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	345291	A. BUILDING _____ B. WING _____	11/10/2016

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UNIVERSAL HEALTH CARE / OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to dress the resident properly by leaving his trousers down, during 2 observations of staff entering the room, which resulted in his brief being observed from the hall and restricting the movement of his legs for 1 of 1 residents (Resident # 199) reviewed for dignity. Findings included: Resident #199 was admitted to the facility on 10/25/16 with stroke, visual impairment and moderate to severe dementia. The hospital discharge summary, dated 10/25/16, indicated Resident #199 was dependent, demented, was alert but had no effective communication. An undated interim care plan indicated Resident #199 had a functional decline with activities of daily living and required assistance. The 11/1/16 Admission Minimum Data Set coded Resident #199 with impaired short and long term memory and severely impaired cognitive skills for daily decision making. He required extensive to total assistance for all activities of daily living.	F 241	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirements under state and federal law and to demonstrate the good faith attempt by the provider to improve the quality of life of our residents. F241 Immediate Action taken for those resident(s) named to be affected by this alleged deficient practice: Resident 199's pants were immediately pulled up to the proper position around his waist by Nurse's aide #2 on 11/7/2016. Nurse's aide # 1 (NA #1) and nurse's aide #2 (NA #2) were educated by the charge nurse # 1 on 11/7/2016 regarding dignity and respect of individuality at the time of this occurrence. This education emphasized on the importance of ensuring resident pants are pulled to the waist level to avoid resident's	12/6/16

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

Electronically Signed | 12/04/2016

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

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F 241	Continued From page 1 During an observation on 11/7/16 at 2:48 PM, Resident #199 was observed from the hall, lying in bed, with his pants around his knees. His brief was visible from the hall. At 2:50 PM, Nursing Assistant (NA) #1 entered the resident ' s room, spoke to the resident and replied that she needed to find NA #2. After NA #1 left the room, the resident continued to lie in bed, pants at knee level with his brief exposed. At 2:51 PM, both NA #1 and NA #2 entered the resident's room. After speaking to the resident, both NAs left the room. Resident #199 was left lying in bed with his pants to his knees. The NAs had thrown a sheet over the resident. At 2:58 PM on 11/7/16, NA #2 was interviewed. She acknowledged she was caring for the resident that day. The NA stated she had left the resident's pants at knee level so the 3:00 PM to 11:00 PM shift would know he had been changed. NA #1 was interviewed on 11/7/16 at 3:15 PM. She stated she had not pulled Resident #199's pants up because he was not assigned to her. NA #1 added she had not known why the pants had been left down and that's why she went to get NA #2. The NA acknowledged she had left the resident's pants down during both times she had entered the resident's room. She added they (NA #1 and NA#2) had thrown a sheet over the resident; so therefore there was not an issue and stated it was not a "big deal" when Resident #199 had been left with his pants pulled to his knees. On 11/9/16 at 2:47 PM, Nurse #1 was	F 241	brief/underpants is not visible unnecessarily. Identification of other resident having potential to be affected by the same deficient practice: All residents have the potential to be affected. 100% audit of all active residents completed by The Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or Staff Development Coordinator (SDC) through facility rounds conducted on 11/7/16 to determine if any other resident pants were not applied to the waist level to ensure total privacy and dignity of each resident. No other residents were noted to have been affected by this alleged deficient practice. Findings of this audit is documented on "Dignity and Privacy Audit" tool. Measures put into place or systemic changes made to ensure the alleged deficient practice will not re-occur: Effective 12/02/2016, nursing assistants will not leave resident pants around the knees during their working shift, off-going nursing assistance and incoming nursing assistance will conduct walking round to ensure residents are cared for timely and also to ensure each resident's clothing is applied appropriately to provide total privacy. Any negative findings related to Activities of Daily Living (ADL) needs or dignity and privacy needs will be corrected promptly and reported to the charge nurse for further follow up. Findings of shift	

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F 241	Continued From page 2 interviewed. She stated she cared for Resident #199 on the 7:00 AM to 3:00 PM shift. The nurse stated leaving the resident's pants around his knees was a dignity issue and was uncomfortable since it restricted his legs if he tried to move them. The Director of Nursing (DON) 11/6/16 at 10:38 AM. The DON stated if Resident #199's brief was showing and his pants were to his knees, the pants should have been removed and the resident covered or the pants should have been pulled all the way up. She stated she saw leaving the resident's pants down as a dignity issue. She added staff were taught all residents were to be cared for by all staff and stated staff were not taught to leave outer pants down so the on-coming shift would know the resident had been provided care.	F 241	rounds will be documented on the "Nursing Aides Observational Rounds Report" located at each nurse station. The Director of Nursing, Assistant Director of Nursing, Nursing supervisors and/or Staff Development coordinator completed 100% education of all current nursing staff (licensed nurses & certified nursing assistants), to include full time, part time and as needed employees. This education will be completed by 12/3/2016. This education will cover nursing assistant's responsibility for resident dignity, respect, safety, and proper positioning of clothing. It will also emphasize on ensuring shift rounds are completed at the beginning of each shift and documented on nursing aide observational round tool. Any nursing staff not educated by 12/03/2016 will not be allowed to work until educated. This education will be provided annually for all licensed nurses and nursing assistants and will be added to the new hire orientation packet effective 12/03/2016. Monitoring Process Effective 12/05/2016 The Director of Nursing, Assistant Director of Nursing, Staff Development coordinator and/or Nurse Supervisors will monitor compliance by completing facility rounds to check on each resident daily (Monday - Friday) for two weeks, to ensure each resident is dressed in a manner that maintain his/her dignity, while respecting resident choice and individuality. The rounds will then be reduced to cover 50%	

