STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345406	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWN EAST HEALTH AND REHAB CEN	38 CARTERS ROAD GATESVILLE, NC 27938

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to initiate a care plan addressing an indwelling urinary catheter for 1 of 3 residents (Resident #61) reviewed for indwelling catheters. Findings included: Resident #61 was admitted 12/18/15 with cumulative diagnosis which included septicemia, diabetes mellitus, and pressure ulcers. A Care Plan dated 1/5/16 listed a problem of altered bladder elimination. Goals stated resident will not experience complications related to incontinence and will remain free from skin breakdown due to incontinence and brief use. A	F 279	F-279 1. Resident #61's care plan was developed for indwelling urinary catheter on 2/18/16 by the MDS Coordinator. 2. All other residents with indwelling urinary catheter care plans were developed and/ or updated on or before March 17, 2016. 100% chart review was completed to identify resident with indwelling urinary catheters. 3. MDS Coordinator/Director of Clinical Services/Executive Director was re-educated on the policy and procedures for developing care plans by the Regional MDS Coordinator by 3/17/16. The MDS/DCS will review all new admission medical records within 24 hours after admission and new physician orders, for changes to assure residents with indwelling urinary catheter have a care plan. The DCS/ED will conduct QI monitoring of care plans 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 3 months on Quality Assurance Improvement Form. 4. The DCS will report the findings to the reviews to the Quality Assurance Performance Improvement Committee (QAPI) Meeting monthly for (3) month. The QAPI committee will recommend revisions to the plan as need to assure sustained compliance. 5. The allegation of compliance date is March 17, 2016.	3/17/16 3/17/16 3/17/16 3/17/16 3/17/16

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

Pamela O'Chesney, Executive Director | 3/14/16

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 279	Continued From page 1 notation was made on 1/21/16 regarding Stage 2 pressure ulcer to sacrum was changed to Stage 3. No further updates were noted on the care plan for bladder elimination. A review of physician orders for January revealed an order on 1/21/16 for an indwelling urinary catheter to be inserted for promotion of wound healing. A review of the most recent Minimum Data Assessment (MDS) from 1/26/16 revealed the resident was severely cognitively impaired and was totally dependent on staff for all activities of daily living (ADL). She was noted to have a Stage 3 pressure ulcer and an indwelling catheter. On 2/18/16 at 3:30 PM, an interview was conducted with the MDS Coordinator. She stated it was her responsibility to develop care plans and this should be completed within a day or so after orders were written. She stated she was also responsible for updating the MDS and if the indwelling urinary catheter was noted on the assessment of 1/26/16, it should have been care planned. An interview was conducted 2/18/16 at 5:20 PM with the Director of Nursing (DON). She stated the MDS Coordinator was responsible for developing care plans. She indicated an order for an indwelling catheter should be communicated to the MDS nurse as soon as possible and a care plan should be developed. She stated an order written on 1/21/16 should have been addressed on the care plan by now.	F 279		
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	F 309		

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F 309	Continued From page 2 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 record review and interviews the facility failed to obtain vital signs per facility policy upon return from dialysis for 1 of 1 residents (Resident #20) receiving hemodialysis. The findings included: A review of the facility's Policies and Procedures with the subject: Coordination of Hemodialysis Services read in part "The facility will complete the post dialysis information on the Dialysis Communication form and file the completed form in the Resident's Clinical Record." Resident #20 was readmitted to the facility on 7/23/15 with diagnoses which included chronic kidney disease stage IV, hemodialysis, diabetes, stroke, bilateral above the knee amputations and dementia. The quarterly Minimum Data Set revealed Resident #20 was moderately cognitively impaired and required extensive to total assistance for activities of daily living (ADLs). The care plan revealed a problem of "resident requires HD (hemodialysis) on Monday, Wednesday and Friday related to end stage renal disease as evidenced by AV shunt." On 2/17/16 at 1:17 PM nurse #4 stated Resident #20 was at dialysis and she usually returned around 4:00PM so the nurse working on the 3:00-11:00 PM shift would be responsible for obtaining the resident's vital signs. She added that the resident had a dialysis notebook which	F 309	F-309 1. Resident #20 post dialysis information on the Dialysis Communication Form was completed including vital signs and filed in the resident's clinical record. 2. All residents receiving dialysis services were audited to ensure dialysis communication form completed and filed in the resident's medical record. 3. All licensed nurses will be re-educated by the Director of Clinical Services on assessing residents post dialysis to include vital signs by March 17, 2016. The completed assessment will be documented on the Dialysis Communication Form and filed in the resident's medical record. The DCS/ED will review dialysis communication form to ensure assessment complete 3 x weekly x 4 weeks, then 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 3 months. The audit will be documented on the Quality Improvement Form. 4. The DCS will report the findings of the reviews to the Quality Assurance Performance Improvement Committee (QAPI) Meeting monthly for (3) months. The QAPI committee will recommend revisions to the plan as needed to assure sustained compliance. 5. The allegation of compliance date is March 17, 2016.	3/17/16 3/17/16 3/17/16 3/17/16 3/17/16

