DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING ______ B. WING ______	08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING & REHABILITATION-HENDERSON	**280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		9/24/15

483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on observations and staff and resident interviews the facility failed to wait, after knocking, to receive permission to enter resident rooms to maintain dignity for 4 of 36 residents (Residents #61, 34, 20, and 57) reviewed for dignity.

Findings included:

1.The Minimum Data Set (MDS) dated 6/2/15 indicated Resident #61 was cognitively intact, had adequate hearing and clear speech, made herself understood and understood others.

During an interview with Resident #61 on 8/25/2015 at 11:05 am, Nurse aide (NA) #1 knocked on Resident #61's door and walked into the room without waiting for a response from the resident and stated, "I need to find a lift pad." While NA #1 was in the room, two additional nurse aides, who were talking to each other, walked into the resident's room without knocking or requesting permission to enter the room. Once in the room, one of the nurse aides paused and asked the resident how she was doing.

During an interview on 8/27/15 at 3:30 pm with the Administrator regarding her expectations of staff entering resident rooms she stated, "Our staff is good about knocking on the door, but they

This plan of correction is the center's credible allegation of compliance.
Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.
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It is the practice of this provider to promote care for residents in a manner and in an environment that maintains or enhances each resident¿s dignity and respect in full recognition of his or her individuality.
No adverse effects were noted as a result of this deficient practice. All residents have the potential to be affected.

1.ED/DNS interviewed residents # 34, 57 and 61. (there was no resident #20 listed on resident sample). These residents did not report a loss of dignity or respect. No adverse reaction reported by resident from staff failing to knock. C.N.A staff and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/17/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 can't wait for the resident to say come in because the resident may not be able to answer. Staff should stop before they enter the room and not just walk in if the resident is able to respond." The administrator indicated that staff is trained on and is aware of the expectation to knock on resident doors prior to entering the resident room. During an interview on 8/27/15 at 3:30 pm with the Director of Nursing (DON) she stated, "As long as it is someone who can ' t respond it is ok to go on in." She indicated if the resident is able to respond that staff should wait to enter the resident's room. 2.The MDS dated 7/14/15 indicated Resident #34 was cognitively intact, had clear speech, made himself understood and understood others. During an observation on 8/26/15 at 1:46 pm, NA#2 knocked on Resident #34's door but did not request permission to enter the room. She walked into the room and stated her intent was to provide care to Resident #34. She exited the room at 1:48 pm and re-entered the room a few minutes later, opening the closed door and entering without knocking, without requesting permission from the resident, or announcing herself. During an interview on 8/27/15 at 3:30 pm with the Administrator regarding her expectations of staff entering resident rooms she stated, "Our staff is good about knocking on the door, but they can't wait for the resident to say come in because the resident may not be able to answer. Staff should stop before they enter the room and not just walk in if the resident is able to respond."	F 241	all staff on duty on 8/27/15 upon identification of failure to knock were in-serviced on expectations for entering a resident¿s room. (knock, receive permission to enter room, as indicated and announce self) 2.Other residents throughout the facility were randomly interviewed. Residents report that staff knocks on their doors and waits for a response prior to entering their rooms. 3.In-servicing began immediately on 8/27/15 on expectations of entering a resident¿s room. In-servicing to be completed by 9/18/2015. Ongoing observations and random resident interviews ongoing. We will also assess knocking during resident council meetings for improvement, or ongoing education needs of staff. 4.Audits for entering a residents room(knocking, receiving permission to enter and announcing self) will be conducted daily for 4 weeks, then twice weekly for 2 weeks, then weekly for 2 months and then randomly thereafter. All findings will then be reported to the facility¿s QA committee for review and further recommendations. If any findings are out of compliance, then additional monitoring and an additional action plan will continue as determined by the committee. 09/24/2015	