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F 241	Continued From page 3	F 241	of the facility population, selected randomly, completed daily (Monday through Friday) for two more weeks. With the pattern of compliance noted after four weeks for monitoring, The Director of Nursing, Assistant Director of Nursing, Staff Development coordinator and/or Nurse Supervisor will pick 10 random residents and monitor once weekly for four weeks, then monthly for three months. Any negative findings identified during this monitoring process will be corrected promptly. This monitoring will be documented on “Dignity and Respect monitoring tool”. Effective 12/05/2016 The Director of Nursing, Assistant Director of Nursing, Staff Development coordinator and/or Nurse supervisor will monitor compliance by completing interviews for five random nursing assistants daily (Monday - Friday) for two weeks, then five interviews 3x/week for 2 more weeks, then five interviews per weeks for four more weeks and/or until the pattern of compliance is maintained. This interview will consist of 4 questions asked to each interviewee to ensure awareness of unacceptable practices in relation to dignity and respect in the facility. Any negative findings identified during this monitoring process will be corrected promptly by re-education and counseling when applicable. This monitoring will be documented on “Dignity and respect Staff interview tool”. Effective 12/05/2016 The Director of Nursing and/or Assistant director of Nursing will report findings of the dignity	

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F 241	Continued From page 4	F 241	and respect monitoring process to the next scheduled Quality Assurance and Performance Improvement Committee meeting monthly for discussion and review x three months or until a pattern of compliance is achieved for three consecutive months.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide maintenance services necessary to maintain a homelike environment by not keeping rooms painted and by not keeping the walls, furniture and toilets in good repair for 5 of 16 resident rooms observed. Findings included: 1. On 11/08/16 at 3:00 p.m., an observation of Room #507 revealed the following: a. The wall to the right of the A bed with nine areas of white spackling which did not match the paint color of the room. 2. On 11/08/16 at 4:10 p.m., an observation of the bathroom in Room #408 revealed the following: a. The baseboard underneath the sink to be pulling away from the wall. b. The lid to the toilet removed from the toilet and placed on the floor against the wall behind the toilet to the left of the toilet. 3. On 11/08/16 at 4:05 p.m., an observation of	F 253	Immediate Action No resident was named in this deficiency. Rooms 507, 408, 409, 411, 204, and 508 were repaired by the maintenance director on 11/10/16. Room 507 was patched by the maintenance director to match the paint color of the rest of the room on 11/10/16. In room 408, the maintenance director secured the bathroom baseboard to the wall, installed a new toilet lid, and removed the previous toilet lid on 11/10/16. The maintenance director repainted the adjoining bathroom door frame and wall, during survey 11/10/16, for room 409 and 411. On 11/10/16, the maintenance director repaired the wall in room 204 and painted over the areas of paint that were noted to be peeling. Identification of Others The maintenance director completed a 100% facility audit, as of 12/2/2016, for	12/6/16

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F 253	Continued From page 5 the bathroom adjoining Room #409 and #411 revealed the following: a. The door frame to be scratched and marred b. Scuffed walls with missing paint under the light switch c. Missing paint on the wall to the right of the door to room 411 4. On 11/08/16 at 3:22 p.m., an observation of the bathroom in Room #204 revealed the following: a. The wall area directly above the backsplash of the sink to be cracked and in need of repair. b. Two areas of peeling paint on the wall to the left of the sink. 5. On 11/08/16 at 4:30 p.m., an observation of Room #508 revealed the following: a. A 3-drawer dresser closest to the window to be marred with scratches b. The top of the 3-drawer dresser closest to the window set askew from the base of the dresser and not firmly attached to the base of the dresser. During an interview with the Maintenance Director (MD) on 11/10/16 at 10:45 a.m., the MD stated he was the only person who worked in the Maintenance Department at the facility. The MD stated he did not inspect the rooms to see if they were in need of repair. The MD stated he relied on staff such as housekeeping and nursing to inform him when repairs were needed. During an interview with the Administrator on 11/10/16 at 4:15 p.m., the Administrator stated it was his expectation the facility be maintained in a sanitary, orderly and comfortable manner.	F 253	resident room needs related to: paint needs, wall repair, toilet repair, and furniture repair. The maintenance director identified these needs and is in the process of repairing them as of 12/2/2016. Systemic Changes Effective 12/2/2016, the facility has implemented a service request log to be located at all nursing stations. The maintenance director will check these logs Monday-Friday, complete the requested service, and initial to acknowledge the completion of the job. All staff will be in serviced as of 12/2/2016 on the location and utilization of these service request logs. Any staff members not in serviced by 12/2/2016 will be required to report to supervisor for in-service training prior to being permitted to work. Monitoring process These service logs will be presented by the maintenance director at the monthly quality assurance meeting for discussion and review. The quality assurance team will review for completion of these logs and discuss and update as needed.	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		12/6/16

