiated or unsubstantiated. When a resident, family, or staff member report an allegation of resident abuse, misappropriation of property, or neglect the facility abuse protocol will be immediately initiated to include ensuring safety of the resident, immediate assessment of resident for injuries; the person accused of the resident abuse will immediately be removed from the resident care area, be asked to provide a statement regarding the incident, and be drug tested and suspended pending an investigation of the allegation; the accused party will then be escorted by a facility staff member from the facility and will be allowed to return only upon full completion of the investigation per policy and only if it is determined that the allegation was unsubstantiated; the administrator or DON will then conduct an investigation to include interviewing the identified resident, resident family members, other staff members, and other alert and oriented residents to determine if they were aware or had experienced any episodes of resident abuse; If the investigation shows no evidence that the alleged abuse, misappropriation of property, or neglect occurred the accused party will be allowed to return to the facility; a report that the allegation was either substantiated or unsubstantiated will be submitted to the appropriate agencies, to include the Health Care Registry, within 5 days of the incident as	

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F 225	Continued From page 7	F 225	required by law, but not until a full investigation has been conducted per policy. The Regional Vice President (RVP) or Facility Consultant will be notified of all abuse allegations by the administrator. The RVP or Facility consultant will review all investigations of resident abuse, neglect or misappropriation of property to ensure a full investigation was completed per policy to include interviewing the identified resident, resident family members, other staff members, and other alert and oriented residents prior to submitting the report to the Health Care Registry that the allegation was substantiated or unsubstantiated weekly x 8 weeks then monthly x 2 months to ensure all allegations of abuse, neglect or misappropriation of property have been fully investigated per policy using a QI Abuse Investigation Audit Tool.The Administrator will compile the results of the QI Abuse Investigation Audit Tool and report to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		5/15/15

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F 226	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement their policy in the areas of investigation and protection for 1 of 1 sampled residents (Resident #2) when an allegation of abuse was reported to the facility. Findings included: A review of the facility Abuse, Neglect, Or Misappropriation of Resident Property Policy revised 05/01/13 showed under Investigation, "Allegations of abuse, neglect, or misappropriation of resident property and injuries of unknown origin will be investigated by the facility. The Administrator is responsible to direct the investigation process and to ensure that appropriate agencies are notified, as indicated." Under Protection, the policy showed, "Employees accused of being directly involved in allegations of abuse, neglect, or misappropriation of property will be suspended immediately from duty pending the outcome of the investigation." Resident #2 was admitted to the facility on 06/28/14 with cumulative diagnoses of chronic pain, insomnia and stomach problems. Resident #2's Quarterly Minimum Data Set (MDS) dated 03/31/15 indicated Resident #2 was cognitively aware. Resident #2 was able to move around the facility with the use of a wheelchair. Review of the facility Grievance Log for 03/31/15 showed a concern had been raised regarding alleged sexual abuse from a person in authority by Resident #2. Review of the facility investigation into the alleged abuse revealed that a 24 hour report and a 5 working day report were completed. The incident was reported to the Nags Head Police Department on 04/01/15 and was investigated as a sexual battery case. No charges were filed.	F 226	Resident # 2 is no longer a resident of the facility. A 100% audit was conducted by the facility consultant on 5/7/15 for all allegations of abuse, neglect, or misappropriation of resident property from 3/31/15 thru 5/7/15 to ensure all allegation of abuse, neglect, or misappropriation of property, had been fully investigated prior to submitting a report to the Health Care Registry that the allegation had been substantiated and unsubstantiated. No further allegations of abuse, misappropriation of property, or neglect have been reported since 3/31/15. An inservice was conducted with the Administrator, DON, Quality Improvement (QI) Nurse, Staff Facilitator, Minimum Data Set (MDS) Coordinator, Activities Director, Social Worker, and Dietary Manager on 5/ 15 /15 by the facility consultant regarding the procedure for fully investigating allegations of abuse, misappropriation of property, or neglect per policy prior to submitting a report to the Health Care Registry that the allegation is substantiated or unsubstantiated. All newly hired department heads will be inserviced by the staff facilitator during orientation regarding the procedure for fully investigating allegations of abuse, misappropriation of property, or neglect, per policy, prior to submitting a report that the allegation is substantiated or unsubstantiated.	