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F 241	Continued From page 2 The administrator indicated that staff is trained on and is aware of the expectation to knock on resident doors prior to entering the resident room. During an interview on 8/27/15 at 3:30 pm with the DON she stated, "As long as it is someone who can't respond it is ok to go on in." She indicated if the resident is able to respond that staff should wait to enter the resident's room. 3.The MDS dated 6/23/15 indicated Resident #20 was cognitively intact, had clear speech, made himself understood and understood others. During an observation on 8/26/15 at 1:56 pm, NA #2 knocked on Resident #20's door as she walked into his room. NA #2 did not request permission to enter the room or wait for a response from the resident. Once in the room at the bedside she asked the resident, "You ready?" to which he nodded his head. NA #2 walked out of room and re-entered Resident #20's room about a minute later, knocking on the door, but not requesting entrance or waiting for a response from the resident. During an interview on 8/27/15 at 3:30 pm with the Administrator regarding her expectations of staff entering resident rooms she stated, "Our staff is good about knocking on the door, but they can't wait for the resident to say come in because the resident may not be able to answer. Staff should stop before they enter the room and not just walk in if the resident is able to respond." The administrator indicated that staff is trained on and is aware of the expectation to knock on resident doors prior to entering the resident room. During an interview on 8/27/15 at 3:30 pm with the DON she stated, "As long as it is someone who can't respond it is ok to go on in." She	F 241		

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F 241	Continued From page 3 indicated if the resident is able to respond that staff should wait to enter the resident's room. 4. A received of Annual Minimum Date Set (MDS) dated 6/23/2015 indicated that Resident# 57 was moderately cognitively impaired. Resident #57 was totally dependent on staff for all her Activities of Daily Living need except for feeding, she was able to feed herself with set up help only. Resident #57 had clear speech, made herself understood and understood others. A review of Resident #57' s care plan revealed that Resident # 57 received assistance needed in Activities of daily Living from staff. Resident #57 was totally dependent on staff for toileting. Resident #57 required total staff participation with a mechanical lift for transfers. Resident #57 required staff participation to reposition and turn in bed. During an interview on 8/25/2015 at 9:59 am with Resident # 57, NA #1 knocked on Resident # 57 door and walked into the room without waiting for a response. Once in the room NA # 1 asked Resident # 57 if she wanted to go to Church and got Resident #57 breakfast tray and left the room. Interview with the Resident # 57 on 8/26/2015 at 2pm revealed that she had no problem with NA #1 entering her room before giving her permission to come in. Resident # 57 stated " the girls always knock." Resident# 57 indicated that NA # 1 was a "nice girl and would do anything for her.	F 241		

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F 241	Continued From page 4 During an interview on 8/27/2015 at 3:30pm with the Administrator regarding her expectation of staff entering resident rooms she stated " Our staff is good about knocking on the door, but they can ' t wait for the resident to say come in because the resident may not be able to answer. Staff should stop before they enter the room and not just walk in if the resident is able to respond. " The administrator indicated that staff is trained on and is aware of the expectation to knock on resident door prior to entering the resident room. During an interview on 8/27/2015 at 3:30pm with the DON she stated, " As long as it is someone who can ' t respond it is ok to go on in. " She indicated if the resident is able to respond that staff should wait to enter the resident ' s room	F 241		
F 253 SS=E	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, interviews with staff, and record review the facility failed to provide a maintained, safe, and comfortable interior on 3 of 4 resident halls (the rehab hall - rooms 107-122, the main hall - rooms 123-136, and the back hall - rooms 137-151). Findings included: Upon entrance to the facility on 8/24/15 and throughout the survey until 8/27/15 at 9:00 am, the following areas were observed to be in need of maintenance:	F 253	This plan of Correction is the center¿s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal	9/24/15

