STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345555	A. BUILDING _____ B. WING _____	C 05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST RALEIGH AT CRABTREE VALLEY	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

(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 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to assure sanitary and orderly bathroom conditions in four bathrooms where seven (Residents # 9, # 10, #11, # 12, #13, # 14, #15) out of fifteen sampled residents resided. Also the facility failed to assure equipment was clean within one of two equipment storage rooms. The findings included: 1. Observations were made on 5/1/16 at 9:30 AM of the bathroom located in Resident #9 ' s and Resident #10 ' s shared room. The bathroom ' s shower stall was observed to have multiple spots of blackish brown dried matter. The administrator was accompanied the next day, 5/2/16 beginning at 8:45 AM, to observe bathroom conditions in multiple rooms. The same observations made on 5/1/16 at 9:30 AM were observed during bathroom observations with the administrator on 5/2/16. Observations were made on 5/1/16 at 10:35 AM of the private bathroom located within Resident # 11 ' s room. The bathroom shower stall was observed to have brown matter particles. There was an uncovered toilet plunger beside the toilet. The lid to the toilet back was not closed. The administrator was accompanied the next day, 5/2/16 beginning at 8:45 AM, to observe bathroom conditions. The same observations made on 5/1/16 at 10:35 AM were observed during bathroom observations with the	F 253	This plan of correction constitutes Hillcrest Raleigh at Crabtree, LLC's (Hillcrest's) written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F253 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The housekeeping supervisor was notified and the bathrooms, showers and mats for residents 9, 10, 11,12,13,14,15 were cleaned immediately. 2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. All resident room bathrooms and showers were audited for cleanliness. Any resident bathroom that was found to have blackish brown dried matter in the shower or toilet area was cleaned immediately. All plungers were removed from resident	5/27/16

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

Electronically Signed | 05/16/2016

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F 253	Continued From page 1 administrator on 5/2/16. Observations were made on 5/1/16 at 10:45 AM of the bathroom located in Resident # 12 ' s and # 13 ' s shared room. The bathroom had brownish black matter on the floor and in the shower stall. There was an uncovered toilet plunger beside the toilet. The administrator was accompanied the next day, 5/2/16 beginning at 8:45 AM, to observe bathroom conditions. The same observations made on 5/1/16 at 10:45 AM were observed during bathroom observations with the administrator on 5/2/16. Observations were made on 5/1/16 at 11:40 AM of the bathroom located in Resident # 14 ' s and # 15 ' s shared room. The bathroom shower stall had brownish matter. The toilet seat, located below a riser toilet seat with rails, had a spot of brownish black matter. The administrator was accompanied the next day, 5/2/16 beginning at 8:45 AM, to observe bathroom conditions. The same observations made on 5/1/16 at 11:40 AM were observed during bathroom observations with the administrator on 5/2/16. Interview with the administrator on 5/2/16 following the bathroom observations at 8:45 AM revealed the shower stalls were not currently used for showering residents but that it was the expectation that they still be cleaned. The administrator also stated toilet plungers should be covered. The administrator stated the facility currently used contracted services for housekeeping. The housekeeping director/contractor was interviewed on 5/2/16 at 9:10 AM regarding cleaning procedures. The director stated each housekeeper was to do a tour of their assigned areas when reporting to work. During this initial tour the housekeepers were to sweep up large objects and observe the bathroom conditions to	F 253	bathrooms and will be stored in a designated area. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. Random audits of resident bathrooms and equipment in regards to cleanliness will be conducted by the housekeeping manager and/or designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The Plan of Correction is integrated into the quality assurance system of the facility. Monitoring of these changes, specifically, the cleaning of resident restrooms and equipment will be performed by the housekeeping manager or designee weekly x4, bi-monthly x2, and monthly x1. The facility QA committee and administrator/designee will review the monitoring results during QA meetings for 3 months. Housekeeping manager/designee will be responsible for monitoring and reporting.	