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F 309	Continued From page 3 she takes to dialysis. On 2/18/16 at 8:43 AM an observation of the dialysis notebook revealed a form titled "Dialysis Communication Record." The form's first section was for the facility to document the resident's vital signs and shunt site information prior to leaving for HD. The second section of the form was for the dialysis unit to document information about the resident while receiving HD and the third section of the form was for the facility to document the resident's vital signs upon return to the facility. Upon inspection of the forms in the dialysis notebook it was noted that of the forms dated 1/13/16, 1/15/16, 1/18/16, 1/20/16, 1/22/16, 1/27/16, 1/29/16, 2/1/16, 2/3/16, 2/3/16, 2/5/16, 2/8/16, 2/10/16, 2/15/16, 2/17/16 had no information documented in the third section of the forms. Only the form dated 2/12/16 had the third section, "Facility to complete on return from dialysis" completed. The information documented on the 2/12/16 form's third section was the resident's vital signs, pulse, respirations, pain, access site observation, bruit. It was signed by Nurse #4. On 2/18/16 at 9:22 AM Resident #20 was seated in her wheel chair near the nursing station. She stated the staff do check her arm for thrill and bruit. She stated they check her vital signs prior to going to HD but do not check her vital signs when she returns. During an interview with Nurse #4 on 2/18/16 at 9:50 AM she stated the vital signs should be checked when the resident returns from HD but the resident usually returned from HD after her shift is over. On 2/18/16 at 10:10 AM the Nursing Supervisor stated the resident's vital signs should be obtained upon return from HD. She reviewed the dialysis notebook and stated the vital signs were	F 309		

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F 309	Continued From page 4 not on the Dialysis Communication Record. She said the vital signs may be in the medical record. A record review of the treatment record revealed documentation of the removal of the bandage 24 hours after the return from HD. There was no documentation on the treatment record or on the medication administration record of the vital signs. On 2/19/16 at 10:47 AM during an interview with the Nursing Supervisor she stated she reviewed the resident's medical record and was unable to find the vital signs documented upon return from HD.	F 309		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to maintain a medication error rate of less than 5% by not administering 2 medications as ordered by the physician for 1 of 6 residents observed during medication pass which resulted in a 6.89% error rate (2 errors out of 29 opportunities). (Resident #62) Findings included: Review of Resident #62's February 2016 physician orders and February 2016 Medication Administration Record (MAR) revealed the resident was scheduled to receive Vitamin C 1000 milligrams (mg) and Calcium Citrate with	F 332	F-332 1. Resident #62 was assessed for adverse reactions with none noted on 2/18/16.. Med error report completed and MD made aware of medication error and new on 2/18/16. 2. All residents with the medication Calcium Citrate with Vitamin D and Vitamin C was reviewed by the DCS, verified with pharmacy, and checked on the MARs for accuracy.	3/17/16 3/17/16