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F 253	Continued From page 5 Resident bathrooms in the main hall with scuffed, rough door with paint missing down to the wood frame. The side of the door frame was pulling away from the frame approximately 3 inches (in.) from the floor. There was missing cove board and the remaining cove board at the corner of the wall was peeling off at the top edge, resulting in the edges pointing out toward the main hallway in a " v " format. Room 110 ' s vinyl edging of the door frame was pulled away from the frame. Room 111 ' s hinged side and door knob side of the resident ' s door was visibly chipped and rough to the touch. Room 112 ' s vinyl edging of the door frame was pulled away from the frame and both sides of the door edges were rough. Room 115 ' s vinyl edging of the door frame was pulled away from the frame. Room 118 ' s vinyl edging of the door frame was pulled away from the frame. Room 120 ' s vinyl edging of the door frame was pulled away from the frame and the resident ' s door edging was chipped and rough to the touch. Room 123 ' s bottom edging of the door frame was pulled away from the wall up to approximately 12 in. from the floor on both sides of the door frame. The hinged side of the door had chipped, rough wood-exposed edging up to 3 feet (ft.) from floor. Room 124 had paint peeling off the closet doors, wood was chipped off of the door to the resident room from the floor up to the door handle on both the door knob side and hinged side. The hinged side edge was rough to the touch as the wood had been painted over with white paint, but remained rough to the touch with a chipped appearance. Room 127 ' s outer laminate covering of the door,	F 253	and state law. F253 1. a. Doors for bathroom in main hall and for resident rooms#: 110, 111, 112, 115, 118, 120, 123, 124, 127, 128, 129, 131, 132, 134, 137, 139, 140, 142, 143: to be repaired. Outside contractor has provided quotes for repairs. Outside contractor to begin repairs as soon as possible. All remaining identified doors to be repaired by outside contractor once all supplies available. b. Vinyl edging/door guards for 110, 112, 115, 118, 120, 139, 143 : Outside contractor has provided quotes and will repair identified door guards. c. Closet doors for painting and repair for rooms 124, 128, 129, 131, 132, 134 to be completed by 9/24/15. d. Cove base near bathrooms, room 131, 132 to be completed by 9.24.15. e. Room 132: behind head of bed to be repaired by 9/24/15. 2. All of the resident¿s room¿ door surfaces, vinyl edging, closet door, cove base and behind head of beds have been inspected. Outside contractor has further inspected and has provided quotes to replace all door guards/vinyl edging for resident rooms and bathrooms. Doors to be replaced as deemed necessary. Work will begin when all materials available. Cove base replacement began during survey and will continue until all replacements completed by Maintenance per maintenance schedule. Closet doors to be	

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F 253	Continued From page 6 on the hinged side, was torn off from floor in a 5 ft. x 1 in. section. The bottom edging of the door frame was pulled away from the wall up to about 12 in. from the floor, on both sides of door frame. Room 128 ' s corner floor board, at the door entrance, was pulled away from the wall on 2 sides. Wood was chipped off the door up to the door handle on the door knob side. Paint was peeled off various areas of the closet door and covered approximately a 1 ft. x 2 ft. area. Room 129 had wood that was visibly chipped off of the door to the resident room from the floor up to the door handle on both the door knob side and hinged side. Paint was peeled off of the closet in approximately a 2.5 ft. x 2 ft. area. Room 131 had paint peeled off of the closet doors and wood chipped off of the resident room door up to the door handle on the door knob side of the door. The bottom edging of the door frame was pulled away from the wall up to approximately 12 in. from the floor on both sides of door frame. The cove board was peeling away from the wall and was pointing out toward the main hallway in a " v " format. Room 132 had paint peeled off of the closet door from the handle to the floor. The closet door did not fit straight on the frame of the closet and could not be closed. The cove board, on the floor, at the head of the resident ' s bed was pulled away from the wall in a 2 ft. area. It revealed gray rocks and dirt on the floor, under the head of the bed, covering the 2 ft. area. Wallpaper in same location was peeled away from the wall in an 8 in. vertical area. Wood was chipped off the door to the resident room from the floor up to the door handle on both the door knob side and hinged side. The door edges revealed rough to the touch, splintered edging. Room 134 had paint peeled off of the closet	F 253	painted/repaired per maintenance schedule. 3.These inspections for resident room doors, bathroom doors, closet doors and cove base repair will be added to the monthly preventative maintenance program. Maintenance will continue daily rounds to assess other housekeeping/maintenance issues. 4.Results of quarterly maintenance program will be reported to the Administrator and QA Committee meetings monthly. Results of these inspections will be reviewed by the facility¿s QA committee monthly x 3 months: then quarterly, thereafter. 9/24/15	

