

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

PRINTED: 01/05/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345537	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/08/2015
NAME OF PROVIDER OR SUPPLIER SILVER STREAM HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2305 SILVER STREAM LANE WILMINGTON, NC 28401		
(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	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff, physician ' s assistant (PA), Medical Doctor (MD) and Responsible Party (RP) interviews, review of records, the facility failed to</p>	F 157	<p>F157 NOTIFY OF CHANGES</p> <p>1. Resident #1 has been discharged.</p>	1/5/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/23/2015

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 157	<p>Continued From page 1</p> <p>notify the physician about a significant change in condition for 1 of 3 sampled residents (Resident #1) reviewed for a change in condition.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 11/3/15 with active diagnoses that included coronary artery disease with pacemaker and defibrillator placement, hypertension, atrial fibrillation, ischemic cardiomyopathy, anal cancer, diabetes, end stage renal disease requiring peritoneal dialysis and pressure ulcer-Stage IV of the left heel.</p> <p>Review of the 11/3/15 Nursing Admission Assessment indicated the resident received peritoneal dialysis and had a left heel ulcer.</p> <p>Review of the resident ' s genitourinary (GU) status indicated a non- distended bladder and noted the resident was continent. There were no swelling or skin issues identified within the GU system.</p> <p>The 11/10/15 Minimum Data Set (MDS) revealed Resident #1 was cognitively intact. Behaviors and rejection of care were not identified. While the resident was assessed with a Stage IV pressure ulcer, he was not identified with other ulcers, wounds or skin problems. The MDS also indicated the resident required extensive assistance for toilet use and limited assistance for personal hygiene and extensive assistance for bathing. He was identified as always continent of urine and frequently incontinent of bowel.</p> <p>On 11/12/15 at 2:22 PM, the nurse wrote a Skin/Wound note. The note indicated Resident #1 had a Stage IV left heel but there was no mention of redness, swelling or skin breakdown involving the GU area.</p> <p>A Doctor ' s Progress Note, dated 11/12/15 with no time indicated, written by the PA indicated Resident #1 continued to exhibit significant</p>	F 157	<p>2. All residents have the potential to be affected by the cited practice.</p> <p>3. The licensed nursing care staff will receive in-service education regarding: must immediately consult with the resident's physician when there is 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).</p> <p>4. Review of 24 hour shift to shift report sheets will be conducted by DON/designee weekly x 3 months to audit prompt notification of physician when there is a significant change in the resident's condition. Findings will be submitted to the administrator for follow up and appropriate corrective action as warranted. Audit results will be reviewed at the QAPI meeting for compliance.</p>		

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F 157	<p>Continued From page 2</p> <p>amounts of pedal edema, measuring 2-3+, extending up to his thighs. The PA documented she offered to send the resident to the hospital for evaluation, but although the RP was upset, she and the resident refused. The plan was to continue with the extra peritoneal dialysis exchanges.</p> <p>The nurse documented on 11/13/15 at 5:30 AM that Resident #1 ' s scrotum and penis were edematous and black in color. He was medicated for pain. The nurse documented there was a foul odor noted in the room and pain medication had not been effective. The nurse documented she had placed a note in the doctor ' s (MD) book and would continue to monitor. On 11/13/15 at 10:04 AM, the nurse's notes indicated the resident had been sent to the hospital.</p> <p>On 11/24/15 at 2:07 PM, Nurse #1 was interviewed. She acknowledged she worked with Resident #1 on the 11:00 PM to 7:00 AM shift. The nurse stated when a resident had a change of condition during her shift she called the on call MD for directions and any conversations held with the MD would be documented in the resident ' s medical record. For non-emergency situations, Nurse #1 stated there was a communication board to alert the MD about any issue that came up. Nurse #1 added if a body part turned dark she considered that an emergency and would immediately call the MD, rather than write it in the MD communication book. After review of the 11/13/15 at 5:30 AM note, Nurse #1 acknowledged she had written the note. She added she lifted the resident ' s scrotum and found an area the size of a raisin that was dark. No drainage was seen coming from the dark spot and the surrounding skin was observed to be red and swollen. Prior to the assessment</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>documented on 11/13/15 at 5:30 AM, Nurse #1 stated she had not previously assessed the resident ' s scrotum and penis because he refused assessment; adding she had not documented his care refusals. The nurse stated during the assessment, she had assessed the resident ' s vital signs, but had forgotten to document the vital signs; adding she knew he was afebrile. Nurse #1 stated on 11/13/15 she had smelled a foul odor in Resident #1 ' s room, but was unsure if the odor came from the dark spot on his scrotum or from a bowel movement that Resident #1 had. She added she had not called the on-call MD to notify him about the blackened area on the resident ' s scrotum because she knew the PA would be in the building in a few hours.</p> <p>A telephone interview was held with the resident's RP on 11/24/15 at 1:30 PM. The RP stated on 11/12/15, when she visited the resident, she noticed he was swollen to his nipple line and added that when she pressed her fingers into the resident's skin, the swelling was pitting edema (edema is measured in degrees and called pitting if fingers pressed into the skin leave an indention upon release). She stated the PA came into the room and told her and Resident #1 that the hospital could not do anything that could not be done at the facility; adding that if she, the PA, sent the resident to the hospital, he would sit in the Emergency Room (ER) for hours. The RP stated based on that conversation, the resident declined to go to the ER. She added while she was unsure of her visit time, she thought it was after lunch.</p> <p>On 11/24/15 at 2:45 PM, Nurse #2 was interviewed. She stated on 11/13/15 she arrived for work between 6:45 AM and 7:00 AM. The nurse stated she was assigned to care for</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>Resident #1. On that morning, Nurse #2 stated she did not see Resident #1; adding Nurse #1 told her the resident's penis was discolored and blackened and scrotum swollen. Nurse #2 stated Nurse #1 told her during report she had noticed the change in the resident ' s penis and scrotum around 6:00 AM; adding the PA usually arrived around 8:15 AM. Nurse #2 added she had not assessed the Resident or called the on-call MD because the PA would be in the facility within the hour.</p> <p>Nurse #3 was interviewed on 11/24/15 at 3:24 PM. She stated on 11/13/15, she had arrived for work between 7:30 AM and 8:00 AM. Nurse #1 reported to her that Resident #1 ' s penis was discolored and his scrotum edematous. The nurse stated she notified both the PA and the Director of Nursing (DON) of the report. With the PA, she went into Resident #1 ' s room and assessed the resident between 8:15 and 8:30 AM. She described Resident #1 ' s scrotum as approximately between golf ball and lemon sized; adding his penis was dark and maybe a charcoal color. At that point, the PA made the statement that Resident #1 needed to be sent to the ER immediately. Nurse #3 stated the MD communication board was not for emergency situations. She reviewed the 11/13/15 at 5:30 AM note, written by Nurse #1 and stated based on what she had read the situation sounded emergent and Nurse #1 should have called the MD.</p> <p>The DON was interviewed on 11/25/15 at 9:34 AM. The DON stated the MD communication book was a place non-emergency situations, such as a cough could be addressed. The DON reviewed the 11/13/15 note at 5:30 AM, written by Nurse #1. She stated this situation should not have been placed on the MD book and the MD</p>	F 157			