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F 332	Continued From page 5 Vitamin D 315 mg/250 IU at 9:00 AM daily. An observation of medication pass on 2/18/2016 at 8:35 AM revealed Nurse #1 preparing medications for Resident #62. She placed all of the resident's scheduled medications into a cup which included only one 500 milligram tablet of Vitamin C and a half tablet of Calcium Citrate with Vitamin D which was a 600 mg/400 international units (IU) tablet. The nurse locked her medication cart and proceeded into the resident's room and administered the medications to the resident. An interview was conducted with Nurse #1 on 2/18/2016 at 9:10 AM. The nurse indicated she had read the Vitamin C order as 'give one tablet' and did not read the milligrams ordered on the MAR. The nurse stated "I should have given two tablets to equal 1000 mg." The nurse further stated the dose administered of Calcium with Vitamin D was 300 mg/200 IU. The nurse stated she had not clarified this dose with the pharmacy or the physician. An interview with the Director of Nursing (DON) was conducted on 2/18/2016 at 9:28 AM. The DON stated certain doses of supplements are not stock medications and are received from the pharmacy. The DON stated Resident #62's Calcium with Vitamin D was not a stock medication and should have been sent from the pharmacy. The DON stated it was her expectation of the nurse to clarify medications and dosages with the physician if there were any questions. The DON stated it was her expectation of the nurse to read the order and the stock medication bottle and verify medications before administering.	F 332	F332 3. All licensed nurses were re-educated by the Director of Clinical Services on safe and accurate medication administration, and physician orders, by March 17, 2016.. The DCS/UM will review medication administration pass and will audit the MAR and cart to ensure medications are available. 3 x weekly x 4 weeks, then 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 3 months. The audit will be documented on the Performance Improvement: Review of Medication Pass Form. 4. The DCS will report the findings of the reviews to the Quality Assurance Performance Improvement Committee (QAPI) Meeting monthly for (3) months. The QAPI committee will recommend revisions to the plan as needed to assure sustained compliance. 5. The allegation of compliance date is March 17, 2016.	3/17/16 3/17/16 3/17/16
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 6 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to discard food after its use by date and failed to keep facial hair covered on 2 of 2 employees with facial hair. The findings included: 1) On 2/16/16 at 10:26 AM an observation of the reach in refrigerator revealed a container of tomato soup dated 2/10/16, a container of mandarin oranges dated 2/10/16 and a container of vegetable soup dated 2/12/16. On 2/16/16 at 10:30 AM the Dietary Manager stated the soup was going to be used during the dinner meal that night. When questioned about the date on the containers she stated the date was the date the container was placed in the refrigerator and the items should be used within 3 days of the date on the container. After observing the date on the containers the Dietary Manager stated the tomato soup, the mandarin oranges and the vegetable soup needed to be discarded since they were more than 3 days old. An observation of the outside of the reach in refrigerator revealed refrigerator and freezer storage guidelines from the US Food & Drug Administration dated September 2001. These	F 371	F-371 1. All outdated food has been discarded. All staff with facial hairs is covered with beard cover. 2. The Dietary Manager checked the refrigerator to assure all food was within used date. DM observed that staff with facial hair was covered. 3. The District Food Service Manager for the Dietary Department re-educated the Dietary Manager on refrigerator and freezer storage guidelines, discarding out dated food after its use date, and beard cover to be worn to cover facial hair on 2/26/16. The Dietary staff was re-educated by the Dietary Manager on refrigerator and freezer storage guidelines, discarding out dated food after use date, beard cover to be worn to cover facial hair by 3/17/16. The Executive Director/Dietary Manager will monitor this daily for five times a week for 2 weeks, then 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 3 months.	3/17/16 3/17/16 3/17/16