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F 253	Continued From page 7 doors. Wood was chipped off the door to the resident room from the floor up to the door handle on both the door knob side and hinged side. The hinge side of the door was rough to the touch and the door knob edge of the door had been painted over with white paint but remained rough to the touch and chipped. Room 137 ' s door edges were splintered and rough to the touch on both the hinge and door knob side of the door. Room 139 ' s door edges were visibly splintered and rough to the touch on both the hinge and door knob side of the door. The vinyl covering of the door frame on both sides was peeled. Room 140 had paint chipped off of the door frame up to door knob, revealing a black material under the white, chipped paint. The door edge was visibly chipped and rough, and the vinyl was peeled on one side of the door. Room 142 ' s door edges were visibly splintered and rough to the touch on both the hinge and door knob side of the door. Room 143 ' s door edges were visibly jagged and rough to the touch. The vinyl covering of the door frame was split. An interview, and subsequent walk-through the facility, was conducted on 8/27/15 at 9:03 am with both the Maintenance Director and the Administrator. · The Maintenance Director indicated maintenance work orders were located at both nurse stations, that any staff member knew how to and could fill out a form if they noticed repairs that needed to be made, and he checked for any new work orders " sometimes hourly " . He further stated, " If I see something frequently like bent blinds, especially if it is in multiple rooms then we go ahead and fix them. " He indicated improvements/renovation to the building, to	F 253		

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F 253	Continued From page 8 include complete room overhauls, were being done and started from the front of the building and would work to the back of the building. He further indicated the facility has cove board on-hand and could replace immediately as needed and that doors could be either replaced or taken down, sanded, and painted. · The Administrator indicated Rooms 101-106, located at the front of the building with the Administrator ' s office, Business office, and Admissions office, were the initial rooms that were completed and that the Rehab hall was " next. " When asked when the initial rooms were completed, the Administrator stated, " The front rooms were completed at the end of last year. " She further stated, " We have noticed the cove bases are pulling off the walls. We don ' t wait [until the renovation] for cove bases, wallpaper, cracks. We will do those daily before the renovation. " The Administrator and the Maintenance Director were unable to provide any documentation of when the next renovation phase would start and both indicated they were not aware of when the next phase of renovation would begin. The Administrator provided an email sent from the Divisional Facility Manager on 8/27/15 at 9:46 am which stated in-part, " Maintenance makes weekly rounds to look for any maintenance repairs as needed. We replace base as needed. We refurbished some rooms in the front hall last year and hope to try to do more rooms in the 2016 year. I did budget that for 2016 and will try to do more resident bathrooms. Of course this is with corporate approval first. Maintenance has a painting program to paint rooms and touch up rooms as time allows. We have been updating windows and have done many of these. We have replaced some [air condition] units as well. We	F 253		