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F 157	Continued From page 5 should have been notified immediately when the assessment was completed. Nursing Assistant (NA) #2 was interviewed on 11/25/15 at 11:19 AM. The NA stated she had cared for Resident #1 on the 11:00 PM to 7:00 AM shift the night prior to his transfer to the ER. The NA stated a little after 5:00 AM, Nurse # assisted her in providing incontinent care since the resident had been incontinent of stool. The NA stated Resident #1 ' s scrotum was a dark blue/black color extending from half way the front all the way to the back. She stated she had not observed his scrotum to be that color before. The NA stated she had not noticed a change in color for the resident ' s penis. Earlier in the shift, around 12:00 to 12:15 AM, NA #2 stated she had applied powder to the resident's groin area. At that time Resident #1 ' s scrotum was a dark red. The NA added she reported redness to Nurse #1 who assessed Resident #1 at that time. The PA was interviewed on 11/25/15 at 11:47 AM. The PA during Resident #1 ' s admission assessment performed on 11/4/15, his edema was not bad; adding it was probably trace to 1+ pitting edema, and only involved his lower extremities up to his knees. She stated if the edema worsened, she would have expected staff notification. The PA reviewed her note written on 11/10/15. The PA stated RP and the resident informed her of the edema involving the scrotal area and extending to the thighs. On assessment, the PA stated the edema stopped mid -thigh and she had not felt, based on her assessment, that the edema had progressed to the scrotum; therefore she had not assessed his scrotum and penis. The PA stated the MD book was used for communication when the nurse did not think a situation was emergent enough to call the on call MD, but still something that needed to	F 157			

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F 157	Continued From page 6 be communicated. The PA reviewed the note for 11/13/15 at 5:30 AM, written by Nurse #1. She stated Nurse #1 had written almost the exact statement in the MD communication book. The PA added she usually arrived at the facility around 8:10 AM. Her usual course was to look through orders, talk with the nurses and review labs. The PA stated she would guess it was probably 8:30 AM before she read the note left by Nurse #1 in the communication book. She added upon reading the note, she was concerned and assessed the resident. The PA stated on entering the room there was a very foul odor. She found Resident #1 much more lethargic than the day before and he was not alert and oriented as he had been the day before. She stated she pulled the sheet back and found the penis to be 2-3 centimeters (cm), shriveled and dry looking with the anterior portion of the scrotum black and the entire penis black and immediately made arrangements for the resident ' s transfer to the hospital. Based on what she had read, gangrene could spread 2-3 cm an hour which was possibly the worse-case scenario. The PA stated she thought Nurse #1 should have called the on call MD and sent the resident to the hospital when the change in condition was discovered on 11/13/15 at 5:30 and not waited for her arrival hours later. A telephone interview was conducted with Resident #1 ' s facility MD on 12/8/15 at 12:40 PM. She stated the resident had Fournier ' s gangrene which was essentially a vascular disease that affected the resident ' s perineal area. The MD added the disease could have a rapid onset and progress rapidly. The expectation was for Nurse #1 to have reported Resident #1 ' s significant change in condition on 11/13/15 at 5:30 AM to her or the MD on call and not wait until the PA came to the facility. The	F 157			

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F 157	Continued From page 7 MD also stated the resident was alert and oriented and was able to notify staff of increased pain or edema. On admission, Resident #1 ' s edema was a 1+ pitting that extended to below his knees.	F 157			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff, physician ' s assistant (PA), Medical Doctor (MD) and Responsible Party (RP) interviews, review of records, the facility failed to educate the resident on the consequences of refusing assessments and failed to follow through after assessing a resident ' s scrotal area for 1 of 3 sampled residents (Resident #1) reviewed for a change in condition. Findings included: Resident #1 was admitted to the facility on 11/3/15 with active diagnoses that included coronary artery disease with pacemaker and defibrillator placement, hypertension, atrial fibrillation, ischemic cardiomyopathy, history of anal cancer, diabetes, end stage renal disease requiring peritoneal dialysis and pressure ulcer-Stage IV of the left heel. Review of the 11/3/15 Nursing Admission Assessment indicated the resident received	F 309	F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 1. Resident #1 has been discharged. 2. All residents have the potential to be affected by the cited practice. 3. The licensed nursing care staff will receive in-service education conducted by staff developer regarding the importance of documenting education, educating the resident on the consequences of refusing assessments and following through after assessing change in resident's status. 4. Weekly review of 24 hour shift to shift report sheets will be conducted by DON/designee x 3 months to audit refusal	1/5/16	