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F 371	Continued From page 7 storage guidelines read that soups and stews could be stored in the refrigerator for 3-4 days. 2) On 2/16/16 at 10:35 AM Cook#1 was observed preparing foods near the stove in the kitchen. He had facial hair but he was not wearing a beard cover. On 2/18/16 at 2:40 PM Dietary Aid #1 was observed entering and working in the kitchen. He was observed to have facial hair which was not covered. On 2/18/16 at 2:42 PM the Dietary Manager was interviewed. She stated she thought the 2 employees should be wearing bead covers but she had never seen any beard covers in the kitchen since she had been working there. She stated the staff with facial hair had never worn beard covers. She stated it was her responsibility as the manager to be knowledgeable of the rules and to enforce the rules.	F 371	F 371 4. The Dietary Manager will report the finding of the monitoring to the Quality Assurance Performance Improvement Committee (QAPI) Meeting monthly for (3) months. The QAPI committee will recommend revisions to the plan as needed to assure sustained compliance. 5. Allegation of Compliance Date 3/17/16.	3/17/16 3/17/16
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.	F 441		

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F 441	Continued From page 8 (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. (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 failed to prevent cross contamination by placing dressing supplies on an uncovered bedside table, and on the residents bed during wound care, and then placing items back in the facility wide wound treatment cart for 1 or 3 dressing changes observed (nurse #1); and failed to disinfect glucometer according to manufacturer instructions for 2 of 2 observed blood sugar checks (nurse #3). The findings included: 1. An observation of dressing change was observed on 2/18/2016 at 10:06 AM. The nurse (nurse #1) had a blue tote box, a package of 4 x 4 gauze sponges, a box of tape, a small bottle labeled sterile water, and a partially used tube of	F 441	F 441 1. Dressing supplies were removed and discarded from wound treatment cart 2/18/16. Glucometer was properly disinfected and placed on a barrier on the cart on 2/18/16. 2. All wound treatment carts were audited for proper storage of supplies 2/18/16. All glucometers were properly disinfected and stored properly 2/18/16. 3. All licensed nurses will be re-educated by the Director of Clinical Services on the infection control policy related to wound care and the proper way to disinfect glucometers by March 17, 2016. The DCS/UM will monitor wound care and the proper way to disinfect glucometer 3 x weekly x 4 weeks, then 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 3 months. The audit will be documented on the Quality Improvement Form. 4. The DCS will report the findings of the reviews to the Quality Assurance Performance Improvement Committee (QAPI) Meeting monthly for (3) months. The QAPI committee will recommend revisions to the plan as needed to assure sustained compliance. 5. The allegation of compliance date is March 17, 2016.	3/17/16 3/17/16 3/17/16 3/17/16 3/17/16

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F 441	Continued From page 9	F 441		

santyl ointment placed on the bedside table. No barrier cloth was placed on the bedside table under the dressing supplies. The resident was positioned on her left side, with help from the nursing assistant (NA).
The nurse cleaned and dressed the sacral wound, and as she finished, the resident had several loose bowel movements. The nurse and NA cleaned the resident, and the nurse cleaned and reapplied the dressing. During the next dressing change the nurse moved the tape, water and ointment to the bed and laid them beside the resident. After the wound was dressed the nurse put the items back in the blue tote and took all the items to the cart room, and placed the tape and ointment back into the facilit's treatment cart, and the bottle of water was placed on top of the cart.
An interview was conducted with the nurse immediately following at 10:42 AM, on 2/18/2016. The nurse stated she only got out of the treatment cart the items needed for that treatment. She indicated she usually set up the items on the resident's bedside table, but it would just depend on where it was convenient for her to set up. She stated she only took out what tape was needed from the box, or ointment from the tube, and the inside of the box and ointment had never touched anything and were clean, so it didn't matter that they had lain on the bed beside the resident. The nurse stated she would label the ointment and water so that they were only used by that resident, but did not see any reason not to leave them in the treatment cart. She stated there were no germs on the resident's bed.
On 2/18/2016 at 3:31 PM, an interview was conducted with the nursing supervisor/staff educator (NS). The NS stated she taught the staff infection control and it was not okay to take items off the bed and place them back in the

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F 441	Continued From page 10	F 441		

treatment cart. She indicated cross contamination could occur in the situation of placing items back in the cart because they would not know what germs had been picked up and spread with in the cart and to the next resident.