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F 278	Continued From page 6 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 5 of 26 residents reviewed to include therapy, dental, behaviors and infections (Residents #168, #140, #61, #199 and #133). Findings included: 1. a. Resident #168 had been admitted to the facility on 5/10/2016. Admission diagnoses included closed fracture of the right femur, hypertension and schizophrenia. Resident #168 '	F 278	Immediate Action taken for those resident(s) named to be affected by this alleged deficient practice: 1. Resident #168 Resident #168 is no longer in the facility 2. Resident #133 Minimum Data Set dated 10/01/16 was modified/corrected by MDS Nurse #2 on 11/20/16 to indicate in Question L0200,	

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F 278	Continued From page 7 s admission MDS assessment dated 5/17/2016 indicated he had received Physical Therapy (PT) starting on 5/10/2016 and Occupational Therapy (OT) starting on 5/11/2016. Record review indicated he had received PT and OT services through 8/05/2016. A discharge return anticipated MDS assessment was dated 8/05/2016. The discharge MDS did not indicate Resident #168 had received skilled therapy services. An interview with MDS Nurse #1 was conducted on 11/09/2016 at 2:44 PM. The nurse stated therapy start and end date information should have been included on the MDS discharge assessment. An interview with the Director of Nursing (DON) was conducted on 11/10/2016 at 4:00 PM. The DON stated the MDS assessment should be accurate and include the information about therapy start and end dates. b. Resident #168 had been admitted to the facility on 5/10/2016, discharged return anticipated on 8/05/2016 and readmitted on 8/07/2016. Admission diagnoses included closed fracture of the right femur, hypertension and schizophrenia. Resident #168 ' s admission MDS assessment dated 5/17/2016 indicated he had received Physical Therapy (PT) starting on 5/10/2016 and Occupational Therapy (OT) starting on 5/11/2016. Record review indicated he had received PT and OT services through 8/08/2016. A discharge return not anticipated MDS assessment was dated 8/09/2016. The discharge MDS did not indicate Resident #168 had received skilled therapy services. An interview with MDS Nurse #1 was conducted on 11/09/2016 at 2:44 PM. The nurse stated therapy start and end date information should have been included on the MDS Discharge	F 278	that resident had no natural teeth. The modified assessment transmitted on 11/30/16 by MDS nurse #2 3. Resident #140 Resident #140 is no longer in facility. 4. Resident #199 Minimum Data Set dated 11/1/16 was modified/corrected by MDS Nurse #1 on 11/15/16 to indicate the presence of behaviors in section E of MDS 3.0. The modified assessment was transmitted on 11/19/16 by MDS nurse #1. 5. Resident #61 Minimum Data Set dated 10/5/16 was modified/corrected by MDS Nurse #1 on 11/10/16 to indicate the active diagnosis of Amoxicillin resistant staphylococcus aureus (MRSA) in section I and Isolation in section O of MDS 3.0. The modified assessment was transmitted on 11/10/16 by MDS nurse #1. Identification of other resident having potential to be affected by the same deficient practice: All residents have potential to be affected. 100% audit of all active residents most recent MDS assessment was conducted by MDS Nurse #1 and #2 on 12/01/2016, 12/02/16 and 12/03/2016 to ensure resident's behaviors are coded correctly in section E, ambulation status coded appropriately in section G, active diagnoses coded appropriately in section I, Oral/Dental status in question L0200 and isolation coded appropriately in section O per RAI guideline. The behavior audit for Section E revealed 12 other assessments were coded	