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F 226	Continued From page 9 Review of the 5 working day investigation dated 04/08/15 showed the allegation of abuse had been unsubstantiated by the facility. Review of the Physician Telephone Orders dated 04/09/15 showed Resident #2 was sent to the hospital due to confusion and an altered mental status. Review of the interviews from alert and oriented residents in regards to the allegation of abuse revealed they had not been done until 04/13/15. Although the alleged abuse had not been witnessed, interviews with alert and oriented residents may have uncovered concerns these residents had regarding this person in authority at that time. In an interview on 04/15/15 at 12:00 PM the Interim Administrator confirmed that interviews with alert and oriented residents were not done until 04/13/15 and that would be the true date of the completion of the investigation. She indicated the accused was in the facility on 04/07/15 working with other residents while the resident who had made the accusation was in the facility. The interim Administrator indicated the accused was never left alone with any resident. She stated every resident could have been affected by this allegation as the accused had access to every resident. She stated she saw it as a problem that the facility policy was not followed and that the alleged perpetrator was allowed back into the building prior to the completion of the investigation.	F 226	When a resident, family, or staff member report an allegation of resident abuse, misappropriation of property, or neglect the facility abuse protocol will be immediately initiated to include ensuring safety of the resident, immediate assessment of resident for injuries; the person accused of the resident abuse will immediately be removed from the resident care area, be asked to provide a statement regarding the incident, and be drug tested and suspended pending an investigation of the allegation; the accused party will then be escorted by a facility staff member from the facility and will be allowed to return only upon full completion of the investigation per policy and only if it is determined that the allegation was unsubstantiated; the administrator or DON will then conduct an investigation to include interviewing the identified resident, resident family members, other staff members, and other alert and oriented residents to determine if they were aware or had experienced any episodes of resident abuse; If the investigation shows no evidence that the alleged abuse, misappropriation of property, or neglect occurred the accused party will be allowed to return to the facility; a report that the allegation was either substantiated or unsubstantiated will be submitted to the appropriate agencies, to include the Health Care Registry, within 5 days of the incident as required by law, but not until a full investigation has been conducted per policy. The Regional Vice President (RVP) or Facility Consultant will be notified of all	

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F 226	Continued From page 10	F 226	abuse allegations by the administrator. The RVP or Facility consultant will review all investigations of resident abuse, neglect or misappropriation of property to ensure a full investigation was completed per policy to include interviewing the identified resident, resident family members, other staff members, and other alert and oriented residents prior to submitting the report to the Health Care Registry that the allegation was substantiated or unsubstantiated weekly x 8 weeks then monthly x 2 months to ensure all allegations of abuse, neglect or misappropriation of property have been fully investigated per policy using a QI Abuse Investigation Audit Tool. The Administrator will compile the results of the QI Abuse Investigation Audit Tool and report to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide housekeeping and maintenance services to	F 253	A crew from the Support Services division of the company□s home office has been dispatched to the facility to reframe and	5/15/15