2. Review of the directions of the germicidal wipes, the facility used to clean and disinfect glucometers, revealed: a 30 second contact time was required to kill all kinds of bacteria and virus, except one minute contact time is required to kill candida albicans (fungus), 3 minutes required to kill Clostridium-Difficile (infectious diarrhea). Allow to air dry.

An observation on 2/17/2016 at 4:10 PM of Nurse #3 performing a glucometer check on Resident #17. Nurse #3 donned gloves, performed the finger stick and obtained the blood sample. The nurse removed the glucometer test strip, removed her gloves and placed the used glucometer on top of the medication cart. The nurse then donned new gloves and wiped the glucometer with a germicidal wipe for 10 seconds and placed the glucometer back on top of the cart where it had been and threw away the wipe and removed her gloves. The glucometer was observed to dry within a few seconds.

An observation on 2/17/2016 at 4:25 PM of Nurse #3 performing a glucometer check on Resident #54. Nurse #3 donned gloves, performed the finger stick and obtained the blood sample. The nurse removed the glucometer test strip, removed her gloves and placed the used glucometer on top of the medication cart. The nurse then donned new gloves and wiped the glucometer with a germicidal wipe for 10 seconds and placed the glucometer back on top of the cart

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	345406	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWN EAST HEALTH AND REHAB CEN	38 CARTERS ROAD GATESVILLE, NC 27938

(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 441	Continued From page 11 where it had been and threw away the wipe and removed her gloves. The glucometer was observed to dry within a few seconds. An interview with Nurse #3 was conducted on 2/17/2016 at 4:30 PM was conducted. The nurse stated the glucometer needed to be wiped off for a few seconds with a germicidal wipe, allowed to air dry and should not be soaked. The nurse stated sometimes the wipes are very wet which caused problems for the glucometer because of too much moisture on the wipe. An interview with the Director of Nursing (DON) was conducted on 2/17/2016 at 5:14 PM. The DON stated three minutes was the contact time necessary for the germicidal wipe to be effective. The DON stated it was her expectation of the nurse to be aware of the necessary contact time for decontamination and to clean glucometers per manufacturer's recommendations.	F 441		
F 520 SS=E	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 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.	F 520	F-520 1. The Executive Director held a Quality Assurance Performance Improvement meeting with the Interdisciplinary Team. Attendees were Medical Director, Director of Clinical Services, Social Services Director, Dietary Manager, Maintenance Director, Housekeeping & Laundry Supervisor, Activities Director, Central Supply Clerk, and Executive Director on 3/9/16. The focus of the QAPI meeting was infection control, care services and dietary services with implementation of plan of correction and ongoing monitoring to sustain improvement.	3/17/16

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F 520	Continued From page 12 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. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitoring practices to address interventions put into effect after the 3/13/15 recertification survey. During the survey of 3/13/15 the facility was cited at F441 for failure to maintain infection control practices, at F371 for failure to store, prepare, distribute and serve food under sanitary conditions, and at F309 for failure to provide care and services for the highest wellbeing. During the recertification survey of 2/19/16, the facility was recited for F441, F371, and F309. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assurance program. The findings included: This tag is cross referenced to: 1. a. F441: Infection Control. Based on observation and staff interviews the facility failed to prevent cross contamination by placing dressing supplies on an uncovered bedside table and on the residents bed during wound care and	F 520	F 520 2. All resident have the potential to be effected by this alleged deficient practice. . 3. The Executive Director will continue to conduct Quality Improvement Assurance Performance Meetings at least monthly and quarterly. The basis of these meeting is identifying new concerns and reviewing past identified concerns with updated interventions as needed. The Regional Director of Clinical Services will attend QAPI meeting monthly for 3 months for validation. All areas of identified concerns will be corrected by the Executive Director and Regional Director of Clinical Services. 4. The results of these reviews will be submitted to the QAPI Committee by the Executive Director for review by QAPI Committee each month for 3 months. The QAPI committee will evaluate and recommend revisions to the plan as needed to assure sustained compliance. 5. Allegation of Compliance Date 3/17/16.	3/17/16 3/17/16 3/17/16 3/17/16

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F 520	Continued From page 13	F 520		

then placing the items back in the facility wide wound treatment cart for 1 of 3 dressing changes observed (Nurse #1), and failed to disinfect glucometer according to manufacturer instructions for 2 of 2 observed blood sugar checks (Nurse #3).