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F 309	Continued From page 8 peritoneal dialysis and had a left heel ulcer. Review of the resident ' s genitourinary (GU) status indicated a non- distended bladder and noted the resident was continent. There were no swelling or skin issues identified within the GU system. The 11/10/15 Minimum Data Set (MDS) revealed Resident #1 was cognitively intact. Behaviors and rejection of care were not identified. While the resident was assessed with a Stage IV pressure ulcer, he was not identified with other ulcers, wounds or skin problems. The MDS also indicated the resident required extensive assistance for toilet use and limited assistance for personal hygiene and extensive assistance for bathing. He was identified as always continent of urine and frequently incontinent of bowel. Resident #1 ' s care plan, reviewed on 11/11/15, indicated he required limited to extensive assistance with his activities of daily living. Interventions to make sure his needs were met included individual/caregiver education as needed. The care plan also addressed the resident was at risk for skin breakdown. Interventions included educating the resident/family/caregivers as to causes of skin breakdown. Furthermore, the care plan interventions indicated if the resident refused treatment, a conference should be held with the resident, the interdisciplinary team and family to determine the reason of treatment refusals and to try alternative methods to gain compliance. Any alternative methods attempted were to be documented. The care plan did not address refusal of care as a problem for Resident #1. The nurse documented on 11/13/15 at 5:30 AM that Resident #1 ' s scrotum and penis were edematous and black in color. He was medicated for pain. The nurse documented there	F 309	of assessments and follow through after assessing change in the resident's condition. Findings will be submitted to the administrator for follow up and appropriate corrective action as warranted. Audit results will be reviewed at the QAPI meeting for compliance.		

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F 309	<p>Continued From page 9</p> <p>was a foul odor noted in the room and pain medication had not been effective. The nurse documented she had placed a note in the doctor ' s (MD) book and would continue to monitor. There were no nursing notes that indicated the nurse had continued to monitor the change in Resident #1 ' s scrotum and penis throughout the remainder of her shift. There was no documentation the resident had refused assessment and no documentation the resident was educated on the consequences of refusal as outlined in the resident ' s care plan.</p> <p>On 11/13/15 at 10:04 AM, the nurse's notes indicated the resident had been sent to the hospital.</p> <p>An Emergency Department (ED) Encounter note, dated 11/13/15 at 10:14 AM, indicated Resident #1 presented to the ED with worsening pain, swelling and black discoloration of the skin of his penis and scrotum with a foul odor since yesterday (11/12/15). The Physical Examination revealed necrotic appearing skin surrounding the penis and anterior scrotum with tenderness and mild edema. Under ED Course, the MD documented that after the evaluation he was concerned about Fournier ' s gangrene. The Clinical Impression/Assessment and Plan included Fournier ' s gangrene (Fournier ' s gangrene is a polymicrobial necrotizing fasciitis of the perineal, perianal or genital areas. Rates of fascia destruction can be as high as 2-3 centimeters have been described).</p> <p>Nurse #1 was interviewed on 11/24/15 at 2:07 PM. Nurse #1 acknowledged she worked with Resident #1 on the 11:00 PM to 7:00 AM shift. She read the 11/13/15 at 5:30 AM note and acknowledged she had written the note, but added the event did not actually occur at 5:30 AM, but rather around 6:00 AM. The nurse stated</p>	F 309			

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F 309	<p>Continued From page 10</p> <p>she had entered the time as 5:30 AM on her note because she was busy and had other tasks to finish and had guessed at the time. At the time, she noticed a raisin sized dark spot on Resident #1 ' s posterior scrotal area she had been assisting the nursing assistant with incontinent care. No drainage was seen coming from the dark spot and the surrounding skin was observed to be red, swollen and malodorous. The nurse stated she had not been previously notified of any issues with the resident ' s perineal area and had not assessed the resident ' s scrotal area because he refused assessment; adding she had not documented his care refusals. Nurse #1 stated she had not called the on-call MD to notify him about the dark, malodorous, raisin sized area on the resident ' s scrotum because the PA would be in the facility within a few hours.</p> <p>On 11/24/15 at 2:45 PM, Nurse #2 was interviewed. She stated on 11/13/15 she arrived for work between 6:45 AM and 7:00 AM on 11/13/15 and was assigned to care for Resident #1. During report Nurse #1 told her the resident's penis was discolored and blackened and scrotum swollen. Nurse #2 added she had not assessed the resident ' s scrotal area because the PA would be in the facility within the hour.</p> <p>Nurse #3 was interviewed on 11/24/15 at 3:24 PM. She stated on 11/13/15, she had arrived for work between 7:30 AM and 8:00 AM. As unit manager for Resident #1, Nurse #1 had reported to her that Resident #1 ' s penis was discolored and his scrotum edematous. The nurse stated she notified both the PA and the Director of Nursing (DON). After the report was given, Nurse #3 stated she went with the PA to assess Resident #1. His scrotum was described as approximately between golf ball and lemon sized, with his penis a dark, charcoal color. The nurse</p>	F 309			

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F 309	<p>Continued From page 11</p> <p>stated the PA made the statement that Resident #1 needed to be sent to the ER immediately. Nurse #3 stated the MD communication board was not for emergency situations. She reviewed the 11/13/15 at 5:30 AM note, written by Nurse #1 and stated based on what she had read the situation sounded emergent and the nurse should have called the MD.</p> <p>Nurse #5 was interviewed on 11/24/15 at 4:10 PM. The nurse stated Resident #1 ' s RP came to the facility on 11/12/15, time unknown and stated Resident #1 needed to see the PA because of his edema. Nurse #5 stated she had received reports of the resident ' s groin area being red, but the resident denied the redness and declined an assessment. The nurse stated she had not assessed Resident #1 since the PA would arrive after lunch.</p> <p>Nurse #6 was interviewed on 11/24/15 at 4:25 PM. Nurse #6 stated she worked the 3-11 shift on Thursday, 11/12/15 and had cared for Resident #1. She had not observed any changes in Resident #1 and no changes in condition had been reported by other staff members.</p> <p>The DON was interviewed on 11/25/15 at 9:34 AM. The DON stated if a resident was admitted with any skin redness or excoriation or any refusal of care, she expected documentation to be found in the resident ' s medical record. The DON reviewed the 11/10/15 note written by the PA and stated if the PA was aware of redness in Resident #1 ' s groin, then the nurses should have been aware, been assessing and should have documented the findings. The DON stated the MD communication book was a place non-emergency situations were documented so</p>	F 309			