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F 253	Continued From page 9 want to continue room updates as budgets will allow. Maintenance will continue to do what they can to improve as much as possible in house as well. We also install new parking lot asphalt last year because it was failing. We updated kitchen walls last year and some dietary equipment. " On 8/27/15 at 3:40 pm, after interviewing and doing a walk-through of the facility with the Administrator and the Maintenance Director at 9:03 am, the Administrator provided: · A typed maintenance list with a hand-written " November 2014 " was provided by the Administrator. There were hand-written additions to the document which indicated cove bases, door facing, door repair, paint was to be completed " by end of year. " · A document titled " Walk through observation 6/1/15 - areas of correction. Areas to be corrected prior to September 15, 2015. " The document listed numerous areas for maintenance to address, however the above concerns regarding the named rooms were not identified or addressed. The document did state, " Cove base - repairs needed in: Medical records office at front entrance, Main Dining Room, Station II - evaluate to ensure no peeling areas throughout the facility. " On 8/27/15, after interviewing and doing a walk-through of the facility with the Administrator and the Maintenance Director, maintenance staff was noted replacing cove board and making repairs of some of the issues brought to the attention of the Administrator and Maintenance Director on 8/27/15 by the surveyor.	F 253		
F 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures	F 334		9/24/15

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F 334	Continued From page 10	F 334		

that ensure that --
(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING & REHABILITATION-HENDERSON	280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536

(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 334	Continued From page 11 representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review, policy review and staff interviews, the facility failed to document in the clinical record that education was provided to the resident or resident ' s legal representative regarding the benefits and potential side effects of the Influenza Vaccine for 2 of 5 resident ' s reviewed (Resident #62 and #5) and failed to document the reason the Influenza Vaccine was refused for 1 of 5 resident ' s reviewed (Resident #15). The findings included: The facility ' s policy titled Influenza Program dated 10/14/10 under Procedure 3 Read: " Place influenza sticker on patients ' medication	F 334	This plan of Correction is the center¿s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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KINDRED NURSING & REHABILITATION-HENDERSON	**280 SOUTH BECKFORD DRIVE** **HENDERSON, NC 27536**

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F 334	Continued From page 12 administration records for documentation of administration of vaccine or the refusal of the vaccine. " The sticker outlined in the procedure for the influenza vaccine read: " Education provided: risks, benefits, and potential side effects. Check if Refused and document in resident progress notes to whom the education on the vaccine was provided and the reason (s) for the refusal. " 1. Resident #62 was admitted to the facility on 11/17/11. The Quarterly Minimum Data Set (MDS) Assessment dated 9/9/14 revealed the resident was severely cognitively impaired. Review of the Clinical Immunizations form revealed consent was given for the Influenza Vaccination on 10/8/14. An entry on the form read: " Consent Given. " Another entry on the form read: " Education Provided to Resident/Family " followed by a box. The box was blank and the notes section at the bottom of the form provided no information the education was provided. Review of the resident ' s nursing progress notes revealed no information regarding education being provided. An interview was conducted with the Staff Development Coordinator (SDC) and the Administrator on 8/26/15 at 9:55AM. The SDC stated she did not use the sticker referred to in the facility ' s policy but documented on the Immunization form. The SDC stated she did not document that the education was provided to the family. The Administrator stated a letter was sent to the families to let them know it was time for the Influenza Vaccinations to be given along with the education sheets and the family let them know if they wanted the vaccine to be given. 2. Resident #5 was originally admitted to the facility on 7/26/02. The Quarterly Minimum Data Set (MDS Assessment dated 9/2/14 revealed the	F 334	F334 1.Resident #62 and #5 has been educated on risks vs benefits of flu vaccination. Determination of refusal has been documented on resident #15. 2.During upcoming flu season, education will be provided to all residents/family members and documented in resident¿s medical record. 3.Education and documentation will be provided on all eligible residents and / or family members who receive flu or pneumonia vaccination. 4.Audit monthly immunization records to assess compliance. All findings will then be reported to the facility¿s QA committee for review and further recommendations during the flu season. 09/24/2015	