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F 253	Continued From page 11 maintain a sanitary and orderly environment of 48 resident rooms observed (rooms 101, 109, 104 & 307A) and 2 emergency exit doors of 2 of 3 hallways observed (hallway 300 and hallway 100). Findings included: On 04/14/15 from 9:30am until 10:30am, observations of the 300 hall revealed: a.) The emergency exit door, surrounding support wall and threshold exhibited wall paper and plaster board missing from the left (L) side of the threshold, lose door frame molding, peeling wallpaper at both sides of threshold, a partially detached handrail from wall frame at right (R) side, missing floor tiles at threshold which exposed a cement foundation and a ½ inch gap showed visible natural light shining through. b.) Peeling, dirty wallpaper outside room 304, the wall next to room 315's door and to the (R) of room 309's door. c.) In room 307A, the resident's bed was parallel to wallpaper covered wall. The wall had a large plaster patch ½ the size of the bed. The plaster patch had a 1 inch wide by ¼ inch depth hole in it and was in the resident ' s direct eye level view. Broken cracked plaster was inside the hole. The wallpaper from bed level to above the over bed wall light was caked heavily with sticky stains, layered with dust in a splattered pattern disbursement. d.) In room 307A, the call light wall box was missing a screw and was partially dismantled from the wall. On 04/14/15 from 10:30am until 11:00 am, observations of the 400 hall revealed: a.) The emergency exit door had floor tile missing to the (L) side of door, the threshold	F 253	reinstall the door near the nursing station corridor. This includes replacing plaster board and repairing wall paper on 300 Hall where necessary by 5/15/15. In addition, floor tile will be replaced by the Maintenance Manager covering the underlying cement at the emergency exit on 400 Hall by 5/15/15. Finally all handrails were assessed and reinforced by the Maintenance Manager and Maintenance Assistant in connection with repairs implemented pursuant to the plan of correction for F Tag 468 on 4/15/15. The Maintenance Director and Assistant Maintenance Director will re-wallpaper and/or paint the cited areas on 300 Hall to include areas noted outside rooms 304, 315, and 309 and room 307 by 5/15/15. The Maintenance Director and Assistant Maintenance Director will re-plaster the noted section of the wall to include covering the noted hole in the plaster by 5/15/15. Further, the Maintenance Director and Assistant Maintenance Director will re-wallpaper and/or paint as necessary to cover the re-plastered section in room 307 and the wall above the bed will be thoroughly cleaned and painted as needed to remove the patterned stain by 5/15/15. Finally, the call light wall box will be secured to the wall in room 307 by 5/15/15. The Maintenance Director and Assistant Maintenance Director will reframe the emergency exit to include replacement of the rusted out portions of the base of the door at exit near nurses station corridor and the threshold will be repaired and replaced as necessary to level out the	

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	345226	A. BUILDING _____ B. WING _____	C 04/17/2015

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F 253	Continued From page 12 transition was 2 levels and an opening with visible outdoor natural light was shining through. b.) The double door emergency exit near the nursing station corridor on the front of the facility revealed the door frame base rusted out with holes to outside and visible natural light shining through, small pest control traps were on each side. The exit door view revealed a bedside commode standing outside. On 04/14/15 from 11:00 am - 11:30am, observations of the 100 hall revealed: a.) Room 101 & 109 closet doors were uneven and did not fully close. b.) Room 104 baseboard under closet was peeling away from wall, and closet doors were uneven and did not fully close. On 04/14/15 at 11:35am, an interview with housekeeper (HK) #1 and at 11:40 am an interview with HK #2 indicated that responsibilities for cleaning resident rooms included spot cleaning walls, reporting resident room needs including identifying areas for deep cleaning and reporting housekeeping concerns to the HM. On 04/14/15 at 03:00pm, an interview with the Interim Administrator indicated that the corporation had contracted workmen at the facility doing repairs for the last 3 weeks but had been sent home the day before due to issues with the city giving the corporation an eviction notice. On 04/14/15 at 3:30pm, an interview with Nursing Assistant (NA) #2 whom had exited room 307A indicated that he had not noticed the stains on the wall or the hole in the large plaster patch, he indicated that his responsibility included reporting the observation to housekeeping and	F 253	threshold by 5/15/15. The bedside commode was removed from outside of the door on 4/15/15. The Maintenance Director and Assistant Maintenance Director will reattach the closet doors in rooms 101 and 109 so that they are even and will fully close and the baseboard under the closet in room 104 will be replaced and the closet doors reattached so that they are even and will fully close by 5/15/15. The Regional Vice President, Administrator, Maintenance Director, Housekeeping Director and Assistant Maintenance Director conducted a walk-through of the entire facility on May 7, 2015. Special notice was paid to areas of the facility that might require painting, wallpaper or deep cleaning. Further, the walk-through assessed all exit doors for any needed repair. Finally, the walk-through assessed all resident closet doors for any needed leveling or repair. No further problems were identified with closet doors. Finally, it should be noted that the facility acquired a building permit on April 2, 2015 pursuant to which it was granted authority to engage in a significant scope of work as part of its lease obligations with the Town of Nags Head. This scope of work is designed to greatly enhance the physical plant of the building including items identified in the SOD, and enhance the resident experience in the facility. The enhancements will be undertaken in accordance with the construction	