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F 253	Continued From page 2 identify cleaning and housekeeping needs. 2. On 5/2/16 at 9:15 AM the housekeeping director was accompanied to two storage rooms used for resident equipment. The housekeeper stated that the procedure was for dirty resident equipment to be sanitized and cleaned before being placed in the storage rooms. During the observation of the first storage room there were four bedside mats which were folded and stacked. Upon unfolding them, it was observed that all four had white matter on them. The housekeeping director stated the four mats needed to be removed and cleaned again.	F 253		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, for one (Resident # 2) of one sampled resident with a catheter, the facility failed to assure nursing staff communicated regarding the catheter leaking and being changed to a size which was not ordered by the physician. Record review revealed Resident # 2 was admitted to the facility on 9/8/15. The resident	F 315	This plan of correction constitutes Hillcrest Raleigh at Crabtree, LLC's (Hillcrest's) written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is	5/27/16

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F 315	Continued From page 3 had multiple diagnoses. Two of these included multiple sclerosis and neurogenic bladder. Record review also revealed the resident had a suprapubic catheter related to her neurogenic bladder. Review of the resident ' s last MDS (Minimum Data Set) assessment, dated 3/2/16, revealed the resident was assessed to have a " 13 " score on the Brief Interview for Mental Status portion of the MDS. A " 13-15 " score corresponded to " cognitively intact. " Record review revealed the resident had been seen by a urologist on 4/21/16 and her suprapubic catheter was changed secondary to leaking. The urologist noted the size of catheter used for replacement was a 20 French. An order was written on that date, 4/21/16, to change the suprapubic catheter monthly with a 20 French catheter and a 10 cc (cubic centimeters) balloon. The resident was interviewed on 5/1/16 (Sunday) at 12:40 PM. The resident stated she had been seen by a urologist in recent weeks due to her catheter leaking and it had been replaced by the urologist. The resident stated the catheter worked correctly up until one day when she was being repositioned and felt an accidental tug on the catheter. The resident stated following that time the catheter had leaked. The resident was unsure of the exact date the catheter began leaking but knew it was since she had been seen by the urologist. The resident stated two nursing assistants had changed her entire linens around noon that day (Sunday 5/1/16) because the catheter had leaked so badly. The resident stated she had mentioned the leaking catheter to several nurses. Nurse # 1, an agency nurse, was interviewed on 5/1/16 at 2:30 PM. Nurse # 1 stated when she came on duty she had received report from the	F 315	submitted to meet requirements established by state and federal law. F315 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The nurse immediately called the MD to clarify to keep the 18 French catheter in. The physician agreed to the 18 French and scheduled a follow up visit for Resident #2. The unit coordinator immediately checked the catheters in the storage room and ensured catheters were stored to match their designated labeled area. Nurse #1 was immediately educated on communication of resident conditions and verification of orders. Resident #2 was informed of the information and updated on the scheduled follow up visit per MD. 2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. A review of all other residents having a catheter was conducted and found that all other residents had the correct catheter in place by clarification of MD orders, and no catheters were leaking. Nursing communication is in place (24 hour reports and change over communication) All nurses have been educated to this process. Nurses to include agency staff nurses will be trained to check the catheter label at the time it is pulled from	

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F 315	Continued From page 4 nurse who had worked the previous shift about any changes in residents ' conditions. Nurse # 1 stated the previous nurse had not mentioned Resident # 2 ' s catheter had been leaking. Nurse # 1 stated the resident ' s NA (nurse aide) had told her earlier the resident ' s bed had been wet and Nurse # 1 stated she would check the catheter. NA # 1 was interviewed on 5/1/16 at 3:10 PM. NA # 1 stated she had been assigned to care for Resident # 2 both on 4/30/16 (Saturday) and 5/1/16 (Sunday). NA # 1 stated the resident ' s bed was wet from the waist down on 4/30/16 (Saturday). NA # 2 stated the resident ' s bed was again wet on 5/1/16 (Sunday) and she and another NA had changed the entire linens earlier because of the amount of wetness. NA # 1 stated she had told the nurse on both days (4/30/16 and 5/1/16). NA # 1 did not know how long the catheter had been leaking. NA # 2 was interviewed on 5/1/16 at 2:45 PM. NA # 2 stated she had assisted to change Resident # 2 ' s bed linens earlier that same day because the bed was wet from the resident ' s shoulders down. The NA stated she thought the wetness was urine. NA # 2 did not know how long the catheter had been leaking. The resident ' s nursing notes were reviewed on 5/1/16 at approximately 3:30 PM. There was no notation the resident ' s catheter had been leaking 4/29/16, 4/30/16, or 5/1/16. At the time of the review there was no nursing entry for 5/1/16. Resident # 2 was interviewed again on the following day, 5/2/16 (Monday) at 10 AM. The resident stated a nurse had changed the catheter the previous afternoon (Sunday) but that an 18 French catheter had been placed instead of a 20 French catheter as the urologist had instructed. Resident # 2 stated the nurse had told her she	F 315	storage, to ensure it matches the order and educated on the use of the 24 hour acute report system to ensure communication procedures are in place for any worked shift. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. Audits will be performed to ensure communication and catheter clarification orders are in place and communication has occurred. DON/designee weekly x 4, bi-monthly x2 months, and monthly x1. Audits will be performed to ensure proper storage of catheters weekly x4, bi-monthly x2 months, and monthly x1. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. Monitoring of these changes, through audits and education will be performed by the DON/designee weekly x 4, bi-monthly x2 months, and monthly x1. The facility QA committee and administrator/designee will review monitoring during QA meetings for 3 months. DON/designee will be responsible for monitoring and reporting. The monitoring will be implemented to	