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F 334	Continued From page 13 resident was cognitively intact. Review of the Clinical Immunizations form revealed the resident received an influenza vaccine on 10/9/14. The form revealed an entry on the form that read: " Consent Given " with a response of " Consented. " There was a box beside " Education Provided to Resident/Family. " The box was blank and no information on the form to indicate the education was provided. The " Notes " section at the end of the form was blank. Review of the resident ' s nursing progress notes revealed no documentation the education was provided. The Staff Development Coordinator (SDC) stated in an interview on 8/26/15 at 9:55AM that she did not use the sticker referred to in the facility ' s policy but documented on the Immunization form. The SDC stated when it was time for the Influenza Vaccinations to be given she went to the alert and oriented resident with the Influenza Vaccination Information Sheet, obtained verbal consent, provided the education and then administered the vaccine if consent was given. The SDC stated she did not document that the education was provided. 3. Resident #15 was admitted to the facility on 10/4/13. The Quarterly Minimum Data Set (MDS) Assessment dated 9/9/14 revealed the resident had severe cognitive impairment. Review of the Clinical Immunizations form revealed an entry that read: " Consent Given: Family Refused. " Another entry read " Reason Refused: Family Refused. " The form did not provide information as to who refused the vaccination or the reason for the refusal. An interview was conducted with the Staff Development Coordinator (SDC) and the Administrator on 8/26/15 at 9:55AM. The SDC stated she did not use the sticker referred to in	F 334		

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F 334	Continued From page 14 the facility ' s policy but documented on the Immunization form. There was no information in the nursing progress notes regarding the refusal of the vaccine. The Administrator stated a letter was sent to the families to let them know it was time for the Influenza Vaccinations to be given along with the education sheets and the family let them know if they wanted the vaccine to be given.	F 334		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441		9/24/15

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F 441	Continued From page 15 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, and staff interviews, the facility was observed to place soiled washcloths onto clean washcloths being used during incontinence care and to turn off a call bell light with a hand donned with a dirty glove during incontinence care for 1 of 1 residents (Resident #75). Findings included: Observation of Resident #75 ' s incontinence care on 8/26/15 at 11:53 AM revealed NA (Nurse Aide) #3 place soiled washcloths onto clean washcloths being used during incontinence care and turn off a call bell light with a hand donned with a dirty glove being worn during the incontinence care. Prior to beginning the incontinence care, NA #3 donned gloves and placed clean dressing supplies onto a bed side table which had not been observed to have been cleaned nor have a clean barrier placed on it. NA #3 began incontinence care for Resident #75 using packaged disposable washcloths to clean the front perineal area. Then, Resident #75 was repositioned for exposure to the back perineal area and buttocks. When cleaning the back perineal area, NA #3 used cloth washcloths and	F 441	This plan of Correction is the center¿s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F441 There was no adverse affect to resident #75 1.Education provided to NA#3 immediately upon identification of report of observation. Call bell and bed side table for resident #75 was disinfected . 2.All C.N.As on shift were in-serviced on infection control : pre and post peri-care. Call bell lights in all resident rooms were disinfected.	

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F 441	Continued From page 16 then placed the soiled washcloths on top of the opened package of disposable wipes. During the repositioning of Resident #75 during the incontinence care, Resident #3 ' s body made contact onto the call bell and engaged it. NA #3 turned off the call bell button using a hand donned with a dirty glove. In an interview with NA #3 on 8/26/15 at 2:55pm, she stated that she did not place the dirty washcloths on top of the clean wipes container, but rather on either side of the container opening. She stated that she would not do that again. During an interview with the Director of Nursing and Staff Development Coordinator on 8/26/15 at 3:00 PM, they stated that it is not facility practice to put dirty, soiled cloths on the cleaned surface. They stated that the bedside table should have been cleaned or have a clean barrier placed prior to placing the wipes on it. They stated that placing the dirty washcloths on the sides of the container is not appropriate. They stated that turning off the call bell with dirty gloves is not facility practice.	F 441	3.S.D.C will perform infection control competency for C.N.A staff. All new hires will be provided with a infection control competency. 4.All findings will then be reported to the facility¿s QA committee monthly for 3 months, then quarterly thereafter for review and further recommendations. 9/24/15	