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F 253	Continued From page 13 maintenance. On 04/14/15 at 3:45pm, an interview with the Housekeeping Manager (HM) indicated walls were spot cleaned daily and included in deep cleaning once per month. The daily expectation for HK ' s were to report any areas that needed deeper cleaning, resident room concerns and facility concerns. The HM indicated that she would investigate concerns, assign housekeeping needs and report repair needs to maintenance. The HM revealed that she conducted daily tours of the facility that included resident rooms, hallways, lobbies, and all other areas of the facility. She indicated that within one week she observed each room in the facility at least once. The HM indicated she was unaware of room 307A having caked residue on the wall. On 04/14/15 at 4:00pm, the HM's observation of room 307A indicated a need for housekeeping services to deep clean the residents wall. The HM indicated that she would assign the task to an HK for 04/15/15 completion. On 04/14/15 at 4:15pm, Review of the facility HK training materials titled "7 Step Cleaning Method, Job Breakdown" included "Job: Step #6, " Spot Clean Walls and/or Partitions" daily. On 04/14/15 at 4:30pm, a walk-through observation and interview with the Maintenance Manager (MM) indicated: a.) The MM was responsible for a daily walk-through of the facility, and recorded observations on a "General Facility Daily Check List" (GFDCL). b.) The MM indicated that all staff were responsible to report areas of needed repairs, malfunction of equipment and viewable concerns	F 253	schedule by the facility or any other subsequent operator of the facility as required by the lease agreement. An in-service will be conducted by the Administrator by 5/15/15 with the Maintenance Manager and the Maintenance Assistant regarding the need to conduct a daily walk-through of the facility to ensure that all of the facility□s maintenance needs are being met. Specifically, the in-service addressed the appropriate and proper use of the General Facility Daily Check List tool as well as the use and prioritization of work orders. The Administrator will review the General Facility Daily Check List (GFDCL) daily for a period of four weeks to insure that the maintenance needs of the facility are being met using a Quality Improvement Maintenance Audit Tool. After this period, the Administrator will review the GFDCL every other day for four weeks and then weekly x 8 weeks to insure compliance. The Administrator will compile the results of the Quality Improvement Maintenance Audit Tool and present to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	

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F 253	Continued From page 14 via a work order kept at the nurse ' s stations. c.) The MM indicated he reviewed and prioritized work orders daily. d.) The MM revealed the door at the end of the 300 hallway had been replaced approximately 2 years ago which left the door frame/ threshold in need of floor tiles, and reconstruction. e.) The MM revealed that he had made a verbal request to corporate owners 2 years ago for completion of the surrounding door frame after installation of the new door; the request was denied. f.) The MM viewed the wall in room 307 and revealed that the wall had become damaged by the bed rails when the bed was raised and lowered related to lack of bed bumpers on the wall. g.) The MM revealed that repairs included plaster patching to the wall and painting the plaster with light pink to match the other side of the room since the wallpaper was no longer available. h.) The MM indicated the call light box can become dismantled related to staff securing the call bell to the bed and raising the bed which pulls on the call bell cord and subsequently the call bell secured wall plate resulting in disengaging the wall plate. He did not have a work order for this room. i.) The MM indicated that the corporate owner did not approve repairs to door frames, thresholds, exterior repairs, furniture and wallpaper. j.) The MM indicated that the 200 Hall had been closed and corporate had begun contracted work on the 200 hall approximately a month or two ago but no one had been working in the building over the last three weeks. The MM indicated that if corporate sent anyone he would be notified and	F 253		

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F 253	Continued From page 15 know what work was going to be started. k.) The MM indicated that he understood the contracted work had stopped related to an issue with the city giving the corporation an eviction notice. Review of the GFDCL dated 10/2/14, 10/14/14, 12/16/14, and 12/25/14 showed building interior, corridors, exit doors, and resident rooms as "OK" . All areas read "OK" with no abnormalities or actions taken. The CFDCL's were just prior to and after Environmental Health Inspections dated 10/06/14 & 12/19/14.	F 253		
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	F 441		5/15/15