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F 278	Continued From page 8 assessment. An interview with the Director of Nursing (DON) was conducted on 11/10/2016 at 4:00 PM. The DON stated the MDS assessment should be accurate and include the information about therapy start and end dates. 2. Resident #133 was re-admitted to the facility on 10/31/16 with diagnoses that included left hemiplegia and right hemiparesis and contractures of her hands. Review of the annual Minimum Data Set (MDS) dated 10/1/16 indicated Resident #133 was cognitively intact. She was also identified totally dependent on staff for personal hygiene. The resident was not identified as having any dental problems including no natural teeth or tooth fragments. On 11/7/16 at 2:41 PM, the resident was interviewed. She stated she had no natural teeth and at the present time, had no dentures, since they had been broken by a family member. The resident opened her mouth and revealed she was edentulous. MDS nurse #1 and MDS nurse #2 were interviewed on 11/10/16 at 1:50 PM. They stated prior to coding the dental section of the MDS the information would be verified by observation and interview. MDS nurse #1 stated on her review, there were no nurse's notes that indicated Resident #133 had no natural teeth. MDS #2 observed Resident #133 at this time and reported the resident had a few teeth, but they were broken at the gum level. She added based on her observation, the coding for dental status was	F 278	incorrectly. The ambulation status audit for Section G revealed 0 other assessments were coded incorrectly. The audit of dental status for L0200 revealed 8 other assessments were coded incorrectly. The isolation status audit for Section I revealed 1 other assessments were coded incorrectly. Identified incorrect coding corrected/modified and transmitted by MDS nurse #1 and MDS nurse #2 on 11/10/16, 11/19/16, 11/30/16 and 12/2/16. 100% audit for all resident discharged from the facility in the last 6 months 05/01/2016 to 11/30/2016 audited by MDS nurse #1 and MDS nurse #2 on 11/10/16, 11/19/16, 11/30/16 and 12/1/16 to ensure that any resident who received skilled rehabilitation services while a resident in the facility, is coded appropriately as received such services on a discharge assessment per RAI guidelines. 6 other discharge assessments identified to be coded incorrectly. No correction or modification required as these residents are no longer in the facility per RAI guidelines. Findings of this audit is documented on “Discharge MDS audit tool” Measures put into place or systemic changes made to ensure the alleged deficient practice will not re-occur: Regional Clinical Director revised the MDS data collection tool on 12/02/2016.	

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F 278	Continued From page 9 not accurate. She stated she had coded the MDS to reflect no problems since Resident's #133's broken teeth were not readily obvious. 3. Resident #140 was admitted to the facility on 7/18/16 with a diagnosis that included a muscular impairment. Review of the Admission Minimum Data Set (MDS), dated 7/25/16, revalued the resident was cognitively intact with no behaviors. The MDS indicated the resident was able to ambulate with assistance; although, balance was coded to indicate the resident could only maintain balance during transition and walking without staff assistance. He was coded as having a functional limitation in range of motion affecting his bilateral lower extremities. MDS nurse #1 and MDS nurse #2 were interviewed on 11/10/16 at 1:50 PM. The nurses stated ambulatory status was determined by observation and review of the nursing assistant (NA) documented information that reflected the resident's abilities to perform activities of daily living. MDS nurse #1 stated she remembered Resident #140 and knew that due to his disease he was unable to walk. She reviewed NA documented information and stated several NAs had coded the resident was able to walk. MDS nurse #1 added regardless of NA information, the MDS was to be accurate and reflect the resident's actual abilities. She confirmed the MDS did not accurately reflect Resident #140's ability to ambulate. 4. Resident #199 was admitted on 10/25/16 with diagnoses that included acute left parietal stroke and moderate to severe dementia.	F 278	Effective 12/05/2016 MDS Nurse #1 & 2 will utilize revised data collection tool to collect all necessary information needed for accurate coding of MDS assessment. This tool will be maintained in a designated area in the facility for 15 months with other MDS materials. The MDS nurse #1 and #2, Certified Dietary Manager, Director of Social Services and Activities Director were educated by the Regional MDS Consultant on 12/02/2016, regarding accurate completion of MDS assessment according to RAI guidelines. Monitoring Process Effective 12/05/2016, prior to submission, MDS nurse #1 will review completed MDS Assessment by MDS Nurse #2 likewise, MDS nurse #2 will review completed MDS Assessment by MDS Nurse #1 each MDS assessment is coded accurately and per RAI guidelines. These reviews will take place for 4 weeks on all completed MDS assessments prior to submission, 50% of all completed MDS assessments prior to submission for 2 more weeks, then 25% of all completed MDS assessments prior to submission for 2 more weeks or until compliance is achieved. Findings from this monitoring process will be corrected promptly per RAI guidelines and reported to the Administrator for further follow ups. This audit will be documented on “MDS monitoring tool”	

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The 11/1/16 Admission Minimum Data Set (MDS) indicated the resident had impaired cognition with severely impaired cognitive skills for daily decision making. The resident was not identified as having behaviors or rejecting care. Staff assessment of the resident's mood did not identify any problems.

Review of staff progress notes during the assessment period for the MDS, dating from 10/26/16 through 11/1/16 revealed staff had documented the following behaviors for Resident #199: combativeness, spitting out food and medications, having hallucinations, disrobing, insomnia, short tempered, cross demeanor and disagreeable.

MDS nurse #1 and MDS nurse #2 were interviewed on 11/10/16 at 1:50 PM. They stated the behavior and mood section of the MDS was coded by the Social Worker (SW). MDS nurse #2 stated the SW would be expected to utilize staff progress notes and behavior logs and interviews with staff to gain the information needed to code the behavior section of the MDS. MDS #1 and MDS #2 reviewed staff progress notes for the assessment period and confirmed the MDS was not accurate for Resident #199.