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F 309	<p>Continued From page 12</p> <p>the issue could be addressed. The DON reviewed the 11/13/15 note at 5:30 AM, written by Nurse #1. She stated this situation should not have been placed on the MD book and the MD should have been notified immediately when the assessment was completed.</p> <p>Nursing Assistant (NA) #2 was interviewed on 11/25/15 at 11:19 AM. The NA stated she had cared for Resident #1 on the 11:00 PM to 7:00 AM shift the night prior to his transfer to the ER. Around 5:00 AM, Nurse #1 assisted her in providing incontinent care for Resident #1. During provision of incontinent care, the NA stated Resident #1 ' s scrotum was a dark blue/black color extending from half way the front all the way to the back. She stated she had not observed his scrotum to be that color before. Earlier in the shift, around 12:00 to 12:15 AM, NA #2 stated she had provided incontinent care and at that time Resident #1 ' s scrotum was a dark red. The NA added she reported the dark scrotal redness to Nurse #1. NA #2 stated Resident #1 had not refused care for her.</p> <p>The PA was interviewed on 11/25/15 at 11:47 AM. She stated on admission, Resident #1 ' s edema was not bad; adding it was probably trace to 1+ pitting edema, stopping below the knees. She stated if the edema worsened, she would have expected staff notification. The PA reviewed her note written on 11/10/15 and added she had assessed the resident because the RP informed her Resident #1 ' s edema now extended to his thighs and involved his scrotal area. On assessment, the PA stated the edema stopped mid -thigh and she had felt, based on her assessment, that the edema had not progressed to the scrotal area. The PA stated she called the</p>	F 309			

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F 309	Continued From page 13 dialysis center to see if medications needed to be increased. Instead of increasing meds, the dialysis MD increased the number of peritoneal dialysis exchanges. She stated she saw the resident on 11/11/15 and even after the increased exchanges the pedal edema had not significantly improved. On 11/12/15, the PA stated the RP had asked to see her because Resident #1 ' s edema had not improved with the additional exchanges. With lack of edema resolution, the PA stated she had mentioned transfer to the hospital, but both the resident and his RP declined. The PA stated the MD book was used for communication when the nurse did not think a situation was emergent enough to call the on call MD, but still something that needed to be communicated. The PA reviewed the note for 11/13/15 at 5:30 AM, written by Nurse #1 and stated Nurse #1 had written almost the exact statement in the MD communication book. The PA added she usually arrived at the facility around 8:10 AM. Her usual course was to look through orders, talk with the nurses and review labs. She stated it was probably 8:30 AM before she read the note left by Nurse #1 in the communication book and upon reading the note, she assessed the Resident #1. On entering Resident #1 ' s a very foul odor was detected. She found Resident #1 much more lethargic than the day before and he was not alert and oriented as he had been the day before. When she pulled the sheet back, she found the penis to be 2-3 centimeters (cm), shriveled and dry looking with the anterior portion of the scrotum black and the entire penis black. Based on what she saw, the PA stated Nurse #1 should have immediately called the MD when Resident #1 ' s change in condition was discovered at 5:30 AM.	F 309			

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F 309	Continued From page 14 A telephone interview was conducted with Resident #1 ' s facility MD on 12/8/15 at 12:40 PM. She stated the resident had Fournier ' s gangrene which was essentially a vascular disease that affected the resident ' s perineal area; adding the disease could have a rapid onset and progress rapidly. The MD added she expected the nurse that discovered the significant change in condition on 11/13/15 at 5:30 AM to notify her or the MD on call and not wait until the PA came to the facility. The MD stated it was unlikely, but unknown, if the outcome for Resident #1 would have changed if had arrived at the ED at 5:30 when the significant change was noted by Nurse #1, since once the Fournier ' s gangrene started it was difficult to change the course. The RP was interviewed by phone on 12/8/15 at 12:51 PM. She stated she had visited the resident daily and had not seen nurses assessing the resident during her visits. The RP stated the resident had been an alert and oriented person that would not have refused to have nurses assess him; adding Resident #1 had mentioned to her the only time he saw a nurse was during medication pass and when his peritoneal dialysis was due. The resident told him his care was primarily received from the nursing assistants.	F 309			
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.	F 312		1/5/16	

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F 312	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, staff and resident interviews and record reviews the facility failed to provide nail care and removal of facial hair for 4 of 4 sampled residents (Residents # 2, 3, 6 and #8) who was reviewed for activities of daily living. Findings included:</p> <p>1-Resident #2 was admitted on 11/3/15 with diagnoses that included coronary artery disease, hypertension and diabetes.</p> <p>The 11/3/15 Minimum Data Set (MDS) coded the resident as severely cognitively impaired. She was also identified as not refusing care and requiring total assistance for personal hygiene. On 11/24/15 at 12 PM, the resident was observed lying in bed, uncovered, wearing a facility gown. The resident ' s hair was matted.</p> <p>At 9:00 AM on 11/25/15, the resident ' s hair was still matted and she was still wearing a facility gown.</p> <p>Nursing Assistant (NA) #1 was interviewed on 11/24/15 at 3:05 PM. She stated she had been assigned to work with the resident. The NA stated Resident #2 received her bath around 11:00 AM. She stated she had not brushed the resident ' s teeth, but had combed her hair. The NA stated the resident was dressed in a facility gown because she had no clean clothes. NA #1 stated she had not reported the lack of clean clothes to anyone. The NA had no reason why the resident ' s hair had not been groomed or her teeth brushed.</p> <p>The Director of Nursing (DON) was interviewed on 11/25/15 at 8:44 AM. The DON stated mouth care should be given with morning care and as needed. She added residents should not remain in facility gowns unless it is a resident ' s preference.</p>	F 312	<p>F 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <ol style="list-style-type: none"> Residents #2, 3 and 6 and 8, personal hygiene including nail care, oral care and/or removal of facial hair was provided. Residents #2 and 3 have been discharged. All residents have the potential to be affected by cited practice. The direct nursing care staff will receive in-service education conducted by staff developer regarding providing the necessary services to maintain grooming and personal hygiene including but not limited to nail care, oral car and removal of facial hair. Random resident observation audits of 10% of the resident population will be conducted by DON/designee weekly x 3 months. Findings of audits will be communicated to direct care staff to address adl needs. audits will be submitted to the administrator for follow up. Audit results will be reviewed at the QAPI meeting for compliance, further analysis and adjustments as necessary. 		