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F 441	Continued From page 16 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens 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 post an isolation sign outside a resident's door for 1 of 1 sampled residents observed for isolation precautions (Resident #4). Findings included: A review of the Issues in Infection Control for Nursing Homes provided by the Statewide Program for Infection Control and Epidemiology (SPICE) revealed that isolation signs must be posted on the door to the resident's room. The SPICE program has been considered a standard by the Centers for Disease Control (CDC) as a tool for communicating the procedures that healthcare workers, family and visitors should follow to prevent cross transmission. Review of the Physician Telephone Orders dated 04/03/15 showed Resident #4 was on Contact Isolation Precautions for Methicillin Resistant Staph Aureus (MRSA) in a lower leg wound. Resident #4 was started on an antibiotic to be given twice each day for 10 days. An observation on 04/14/15 at 11:30 AM showed	F 441	A Contact Precaution sign for isolation precautions was posted on the door to the room of resident # 4 on 4/15/15 by the licensed nurse assigned to 100 Hall. A 100% audit was conducted by the Director of Nursing (DON) on 4/15/15 to ensure any other resident in the facility who was currently on isolation precautions had an isolation precautions sign posted outside the resident□s door indicating the type of isolation precautions in use. No other concerns were identified. An inservice for 100% of staff to include Nurse #1, Nurse# 2, was initiated by the staff facilitator regarding the need to post an isolation sign to the door to the room of any resident who requires isolation precautions per facility infection control policy. All unlicensed staff to include Nursing Assistant # 1, and the Maintenance Director were inserviced by the staff facilitator regarding notification of	

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F 441	Continued From page 17 an over the door rack containing Personal Protective Equipment (PPE) including gloves, gowns and masks. There was no isolation sign posted on the door of the room. An observation on 04/14/15 at 2:19 PM showed the over the door rack with the PPE was still in place on Resident #4's door. No isolation sign was seen. In an interview on 04/14/15 at 2:20 PM Nurse #1 confirmed that Resident #4 was on Contact Isolation Precautions. An observation on 04/14/15 at 4:05 PM showed the PPE was still in place on Resident #4's door. No isolation sign was seen. In an interview on 04/14/15 at 6:40 PM the Maintenance Director stated he would know someone was on isolation because a sign would be posted on the door. He indicated the sign would tell him which PPE he needed to use if he entered an isolation room. In an interview on 04/14/15 at 6:40 PM Nurse #2 indicated Resident #4 was on Contact Isolation Precautions for MRSA. In an observation on 04/14/15 at 6:45 PM Nursing Assistant #1 was seen donning a gown to enter Resident #4's room. In an interview on 04/14/15 at 6:45 PM Nursing Assistant #1 indicated she was aware of what precautions were needed. She stated others would know what precautions were needed because the sign posted on the door listed them. NA #1 looked for the sign on the door and stated it was not in place on the door. She indicated that visitors may not know Resident #4 was on isolation and would not be protected if they entered the room. In an interview on 04/16/15 at 11:00 AM the Director of Nursing stated the isolation sign on Resident #4's door was posted on 04/13/15. She	F 441	the licensed nurse if an isolation precaution sign is not present outside the door for a resident on isolation precautions prior to entering the room. The inservices will be completed by 5/15/15. All new licensed nursing staff will be inserviced by the staff facilitator during orientation regarding the need to post an isolation sign on the door to the room of any resident requiring isolation precautions per facility infection control policy. All newly hired unlicensed staff will be inserviced by the staff facilitator during orientation regarding the need to notify the licensed nurse if an isolation precaution sign is not present outside the door for a resident on isolation precautions prior to entering the room. When culture reports, including wound culture reports, return with a positive finding, to include MRSA, and require the implementation of isolation precautions to prevent the spread of infection the licensed nurse receiving the report will immediately implement the appropriate isolation precautions, to include Contact Precautions, per the facility Infection Control Manual. The appropriate isolation precaution sign, to include Contact Precautions, will be posted on the door to the resident□s room for communicating procedures by the licensed nurse for healthcare workers, family, and visitors to follow to prevent cross transmission. If an isolation precaution sign is not present on the door, staff will check with the licensed nurse assigned to the resident, prior to entering the room, for instructions. The Licensed nurse will then ensure that the	