The SW was interviewed on 11/10/16 at 2:42 PM. She acknowledged she was responsible for coding the behavior section of the MDS. The SW stated she reviewed information staff had documented in the electronic medical record and reviewed behaviors sheets for the resident. The SW reviewed the notes for Resident #199, written during the assessment period and reviewed the information she had coded on the resident's

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F 278	Continued From page 11 admission MDS. The SW acknowledged based on the documentation of staff she had not accurately coded the MDS. She added missing the documented behaviors was an error. 5. Resident #61 was readmitted to the facility on 9/28/16 with a Amoxicillin resistant staphylococcus aureus (MRSA) infection. Review of his admission MDS, dated 10/5/16, did not capture the infection as an active disease. MDS nurse #1 and MDS nurse #2 were interviewed on 11/10/16 at 1:50 PM. The nurses stated MRSA was coded when determined by a lab report, physician note or hospital discharge. The nurses acknowledged Resident #61 was admitted on contact isolation and remained on contact isolation. MDS #1 and MDS #2 reviewed the admission MDS and acknowledged MRSA and his isolation status had been omitted for Resident #61 and therefore, the MDS was not accurate.	F 278		
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. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide incontinent care to 2 of 4 dependent residents (Resident #36	F 312	F312 Immediate Action Resident #36 and Resident #77 were	12/6/16

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F 312	Continued From page 12 and Resident #77) reviewed for care. Findings included: 1. Resident #36 was admitted to the facility on 6/26/14 with diagnoses that included Parkinson's disease. The 7/3/16 care plan indicated Resident #36 was at risk for skin irritation related to incontinence of bowel and bladder, at risk for pressure ulcer due to incontinence and required assistance with activities of daily living. Interventions included offering toilet assistance during care rounds and providing prompt pericare after each incontinent episode. The 10/6/16 Minimum Data Set (MDS) indicated Resident #36 was cognitively intact with no behaviors. The resident was identified as requiring extensive assistance with toilet use and personal hygiene. He was coded as frequently incontinent of bowel and bladder. On 11/9/16 at 8:15 PM, Resident #36 was observed sitting by the nurse's station in his wheelchair. A large, dinner plate sized yellow stain was seen on his white t-shirt extending from the waistband of his pants up. On interview the resident stated it must be urine because he did not know what else it could be. At 8:20 PM on 11/9/16, Nurse #7 was interviewed while at the nurse's station approximately 8 feet from the resident. She stated she had not noticed Resident #36's yellow stained shirt. At 8:40 PM an observation was made of the resident receiving incontinent care from Nursing	F 312	provided incontinent care on 11/9/16 by nursing assistant #12. Identification of Others A 100% facility audit was conducted on 12/2/16 by DON, ADON, and SDC to identify other residents who may have been affected by this practice. Identified 1 resident and incontinent care was provided by Nursing Assistant on duty on 12/2/2016 Measures put into place or systemic changes made to ensure the alleged deficient practice will not re-occur: All CNA staff were in serviced on 11/7/16, 11/16/16, 11/21/16 and 11/28/16 by the DON, ADON, and SDC regarding the completion of observational rounds to include incontinent care for residents. The observational tool, used by CNAs and requiring signatures of ongoing and off going CNAs, now requires attention to incontinent care. Monitoring process Effective 12/2/16, DON, ADON, and SDC will audit these observational rounding tools daily for three months and weekly thereafter . Findings will be presented at the monthly quality assurance meeting for discussion and review.	

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Assistant (NA) #12. The NA reported in addition to the resident's shirt being wet, his pants were wet and his brief was saturated with urine. On removal of the brief, there was a heavy smell of urine. The NA stated she had last checked Resident #36 for incontinence between 4:00 PM and 4:30 PM. Between 5:00 PM and 7:00 PM she had passed dinner trays and had assisted in feeding residents. The NA had no reason why the resident was not provided incontinent care between 7:00 PM and 8:40 PM.

During an interview with the Administrator at 9:00 PM, he stated staff had informed him of the incident with the resident. The Administrator stated no matter the excuse, the lack of incontinence care was unacceptable.

The Staff Development Coordinator (SDC) was interviewed on 11/10/16 at 10:08 AM. The facility had an expectation for residents to be provided incontinent care every 2 hours and as needed. She added it was never acceptable to wait 4 hours to check a resident for incontinence. The SDC stated the risk of leaving a resident wet with urine for long periods of time would be skin breakdown.

The Director of Nursing (DON) was interviewed on 11/10/16 at 10:30 AM. She stated she expected residents to be checked for incontinence at a minimum every 2 hours. The DON added residents should not be left wet to the point their pants were wet or shirts discolored from urine. The DON stated she had been made aware of how Resident #36 had been found the previous night and she was trying to determine the root cause.

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Resident #36 was interviewed on 11/10/16 at 4:00 PM. He stated it bothered him a little to be wet, but not a lot. The resident stated he was not always aware when he had been incontinent.