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F 312	Continued From page 16 2- Resident #3 was admitted on 11/20/15 with anemia and hypertension. The Admission Minimum Data Set (MDS) with an assessment reference date of 11/27/15 coded the resident with severely impaired vision, requiring extensive assistance with personal hygiene and refusing no care. An observation was made on 11/24/15 at 8:55 AM. Resident #3 ' s nails were long and with black matter underneath the nails, he was unshaven and white debris was seen in his teeth. On 11/24/15 at 5:15 PM, another observation was made. Resident #3 remained unshaven with long nails with black matter. The resident stated he had not received nail care, a shave or had his teeth brushed. The Admission MDS with a date of 11/27/15 indicated Resident #3 was moderately cognitively impaired and required extensive assistance with personal hygiene. He was not identified as refusing care. Nursing Assistant #1 was interviewed on 11/24/15 at 3:05 PM. The NA stated she had been assigned to care for Resident #3. The NA added she was responsible for all of the resident ' s morning care and hygiene needs. NA #1 stated she had not shaven the resident because she was unable to find a razor. Stated she had not asked anyone to find one for her. The NA acknowledged she had not looked at the resident ' s nails, but added she was not responsible for trimming and cleaning residents ' nails. The NA was unsure who was responsible. The Director of Nursing (DON) was interviewed on 11/25/15 at 8:44 AM. She stated residents, both female and male should be shaven per preference and as needed. Preferences and refusal of care were expected to be documented	F 312			

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F 312	<p>Continued From page 17</p> <p>and care planned. The DON added nail care was given as needed and per residents ' preference. The DON observed Resident #3 and stated he needed to be shaved and his nails needed to be cleaned.</p> <p>3- Resident #6 was admitted on 6/2/11 with diagnoses that included hypertension and diabetes. Her quarterly Minimum Data Set, dated 11/4/15, indicated Resident #6 was moderately cognitively impaired. No rejection of care was coded. Supervision was required for completion of personal hygiene. During the tour of the facility, beginning at 8:30 AM on 11/24/15, the resident was observed sitting in her chair. Her shirt was on wrong side out. The shoes the resident wore had yellow-brown stains on the side. Chin hair was present. Resident #6 was identified by staff on 11/24/15 as requiring extensive assistance with activities of daily living. Nursing Assistant (NA) #3 was interviewed on 11/25/15 at 2:18 PM. The NA acknowledged she had been assigned to care for Resident #6 on 11/24/15 and 11/25/15. The NA stated while resident #6 could complete some tasks, she had to brush the resident ' s teeth, comb her hair and shave her. She added she had been taught to shave residents when facial hair was present. NA #3 stated on 11/24/15 she had looked past shaving the resident. She stated she had not noticed she needed to be shaved. The NA added she had been taught if the resident's clothing was soiled or shoes soiled she should either get new clothing or shoes or use gripper socks. NA #3 stated although seen Resident #6 ' s stained shoes before she had not mentioned the stained shoes and had not tried to get the</p>	F 312			

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F 312	Continued From page 18 shoes cleaned. She offered no reason for the omission. 4- Resident #8 was admitted on 11/16/15 with diagnoses that included chronic obstructive pulmonary disease. An Admission Minimum Data Set (MDS), dated 11/16/15, coded the resident with long and short term memory impairment and severely impaired skills for daily decision making. The MDS also indicated the resident required extensive assistance with personal hygiene. There was no indication the resident rejected care. On 11/24/15 at 8:15 AM, the resident was observed lying in bed unshaven. The Director of Nursing (DON) was interviewed on 11/25/15 at 8:44 AM. She stated residents, both female and male should be shaven per preference and as needed. The DON observed Resident #8 at this time and stated he should have been shaven.	F 312			
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with the Responsible Party (RP), Registered Dietician (RD), physician 's assistant (PA) and staff interviews and record review, the facility failed to provide the physician ordered diet for 3 of 3 residents (Residents # 1, 4 and 5) that had physician 's orders for a renal diet with a specified fluid restriction. Findings included:	F 367	F367 THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN 1. For individual residents, Resident #1 has discharged. Residents # 4 and 5 still residing at the facility will be provided education on physician ordered diet, the potential consequences of not following prescribed	1/5/16	

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F 367	<p>Continued From page 19</p> <p>1. Resident #1 was admitted to the facility on 11/3/15 with active diagnoses that included coronary artery disease, hypertension and end stage renal disease requiring dialysis. Review of the hospital discharge orders, dated 11/3/15, indicated the resident received a renal diet.</p> <p>The 11/9/15 Nutritional Registered Dietician (RD) Assessment, indicated Resident #1 required 2548 calories per day, 91-109 grams of protein and fluids were identified as restricted per dialysis with no amount identified. Under Problem/Etiology/Signs and Symptoms statement the RD had written the diet for Resident #1 would be clarified. Nutritional Interventions suggested the diet be clarified to Renal, carbohydrate controlled with a 1000 milliliters (ml) per day fluid restriction. The RD added the suggested diet should promote glycemic control, manage uremia and should maintain the resident's weight. There were no other dietary notes.</p> <p>The 11/10/15 Minimum Data Set (MDS) revealed Resident #1 was cognitively intact. The resident was identified as receiving a therapeutic diet and receiving dialysis. The Care Area Assessment (CAA) for Resident #1 's Nutritional Status indicated the resident received a therapeutic diet to aid in glycemic control. There was no mention of a renal diet or the fluid restriction.</p> <p>On 11/11/15, the physician (MD) ordered a dietary consult.</p> <p>Resident #1 's care plan, created on 11/12/15, indicated he was on a therapeutic diet. The goal of maintaining an adequate nutritional status with no signs and symptoms of malnutrition was to be achieved through explaining and reinforcing the importance of maintaining his diet as ordered and explaining the consequences of non-compliance, providing and serving the diet as ordered, RD to</p>	F 367	<p>diet and MD will be updated for non-compliance of renal diet with fluid restrictions as indicated.</p> <p>2. All residents receiving a renal diet with fluid restrictions have the potential to be affected by the cited practice.</p> <p>3. All residents receiving a renal diet with fluid restrictions will be reviewed by the IDT for compliance to prescribed diet monthly x 3 months then quarterly by the care plan schedule. For individuals choosing to be non-compliant with prescribed renal diet with fluid restrictions education on consequences of not following prescribed diet will be provided by nursing, care plans and MD will be updated as indicated.</p> <p>The dietary and direct nursing care staff will receive in-service education conducted by staff developer on adhering to renal diets with fluid restrictions, the consequences of not following prescribed diet and reporting resident non-compliance.</p> <p>4. The dietary manager/designee will observe meals served in the dining room weekly x 3 months to audit compliance of renal diets with fluid restrictions. Findings of the audit will be submitted to the administrator for follow up. Audit results will be reviewed at the QAPI meeting monthly for 3 months for compliance, further analysis and adjustments as necessary.</p>		