During the recertification survey of 3/13/15, the facility was cited a deficiency at F441 for failure to implement personal protective equipment hazard requirements for sorting soiled laundry for 1 of 1 laundry staff sorting soiled laundry. On the current survey of 2/19/16, the facility failed to prevent cross contamination by placing dressing supplies on an uncovered bedside table and on the residents bed during wound care and then placing the items back in the facility wide wound treatment cart for 1 of 3 dressing changes observed (Nurse #1), and failed to disinfect glucometer according to manufacturer instructions for 2 of 2 observed blood sugar checks (Nurse #3).

b. F371: Food Procurement, Storage, Preparations, and Distribution. Based on observations, record reviews and staff interviews the facility failed to discard food after is use by date and failed to keep facial hair covered on 2 of 2 employees with facial hair.

During the recertification survey of 3/13/15, the facility was cited a deficiency at F371 for failure to maintain coleslaw at a temperature of 41 degrees or less and for failure to store pans as dry and free of food debris and black buildup. On the current survey of 2/19/16, the facility failed to discard food after is use by date and failed to keep facial hair covered on 2 of 2 employees with facial hair.

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F 520	Continued From page 14	F 520		

c. F309: Highest Practicable Potential Physical, Mental, Psychosocial Well-Being. Based on record review and interviews the facility failed to obtain vital signs per facility policy upon return from dialysis for 1 of 1 residents (Resident #20) receiving hemodialysis.

During the recertification survey of 3/13/15, the facility was cited a deficiency at F309 for failure to remove the dressing from the dialysis shunt as ordered by the physician for 1 of 1 residents (Resident #25) reviewed for dialysis care. On the current survey of 2/19/16, the facility failed to obtain vital signs per facility policy upon return from dialysis for 1 of 1 residents (Resident #20) receiving hemodialysis.

On 2/19/16 at 11:45 AM, an interview was conducted with the Administrator, Director of Nursing (DON) and Nursing Supervisor/Staff Development Coordinator (SDC). The Administrator indicated that staff and residents could bring issues to the attention of the Quality Assessment and Assurance Committee which was comprised of the Administrator and all department heads. She stated the Medical Director attended monthly meetings and the Pharmacy Consultant attended quarterly meetings. She revealed that the committee had worked on the areas of wounds including measurements and turning and repositioning residents during the past year. She stated this was accomplished by staff inservices, reviewing policies and documenting weekly to monthly audits to show trends.
The Administrator stated the facility had addressed issues with infection control through audits and education of housekeeping and

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F 520	Continued From page 15 nursing staff. The nursing supervisor was monitoring staff to verify proper gloving through spot checks. The Administrator revealed the facility had followed their plan of correction (POC) for dietary deficiencies and conducted spot checking and maintained audit records of food temperatures and kitchen equipment. She stated the facility followed their POC with monitoring for dialysis dressings. The DON stated the staff had been inserviced and monitored on written documentation for dressing removal.	F 520		

DOWN EAST
HEALTH AND REHABILITATION CENTER
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Originals for
Your Records

March 14, 2016

Mrs. Penny Cobb, Facility Survey Consultant
NC Department of Health and Human Services
Nursing Home Licensure and Certification Section
1205 Umstead Drive
Raleigh, North Carolina 27603

Mrs. Penny Cobb,

On February 16, 2016 to February 19, 2016, a recertification survey was conducted by you and your team. We would like to thank you and your team for the professionalism displayed during the survey process. Attached you will find our plan of correction. The originals are in the mail.

If you have any questions or concerns, please give me a call at 252-357-2124.

Sincerely yours,

Pamela Harvey, Executive Director

38 Carters Road | Gatesville, NC 27938 | *p.* (252) 357-2124 *f.* (252) 357-1436 | www.**consulate**healthcare.com