2. Resident #77 was admitted to the facility on 2/2/14 with diagnoses that included dementia, and contractures of the right and left hand.

The 6/10/16 care plan indicated the resident required assistance with activities of daily living due to muscle weakness, cognitive impairment and impaired mobility. The staff were instructed to provide assistance with toilet use, personal hygiene as needed.

The 10/13/16 quarterly Minimum Daily Set identified the resident cognitively impaired and requiring extensive assistance with toilet use and personal hygiene. He was coded as always incontinent of bowel and bladder.

On 11/9/16 at 8:15 PM, the resident was observed sitting by the nurse's station in his wheelchair. The resident's pants were observed to be wet from the crotch area up to the waist band of his pants.

At 8:20 PM on 11/9/16, Nurse #7 was interviewed while at the nurse's station. Nurse #7 stated she had not noticed the resident's pants were wet.

At 8:30 PM on 11/9/16, an observation was made of the resident receiving incontinent care from Nursing Assistant (NA) #12. The NA verified the resident's clothing was wet and his brief was saturated with urine. On removal of the brief, there was a heavy smell of urine. The NA stated she had last checked Resident #77 for

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F 312	Continued From page 15 incontinence between 4:00 PM and 4:30 PM. Between 5:00 PM and 7:00 PM she had passed dinner trays and had assisted in feeding residents. The NA had no reason why the resident was not provided incontinent care between 7:00 PM and 8:30 PM. During an interview with the Administrator at 9:00 PM, he stated staff had informed him of the incident with Resident #77. The Administrator stated no matter the excuse, the lack of incontinence care was unacceptable. The Staff Development Coordinator (SDC) was interviewed on 11/10/16 at 10:08 AM. The facility had an expectation for residents to be provided incontinent care every 2 hours and as needed. She added it was never acceptable to wait 4 hours to check a resident for incontinence. The SDC stated the risk of leaving a resident wet with urine for long periods of time would be skin breakdown. The Director of Nursing (DON) was interviewed on 11/10/16 at 10:30 AM. She stated she expected residents to be checked for incontinence at a minimum every 2 hours. The DON added residents should not be left wet to the point their pants were wet or shirts discolored from urine. The DON stated she had been made aware of how Resident #77 had been found the previous night and she was trying to determine the root cause.	F 312		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		12/6/16

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F 371	Continued From page 16 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 and interviews the facility 1) failed to maintain a sanitary kitchen when 2 dietary staff did not wear beard covers while working in the food service area, 2) failed to maintain 2 of 4 nourishment refrigerators in a clean condition and have food items labeled with a date and 3) failed to monitor temperatures in 2 of 4 nourishment refrigerators by not having a thermometer present in the refrigerator. The findings included: 1) During an observation on 11/07/16 at 10:15 AM Dietary Aide #1 was observed removing the clean dishes from the dish washing machine. He had a beard just below his bottom lip and a mustache. He was not wearing a beard cover. On 11/10/16 at 11:21 AM the Assistant Food Service Manager was observed working in the kitchen. He had a mustache and a beard. He was observed taking temperatures of the food items on the tray line and he was not wearing a beard cover. The Food Service Manager (FSM) was interviewed. She stated the staff who have beards should wear beard covers. 2) During an observation of the 200 hall nourishment refrigerator on 11/10/16 at 3:45 PM there were 2 containers of orange juice observed with thick dried orange colored rings under each	F 371	Immediate Action taken for those resident(s) named to be affected by this alleged deficient practice: 1) Dietary aide #1 and the assistant food service manager began wearing beard covers immediately upon notification on 11/10/2016. On 11/10/2016 Charge nurse #1, Charge nurse # 2 & charge nurse #3 immediately cleaned, and discarded undated sandwiches from 300 hall refrigerator and open orange juice with dried orange colored ring from 200 hall refrigerators. On 11/10/2016 Food service Manager cleaned the dried sticky orange colored streaks of the back wall of the 100 hall refrigerator, and discarded all open items with no dates off the 100 hall refrigerator. On 11/10/2016, the maintenance director installed thermometers in nourishment refrigerators on 100 and 200 hall. On 11/10/2016 Food Services Manager put in place temperature logs to ensure compliance with refrigerator temperature requirements. Identification of other resident having potential to be affected by the same	