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F 367	<p>Continued From page 20</p> <p>evaluate and make diet change recommendations. The type of therapeutic diet was not specified.</p> <p>A telephone interview was held with the resident's Responsible Party (RP) on 11/24/15 at 1:30 PM. The RP stated she had discussed the resident's diet with the Admission Director. She added although she had mentioned the resident was not receiving a renal diet, facility staff would not discuss the resident ' s diet with her. The RP added the Dietary Manager (DM) came to the room and reviewed Resident #1 ' s food likes and dislikes, but that was all.</p> <p>Nurse #5 was interviewed on 11/24/15 at 4:10 PM. The nurse stated Resident #1 received a renal diet. The resident ' s RP had concerns about what type of diet the resident received. Nurse #5 stated she called Nurse # 3 who then spoke with the Dietary Manager (DM). The nurse stated she thought the DM spoke with the resident and his RP about the resident ' s diet.</p> <p>Nurse #6 was interviewed on 11/24/15 at 4:25 PM. The nurse stated Resident #1 received a low sodium diet, but she was unsure when the low sodium diet started. Nurse #3 added the resident ' s RP had asked about the resident ' s diet several times. The nurse was able to remember one night the resident had been served a submarine sandwich and the RP requested the alternate.</p> <p>The Director of Nursing (DON) was interviewed on 11/25/15 at 9:34 AM. She stated staff used hospital discharge orders for admission orders, including diet orders. Diet orders were then confirmed with the MD and communicated with the dietary department via an in house communication form. The DON added if a resident did not receive the ordered diet, the nursing assistant was expected to go to the</p>	F 367			

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F 367	Continued From page 21 dietary department to get the ordered diet. The DON confirmed the resident's hospital discharge diet was a renal diet and consistent carbohydrate diet. She added the resident ' s diet order should have been included on the physician ' s monthly orders. The DON stated the RP did not have concerns Resident #1 was not receiving a renal diet, but that was based on the fact the family did not cook with salt at home. The DON added she was not aware the resident had not received a renal diet on admission. The DON reviewed the 11/9/15 RD note, recommending the diet be clarified, and stated the note indicated the resident had not received the renal diet. On 11/25/15 at 11:13 AM, the Admissions Director was interviewed. She stated she was Resident #1 ' s facility Ambassador (a facility program in which department managers are assigned to specific residents. The purpose of the program was to talk with residents and family to find out if there were concerns. If there were concerns, the concern was written up and given to the Administrator. The person assigned by the Administrator to investigate the concern reported back to the resident/family). The Admissions Director stated both Resident #1 and the RP had reported concerns related to not receiving a renal diet. She added the concern was written as a grievance and given to the Administrator. The DM then spoke with the resident and the RP about the diet. The Admissions Director reported back at 11:30 on 11/25/15 that she failed to find the written grievance or evidence of concern resolution regarding the renal diet. Nurse #7 was interviewed on 11/25/15 at 11:33 AM. Nurse #3 stated she cared for the resident on the day shift. Nurse #7 stated she could not recall what type of diet was ordered but since he was on dialysis, the diet should have been a renal	F 367			

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F 367	Continued From page 22 diet. On 11/25/15 at 11:47 AM, the PA was interviewed. The PA stated if a resident received dialysis, adhering to a renal diet and the fluid restriction would be extremely important. She added if the type of diet was not specified on admission, she expected staff to call the MD and clarify the diet. The PA stated prior to Resident #1 ' s hospitalization, the RP had concerns he was not receiving the proper diet. She added at that time, she had written an order for the diet to be clarified. The PA added she had been surprised by what the RP told her since it was standard for a resident receiving dialysis to be on a renal diet and she thought he already received a renal diet. The PA stated the RP told her the RD had gone into the room and told the resident he needed to be on a renal diet. The PA added if Resident #1 had not received his renal diet, it had the potential of making his edema worse. On admission, Resident #1 ' s edema was not bad, probably trace to 1+ pitting edema below the knees. The PA stated on 11/10/15, the RP and the resident informed her of the edema involving the scrotal area and extending to the thighs. On assessment, the PA stated the edema extended to mid-thigh. Even after receiving orders from the dialysis center for increased dialysis exchanges, the PA stated the resident ' s edema had not significantly improved. The Dietary Manager (DM) was interviewed on 11/25/15 at 12:57 PM. The DM stated she was unaware why the RD would write the 11/9/15 note to clarify the resident ' s diet to a renal diet since Resident #1 had been admitted on a renal diet. The DM stated she had spoken to Resident #1, but not the RP about the dietary concerns. The DM stated she informed the resident the facility cooked with limited amounts of seasoning, but he	F 367			