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F 441	Continued From page 18 did not know what had happened to the isolation sign but verified Resident #4 was on isolation. She indicated it was her expectation that when a resident was on isolation a sign showing what precautions were needed would be placed on the door. This sign would let the staff and the public know what precautions were needed.	F 441	appropriate sign is posted. The MDS Nurse will review all culture reports daily Mon-Fri x 4 weeks, then weekly x 4 weeks then monthly x 2 months using a Quality Improvement (QI) Isolation Precautions Audit Tool to ensure appropriate isolation precaution signs were placed on the door to the room of a resident as required by the facility Infection Control Policy Manual. The Director of Nursing will review and initial the QI Isolation Precaution Audit Tool weekly x 8 weeks then monthly x 2 months to ensure compliance and completeness of audit tool. The QI Nurse will compile the results of the QI Isolation Precautions Audit Tool and present to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to provide secured handrails in 2 out of 3 hallways observed. (300 Hall and 100 hall) Findings included: On 04/14/15 from 9:30am until 10:30 am, observations of the 300 hall revealed the right side of the emergency exit door adjacent to room	F 468	The handrail adjacent to room 315 and handrail adjoining the 100 Hallway and the corridor to the nurses station were firmly secured to the wall by the Maintenance Manager and Maintenance Assistant on 4/15/15. A walkthrough of the facility was conducted by the Administrator on 5/7/15	5/15/15

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F 468	Continued From page 19 315 had a partially detached handrail. On 04/14/15 from 11:00 am - 11:30am, observations of the 100 hall revealed a handrail adjoining the 100 hallway and corridor to the nurses ' station was detached at one end and unstable. On 04/14/15 at 03:00pm, an interview with the Interim Administrator (IA) indicated that the Maintenance Manager (MM) and Maintenance Assistant (MA) were responsible for daily walk-through of the facility to identify needed repairs. The IA indicated all staff were responsible to report areas of needed repairs, malfunction of equipment and viewable concerns via work orders kept at the nursing stations. The IA indicated that she was unaware of any unstable handrail concerns. On 04/14/15 at 4:30pm, a walk-through observation and interview with the Maintenance Manager (MM) indicated he checked handrails for stability on a daily basis and was not aware of loose hand railing at the 300 hall emergency exit door or 100 hall corridor. The MM indicated he would repair the handrails immediately. The MM indicated that he had not received a work order for handrail concerns and had not discovered unstable handrail concerns on his daily walk through.	F 468	to ensure all handrails were properly secured to the wall. No loose handrails were noted at this time. An inservice was conducted by the Administrator on 5/12/15 with the Maintenance Manager and the Maintenance Assistant regarding the need to conduct a daily walk-through of the facility to ensure all handrails are secured. An inservice to 100% of all staff, to include the Maintenance Manager and Maintenance Assistant, will be initiated by the staff facilitator regarding the need to report any loose handrails to the maintenance department and procedure for completing a work order (a form to notify maintenance of broken/defective equipment). Inservice to be completed by 5/15/15. The Maintenance Assistant will conduct a daily walk-through of the facility to ensure all handrails remain secured. Any handrails determined to be loose will be immediately secured by the Maintenance Manager or Maintenance Assistant. When facility staff identify that a handrail is loose they will complete a work order and notify the Maintenance Manager or Maintenance Assistant of the loose handrail. The Maintenance Manager will check all handrails within the facility daily x 4 weeks then every 2 weeks x 4 weeks then monthly x 2 months to ensure that handrails are being monitored and remain secured using a QI Handrail Audit Tool. The administrator will review the QI Handrail Audit Tool weekly x 4 weeks then every 2 weeks x 4 weeks then monthly x 2 months to ensure completeness and	

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F 468	Continued From page 20	F 468	compliance. The Maintenance Manager will compile the results of the QI Handrail Audit Tool and present to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	