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F 371	Continued From page 17 container. During an observation on 11/10/16 at 3:50 PM the 300 hall nourishment refrigerator contained sandwiches but there was no date label on them indicating when they had been placed in the refrigerator. Nursing Assistant (NA) #8 stated she was not sure who was responsible for monitoring the refrigerators. An observation of the 100 hall nourishment refrigerator on 11/10/16 at 3:55 PM with the Food Service Manager revealed dried sticky orange colored streaks down the back wall of the refrigerator. The refrigerator also contained opened food items which were not labeled with a date. On 11/10/11 at 3:57 NA #9 stated the items in the refrigerator should be labeled with the date and the name of the person the food items belong to. She stated the 3rd shift nursing staff were responsible for cleaning the refrigerators. 3) During the observations of the nourishment refrigerators with the Food Service Manager (FSM) on 11/10/16 no thermometers were present in the 100 & 200 hall refrigerators. There were no temperature monitoring logs for any of the 4 nourishment refrigerators. The FSM stated she was not sure why there were no thermometers in 2 of the refrigerators or why there were no temperature monitoring logs. During an interview with the Director of Nursing on 11/10/16 at 4:23 PM she stated she was aware that nursing was responsible for the medication refrigerators but she was not sure who was responsible for the nourishment refrigerators.	F 371	deficient practice: On 11/10/2016 Nursing staff checked all five nourishment refrigerators, used for residents food storage in the facility, for cleanliness, presence of thermometers, temperature logs and to determine whether food items in each refrigerator is labeled with a date. Findings of this audit include; four of five refrigerators noted to be in need of cleanliness, no other food items other than those identified above noted in any of the five inspected refrigerators. All other refrigerators other than two identified earlier noted to have working thermometers in place. On 11/10/2016 nursing staff cleaned all five refrigerators and discarded any item with no date. On 11/10/2016, the maintenance director installed thermometers in nourishment refrigerators on 100 and 200 hall. On 11/10/2016 Food Services Manager put in place temperature logs to ensure compliance with refrigerator temperature requirements. The Food services manager inspected all staff on duty on 11/10/16 to identify any other staff with a beard that needed to be covered while on duty that day. No other staff member was identified to be on duty who needs his/her beard covered while on duty. Measures put into place or systemic changes made to ensure the alleged deficient practice will not re-occur: On 11/11/2016 a weekly refrigerator cleaning schedule assignment was added to night shift nursing staff responsibility	

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F 371	Continued From page 18	F 371	list. The cleaning of refrigerators will be initialed as completed and reviewed daily by Staff development coordinator and/or food services manager. On, 11/16/16 thru 11/28/16 the Director of Nursing, assistant director of nursing, staff development coordinator and/or food service manager completed 100% education with the nursing staff and dietary staff. Education included proper dating of items, discarding undated, expired, spoiled items, and ensuring nourishment refrigerators are kept cleaned, and the refrigerator temperature are monitored and recorded daily. This education will be given to all active full time, part time and as needed nursing and dietary staff. 100% of this education will be completed by 12/3/2016. Any nursing or dietary staff not educated by 12/03/2016 will not be allowed to work until educated. This education will also be provided annually for all licensed nurses, nursing assistants and dietary staff. The education will be added to the new hire orientation process for nursing and dietary staff effective 12/03/2016. Monitoring Process Effective 12/2/2016; the food services manager, head cook and/or Staff development coordinator will monitor and observe the use of beard nets by dietary employees with facial hair daily for four weeks, 3x/week for four more weeks, then weekly afterwards on an ongoing basis to ensure compliance with covering of facial hair while on duty	

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F 371	Continued From page 19	F 371	Effective 12/2/2016; the food services manager will conduct sanitation inspection (Monday-Friday) for four weeks, 3x/week for four more weeks, then weekly afterwards on an ongoing basis to ensure compliance with food storage and sanitation of dietary department including resident nourishment refrigerators is maintained. This inspection will also monitor competition of temperature logs, dating open items in nourishment refrigerator and presence of the functioning thermometer in each nourishment refrigerator. Effective 12/02/2016; The Registered Dietician will complete a sanitary inspection on their monthly visit to ensure compliance with food storage and sanitation of dietary department including resident nourishment refrigerators. Findings of this inspection will be addressed promptly and results given to the Administrator for further follow ups. The Food Service Manager will report findings of noncompliance to Administrator immediately upon occurrence. The results of the Food services manager daily inspection and the registered dietician monthly inspection will be reviewed in Quality Assessment and Improvement (QAPI) monthly for 6 months at which that time the QAPI committee will determine the need for furthering monitoring.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		12/6/16

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F 441	Continued From page 20 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. (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 observations, staff interviews and	F 441	Immediate Action taken for those	