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F 367	<p>Continued From page 23</p> <p>was used to having no seasoning. The DM stated the Admissions Director had asked her to speak with the resident about the dietary concerns. She added she had not spoken to the RP about the dietary concerns and had no documentation to substantiate her conversations. The RD was interviewed on 11/25/15 at 2:38 PM. The RD stated dietary staff were expected to follow MD orders. The RD stated she expected the DM to call the MD or make sure a staff member notified the MD of dietary non-compliance. The RD stated according to the order screen in the electronic medical record she had been unsure of what type of diet Resident #1 received. She added while she believed he had received a renal diet from admission, she was unsure. The RD stated the electronic system that lists residents and diets was not available to print out a copy of Resident #1 ' s diet since the system only printed current residents ' diets. The RD added while the facility goal was always to comply with the MD order. She added the danger of not complying with renal diet could possibly be elevated potassium or a risk of fluid overload.</p> <p>2. Resident #4 was admitted on 12/16/14. Diagnoses included end stage renal disease requiring dialysis.</p> <p>The 10/17/15 Quarterly MDS indicated the resident was cognitively intact.</p> <p>Current orders, for November 2015, included a fluid restriction of 1000 cc per 24 hours with 520 cc coming from nursing with 7 to 3 shift giving 200 cc, 3-11shift giving 200 cc and 11 to 7 shift giving 120 cc. The resident's diet was liberal renal with reduced concentrated sweets.</p> <p>An observation was made on Tuesday, 11/24/15 for the noon meal. The resident ' s tray card indicated she was on a renal diet and a fluid</p>	F 367			

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F 367	<p>Continued From page 24</p> <p>restriction. The tray card indicated the resident was to have 8 ounces of fluid only. Additionally, the resident was to receive 3 ounces of beef, 2 ounces of gravy, 2 cups of tossed salad, 1 dinner roll, and diet vanilla pudding, 4 ounces of mighty shake and 4 ounces of punch. The resident actually received a chef salad and a banana along with 4 ounces of Mighty shake and 8 ounces of coffee. The meal was served in the dining room by a staff member.</p> <p>The Director of Nursing (DON) was interviewed on 11/25/15 at 10:38 AM. The DON stated resident #4 was alert and oriented. She was identified as receiving dialysis three times a week. The DON stated Resident #4 was non-compliant with renal diet and fluid restriction, but added the facility should have served the diet as ordered by the MD.</p> <p>The PA was interviewed on 11/25/15 at 12:34 PM. She stated she had not been notified of Resident #4 ' s non-compliance with her renal diet and fluid restriction.</p> <p>On 11/25/15 at 12:57 PM, the Dietary Manager (DM) was interviewed. The DM stated she tried to be on the line at all times to make sure the resident ' s received their ordered diet. She stated she had not told anyone about her non-compliance and had not care planned the non-compliance. The DM stated the dietary department only served 4 ounces of mighty shake and added it was staff that served in the dining room giving the resident extra fluids. She added she had educated the resident about bananas not being part of a renal diet, but added she would get into " trouble " if she did not give the resident bananas. On 10/2/15, she stated she and the RD met with the resident and educated the resident on the consequences of not following the renal diet and fluid restrictions, but the resident</p>	F 367			

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F 367	<p>Continued From page 25</p> <p>stated she still wanted more mighty shakes than the renal diet allowed.</p> <p>The RD was interviewed on 11/25/15 at 2:38 PM. The RD stated dietary staff were expected to follow MD dietary orders. She stated the resident requests should be honored, but the dietary department should alert nursing staff if a resident chose not to comply with dietary orders. She added she expected either the DM to call the MD or notify nursing staff to call the MD to alert the MD the resident was non-compliant with the ordered diet. The RD reviewed the tray card for the resident and stated a banana was not part of a renal diet and should not have been served. She stated the goal was always to comply with the MD order; adding the danger of not complying with a renal diet could possibly be elevated potassium or a risk of fluid overload.</p> <p>3. Resident #5 was admitted on 12/25/11 with diagnoses that included end stage renal disease requiring dialysis, diabetes and hypertension. The 11/3/15 Quarterly Minimum Data Set (MDS) noted the resident was cognitively intact, required extensive assistance for activities of daily living and received a therapeutic diet. An observation was made on 11/24/15 at the noon meal. The resident ' s tray card indicated she was on a renal diet with a fluid restriction of only 4 ounces for the meal. The card also indicated the resident was to receive large meat portions. The resident ' s tray card indicated she was to have received 4 ounces of beef, 3 ounces of gravy, 1 cup of salad, ½ cup of spaghetti noodles, 1 roll, ½ cup of diet pudding, 4 ounces of might shake, no ice and fruit for dessert. Observation of the resident ' s plate revealed she actually received 1 grilled cheese sandwich, a bowl of soup with crackers and no mighty shake.</p>	F 367			

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F 367	Continued From page 26 A 6 ounce cup of tea was received. The Director of Nursing (DON) was interviewed on 11/25/15 at 10:50 AM. The DON identified Resident #5 as alert and oriented. The DON stated the resident was non-compliant with her renal diet and her fluid restriction. As a facility the physician's order should be followed. The DON stated there has been no adverse reactions to the resident from dietary non-compliance. The PA stated on 11/25/15 at 12:36 PM she had not been notified the resident was non-compliant with fluid restriction or renal diet. The Dietary Manager (DM) was interviewed on 11/25/15 at 12:57 PM. The DM stated Resident #5 was alert, oriented and very non-compliant with her renal diet and fluid restriction. She stated in order to meet the double meat order, she had used 2 slices of cheese for the grilled cheese sandwich. The DM stated the soup counted toward fluids and acknowledged Resident #5 had received 8 ounces of soup. The DM stated she had notified the MD about the resident's fluid restriction or renal diet non-compliance. The DM had no idea why the resident had not received her mighty shake. The DM stated she tried to be in the kitchen when trays were prepared to assure the residents received the correct portions and diet. The RD was interviewed on 11/25/15 at 2:38 PM. She stated dietary staff were to follow MD orders for diets. She expected them to honor a resident request, but the DM should let nursing staff know when a resident was not compliant with MD dietary orders. The RD indicated she expected the DM to either notify the MD or make sure nursing staff notified the MD of dietary non-compliance. The RD reviewed the tray card for Resident #5 and stated 2 slices of cheese was not an equal substitute for large meat portions.	F 367			

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F 367	Continued From page 27 She added the resident had received too much fluid from the dietary department. The RD stated she had spoken to Resident #5 about her fluid restriction, adding the resident replied she knew about her fluid restriction.	F 367			
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 hand washing is indicated by accepted professional practice.	F 441		1/5/16	