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F 315	Continued From page 5 didn ' t have a 20 French catheter. The resident stated she would wait and see if the 18 French catheter drained without leaking. On 5/2/16 the resident ' s nursing notes were reviewed for the date of 5/1/16. Record review revealed Nurse # 1 had made an entry into the record at 10 PM on 5/1/16 noting she had attempted to flush the resident ' s catheter and it had been obstructed. The nurse documented she changed the catheter and placed an 18 French catheter. There was no notation when the insertion had occurred or why an 18 French catheter had been inserted rather than the ordered 20 French sized catheter. The DON (Director of Nursing) was interviewed on 5/2/16 at 10:30 AM about the facility ' s procedure for communicating regarding residents ' conditions and changes. The DON stated a 24 hour report was maintained to note any changes or concerns and the nurses reported to each other between shift changes. The DON reviewed the 24 hour report at the time of the interview and validated that Resident # 2 had been placed on the report on 4/30/16 due to her catheter leaking. The DON stated the 4/30/16 report would have been started on the 11pm -7am shift which began on 4/29/16. Nurse # 2 was interviewed on 5/2/16 at 10:45 AM. Nurse # 2 stated she had been told earlier in her Monday morning report that Resident #2 ' s catheter was new and not leaking. Nurse # 2 stated she did not know why an 18 French catheter had been inserted instead of the ordered 20 French size and this had not been relayed in nursing report during shift change. Nurse # 3, the unit manager, was interviewed on 5/2/16 at 11 AM. Nurse # 3 stated she had been present the previous day (Sunday 5/1/16) when Nurse # 1 needed a catheter and insertion kit.	F 315	ensure that the audits and education are accurate.	

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F 315	Continued From page 6 Nurse # 3 stated she had gone to the supply room and obtained a kit and catheter from the area labeled as storage for " 20 French " catheters. Nurse # 3 stated she had obtained the catheter from the labeled area and given the supplies to Nurse # 1 and she did not know what had happened to result in the resident having an 18 French catheter. Nurse # 3 also validated Resident # 1 did have a 18 French catheter in place at the current time. Nurse # 1 was interviewed via phone on 5/3/16 at 11:25 AM. Nurse # 1 stated she had tried to flush the resident ' s catheter on 5/1/16 (Sunday) near the end of first shift and found it was occluded. The nurse stated a supervisor had given her the supplies to change it. Nurse # 1 stated when she removed the old catheter, the end of the catheter was blood tinged. Nurse # 1 stated she was preparing to insert the new one when she realized the catheter was an 18 French and not the 20 French she had requested. Nurse # 1 stated the resident told her to go ahead and put the catheter in and she did so for resident comfort since she was in the midst of the procedure. Nurse # 4 was interviewed on 5/3/16 at 2:39 PM via phone. Nurse # 4 was the agency nurse who had been assigned to care for the resident on Saturday (4/30/16) during the dayshift. Nurse # 4 stated no one had told her Resident # 2 ' s catheter was leaking.	F 315		