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F 441	Continued From page 21 record review, the facility failed to wear gloves when entering a resident's room on contact isolation (Resident #) and failed to wash hands before leaving the room and prior to serving meals to another resident (Resident #) during 1 of 2 meal observations. Findings included: Resident #61 was readmitted to the facility on 9/28/16 with methicillin resident staphylococcus aurerus (MRSA) of a wound. The resident had a contact isolation sign on his door and a personal protective equipment cart by his door that held gloves, gowns and masks. During the lunch observation on 11/7/16 at 11:40 PM, Nursing Assistant (NA) #2 was observed serving food to Resident # 61. While not wearing gloves, the NA, with her bare hands pushed the resident's over bed table closer to the bed and opened the containers. Without washing her hands, NA #2 proceeded back to the lunch cart and carried a tray into Resident #121's room. She prepared the resident's lunch, touching his bread with her bare hands, left the room, again, not washing her hands and returned to the lunch cart to continue passing trays. At 12:12 PM on 11/7/16, NA #2 was interviewed. She stated Resident #61 was on isolation, but since she was only delivering his meal tray and not providing patient care, she did not have to wear gloves. The NA was insistent to recreate the events, went in Resident #61's room, again without gloves, touched his over bed table again and left the room again without washing her hands. At this time, NA #2 acknowledged since she had touched objects used by Resident #61	F 441	resident(s) named to be affected by this alleged deficient practice: Resident #61 is no longer on contact isolation Three members of infection control committee (Director of Nursing, Assistant Director of Nursing and Staff Development coordinator) reassessed resident #61 on 11/10/2016 to determine any need for continuous isolation. The committee concluded that, resident #61 no longer needed contact isolation as the infection was contained. Staff Development coordinator notified the Attending Physician on 11/10/2016, and contact isolation discontinued. Resident #121 not receiving food from a staff member who has not washed their hand any longer, resident #121 was not affected by this alleged deficient practice Nursing Assistant #2 (NA #2), caring for resident 61, on 11/07/2016 was in serviced regarding infection control protocol when serving a meal to residents on isolation by the Director of Nursing on 11/7/2016. Identification of other resident having potential to be affected by the same deficient practice: 100% of residents on isolation observed by the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator on 11/10/2016 during dinner meal service to determine if any other employee failed to use proper Personal Protective equipment's (PPE), and to ensure employee wash hands before delivering meals to another	

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F 441	Continued From page 22 she should have used gloves and washed her hands prior to serving other resident's their lunch. The NA stated she had touched Resident #121's bread with her unwashed hands. She stated she had been taught not to touch resident's food with bare hands and had just forgotten During an interview with the Director of Nursing (DON) on 11/10/16 10:51 AM, she stated staff were taught to wear a minimum of gloves when delivering meal trays to residents on isolation. She stated when staff entered a resident's room, there was no guarantee staff would not come in contact with the resident or articles used by the resident, such as the over bed table. The DON stated regardless of staff using gloves or not, she expected hands to be washed prior to leaving the room. She added NA #2's behavior of not washing her hands prior to serving other residents and touching other resident's food with unwashed hands was unacceptable. The Staff Development Coordinator (SDC) was interviewed on 11/10/16 at 11:21 AM. The SDC stated she expected staff delivering meals to a resident on isolation to use a gown and gloves when entering the room, since the staff person may end up providing care while in the room. She stated staff were also taught to wash hands prior to leaving a room and were taught not to touch resident ' s food with bare hands.	F 441	resident. No other residents on isolation were noted to have been affected by this practice. Findings of this observation is documented on “Dining Practices Monitoring tool” Measures put into place or systemic changes made to ensure the alleged deficient practice will not re-occur: Effective 12/02/2016 the facility appointed a registered nurse to work as an infection control practitioner responsible to oversee the infection control program. The infection control practitioner will work with the interdisciplinary team to determine whether a resident should be on isolation or not. Effective 12/02/2016, the facility utilizes Center of Disease Control (CDC) approved isolation signs that specify type of precaution and proper PPE to be utilized by care giver. Signs are posted on a visible location outside resident’s room for all residents on isolation. On, 11/16/16 thru 12/03/16 the Director of Nursing, assistant director of nursing, and/or staff development coordinator completed 100% education with the nursing staff. Education included facility infection control protocol, utilization of Personal Protective Equipment, universal precautions, and how to properly care for residents on isolation with emphasis on Hand washing. This education will be given to all active full time, part time and as needed nursing staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 23	F 441	100% of this education will be completed by 12/3/2016. Any nursing staff not educated by 12/03/2016 will not be allowed to work until educated. This education will also be provided annually for all licensed nurses, nursing assistants and dietary staff. The education will be added to the new hire orientation process for nursing and dietary staff effective 12/03/2016. Monitoring Process Effective 12/05/2016, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator will complete infection control rounds daily (M-F) for 4 weeks, then Weekly x four more weeks then monthly afterwards for three months or until the pattern of compliance is maintained. Infection control rounds will monitor staff compliance with hand washing, and the compliance with the use of PPEs especially for residents on isolation. Any negative finding will be addressed promptly. Findings of the infection control rounds will be documented in “Infection Control monitoring tool” Effective 12/05/2016; the facility will conduct the infection control committee meeting monthly do discuss infection occurrences in the facility, staff compliance with hand washing, uses of PPEs and Isolation. This meeting will be led by the infection control practitioner and attended by interdisciplinary team to include Nursing administrative staff as well as front line staff in particular nursing assistants.	

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F 441	Continued From page 24	F 441	Effective 12/05/2016; The Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator will report findings of the infection control rounds in Quality Assurance and Performance Improvement (QAPI) monthly for six months at which that time the QAPI committee will determine the need for furthering monitoring.	