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F 441	<p>Continued From page 28</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and record review, the facility failed to observe contact isolation precautions when leaving the room for 1 of 3 residents (Resident #7) on contact isolation and failed to post a contact isolation sign for 1 of 3 sampled residents (Resident #7) on contact isolation precautions. Findings included: Resident #7 was admitted to the facility on 11/19/15 with diagnoses that included Clostridium difficile (C.diff -a gram positive bacteria that is easily spread resulting in abdominal pain, nausea and watery stools). Review of the 11/19/15 hospital discharge and facility admission records indicated Resident #7 continued on medication to treat the C. difficile. A continuous observation started during the initial tour of the facility on 11/23/15 at 8:50 AM. There was a cart by Resident #7's door that contained gloves and gowns indicating the resident was on isolation. There was no signage on the door that indicated what type of isolation Resident #7 had been placed. Nursing Assistant (NA) #1 was observed in the resident 's room, wearing gloves, but no gown, adjusting the resident 's over bed table and his television. Prior to leaving Resident #7 's room, the NA pulled the gloves off and was observed disposing of the gloves in the trash can and then walked out of the resident 's room. She was not observed washing her hands The NA</p>	F 441	<p>F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <ol style="list-style-type: none"> 1. Resident #7 still resides at the facility and continues with isolation precautions. Direct care staff member involved with resident #7 has been re-educated on isolation precautions and a new contact isolation sign posted on room door. 2. All residents on isolation precautions have the potential to be affected by the cited practice. 3. All residents on isolation precautions will have posting of contact isolation sign validated by DON/designee. The direct care staff will receive in-service education conducted by staff developer on isolation precautions with emphasis on hand washing prior to leaving resident room. 4. Visual validation of contact isolation signage posting and observation of random employees for hand hygiene will be conducted by DON/designee weekly x 3 months. Findings of the audit will be submitted to the administrator for follow up and corrective action as warranted. Summary of audit findings will be 		

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F 441	<p>Continued From page 29</p> <p>was observed walking to the adjoining room and picked up the resident ' s empty breakfast tray, placed it on the food cart. NA #1 then entered another resident ' s room and donned gloves. She repositioned the resident in bed, set his breakfast tray on his over bed table and assisted Resident #3 with breakfast.</p> <p>NA #1 was interviewed on 11/24/15 at 3:05 PM. She stated she had been taught to put on gloves and a gown when going into a room when a resident was on contact isolation. The NA added when delivering a meal tray, gloves were the only equipment required. The NA stated residents on contact isolation were identified by a bin by the door that contained gowns and gloves adding sometimes a sign would be posted on the door. The NA stated there were 3 residents in the facility that were on isolation in the building, but only 2 had isolation signs posted. NA #1 added prior to leaving an isolation room, gowns and gloves should be removed and hands should be washed. NA #1 acknowledged she had touched Resident #7 ' s over bed table and changed the channel on the TV used by the resident. She stated she had removed her gloves prior to leaving the room, but had not washed her hands. The NA acknowledged she had failed to wash her hands prior to feeding Resident #3. She stated she just was not thinking and failing to wash her hands could contaminate other residents.</p> <p>The Director of Nursing (DON) was interviewed on 11/25/15 at 8:44 AM. During the interview, the DON stated Resident #7 had been placed on contact isolation for Clostridium difficile. She stated physician orders were not needed to place a person on isolation. Contact isolation was determined by culture results and diagnosis at</p>	F 441	<p>reviewed at QAPI for further analysis and adjustments as needed.</p>		

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F 441	Continued From page 30 admission. She added residents were placed on isolation if they exhibited signs and symptoms of a disease pending culture results. The DON stated signage on a resident ' s door made staff and visitors aware the resident was on isolation. She added signage instructed both the staff and visitors what personal protective equipment was needed prior to entering a room when a resident was on isolation. The DON stated she was unsure why Resident #7 had not had a contact isolation sign outside his door. The DON stated she would have expected staff to notice the isolation sign was gone and replace the sign. She added staff were expected to follow the interventions listed on the contact isolation sign which included wearing gloves and a gown. Before leaving the room, the gown and gloves should be removed and the staff member should wash their hands prior to providing care and services to other residents in order to avoid spreading the infection to another resident. The DON stated staff were trained on infection control and contact isolation during the orientation process and annually regarding contact isolation precautions.	F 441			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify	F 520		1/5/16	

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F 520	<p>Continued From page 31</p> <p>issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility ' s Quality Assessment and Assurance (QAA) Committee failed to implement, monitor and revise as needed the action plan developed to correct deficiencies in the areas of activities of daily living (F312) cited during the complaint survey of 10/01/15. As a result, a deficiency in the area of activities of daily living was again cited on the current complaint survey. Findings included: This tag is cross referenced to: F312: Based on observations, staff and resident interviews and record reviews the facility failed to provide nail care and removal of facial hair for 4 of 4 sampled residents (Residents # 2, 3, 6 and #8) who were reviewed for activities of daily living. During the complaint survey of 10/01/15, the facility was cited for failing to provide incontinent care or toileting for 6 of 29 residents interviewed that needed extensive to total assistance for Activities of Daily Living.</p>	F 520	<p>F 520 QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>This tag is cross referenced to F312</p> <p>F 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <ol style="list-style-type: none"> 1. For those individual residents, Residents #2, 3, 6, and 8, nail care, oral care and removal of facial hair was provided. Residents #2 and 3 have discharged. 2. All residents have the potential to be affected by cited practice. 3. The direct care nursing staff will receive in-service education regarding: providing the necessary services to 		

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F 520	Continued From page 32 An interview with the regional nurse consultant and the DON was conducted on 11/25/15 at 9:30 AM. They acknowledged the facility had recently regained compliance in the area of activities of daily living on 10/26/15. They acknowledged that audits and observations should continue.	F 520	maintain grooming and personal hygiene including but not limited to nail care, oral car and removal of facial hair. 4. Random resident observation audits of 10% of the resident population, to include residents #6 and 8, will be conducted by DON/designee weekly x 3 months. Findings of audits will be submitted to the administrator for follow up and corrective action as warranted. Audit results will be reviewed at the QAPI meeting monthly x 3 for compliance, further analysis and adjustments as necessary. QAPI will be conducted monthly x 3 months with regional nurse oversight to ensure compliance.		