STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING _____ B. WING _____	C 01/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to evaluate a resident ' s request for a motorized wheelchair that would allow the resident to have independence for locomotion throughout the facility for 1 of 1 resident requesting a motorized wheelchair (Resident #95). The findings included: Resident #95 was admitted to the facility on 01/20/16 with diagnoses that included chronic obstructive pulmonary disease and bilateral shoulder osteoarthritis. The most recent Minimum Data Set (MDS) dated 10/24/16 specified the resident's cognition was intact and she required 1 person assistance for locomotion of her wheelchair. On 01/03/17 at 11:10 AM Resident #95 was interviewed in her room. At the conclusion of the interview, Resident #95 asked if it was true that motorized wheelchairs were not allowed in the	F 246	F246 SSD 483.15(e)(1) This plan of correction is the facility's credible allegation of compliance. Resident #95 's family brought motorized wheelchair from home on 1/19/2017. She was assessed by therapy for safety and is currently on caseload for training and safety awareness for wheelchair safety. All staff were educated to promptly report any special requests by residents or responsible parties to the Administrator or DON immediately. Interview was conducted of current residents or responsible parties for other preferences to identify individual needs, preferences and accommodation of special equipment and changes in place of care made accordingly. Letter was sent out to families and reviewed with alert and oriented residents to notify residents and families of resident□s right to have special	2/3/17

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

Electronically Signed | 02/01/2017

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F 246	Continued From page 1 facility. The Resident reported that she had a motorized wheelchair at home and asked if she could have it in the facility and was told, "No." Resident #95 added that she was unable to propel her wheelchair because of her shoulders and was subsequently dependent on a staff member to push to her various out room activities. Resident #95 stated having her motorized wheelchair would, "give her freedom again and improve her quality of life." On 01/04/17 at 10:18 AM staff were observed pushing Resident #95 in her wheelchair to the activity room. On 01/05/17 at 4:15 PM the Director of Nursing (DON) was interviewed and reported that motorized wheelchairs were allowed as long as the resident was assessed to be safe to use one. The DON stated she was unaware Resident #95 had requested to have her motorized wheelchair in the facility and added Resident #95 would be safe to use one. On 01/05/17 at 4:16 PM the DON went to Resident #95 to ask her about the motorized wheelchair and Resident #95 told the DON she was told by the former Social Worker she could not have her motorized wheelchair. On 01/05/17 at 4:20 PM the Administrator was interviewed and explained the facility allowed motorized wheelchairs but had a process for evaluating a resident's ability to safely operate a motorized wheelchair in the facility. The	F 246	equipment along with the process of bringing in equipment for evaluation of safe use. Admissions will ask upon preadmit if resident has any special equipment needs. Director of Resident Services will continue to interview residents or responsible party on resident preferences and special equipment coinciding with the MDS schedule. The DON or Administrator will be made promptly aware of any special needs by the Director of Resident Services. Outcomes of interviews and follow-up actions will be reviewed monthly at the QAPI meeting x 3 months. Any identified changes needed to QAPI plan or continuance of plan will be modified accordingly by QAPI committee. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of state and federal law.	

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F 246	Continued From page 2 Administrator reported that if s request was made for a motorized wheelchair, she would expect to be notified so that a referral could be made to therapy. The Administrator was unaware of Resident #95's request for a motorized wheelchair. The Administrator offered no explanation why the former Social Worker would have told Resident #95 she could not have her motorized wheelchair but added the request should have been brought to the "morning meeting" for discussion. On 1/06/17 at 8:22 AM the former Social Worker was interviewed and stated he could not recall the conversation he had with Resident #95. He added that he thought electric wheelchairs were allowed in the facility. On 01/06/17 at 9:10 AM the Social Worker Assistant was interviewed and stated she was newly hired when Resident #95 was admitted to the facility but recalled the Resident asking about accessing her motorized wheelchair. The Social Worker Assistant reported that she was told the former Social Worker would handle the request.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 248		2/3/17

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F 248	Continued From page 3 by: Based on record observations, record reviews, family and staff interviews the facility failed to provide an individualized activity program for 1 of 3 sampled residents (Resident # 39). The findings included: Resident # 39 was admitted to the facility 11/18/13 with diagnosis that included severe right side paralysis, dysphagia, Hypertension, and depression disorder. The annual Minimum Data Set assessment dated 10/19/16 indicated that Resident # 39 had unclear speech and had some dementia and difficulty making decision concerning daily care. Resident # 39 required extensive assistance for bed mobility, personal care, and was dependent for transfers and bathing. Record review revealed an annual Activity summary dated 10/19/16 indicated Resident #39 spent most of time in room due to diagnosis of muscle weakness, cognitive deficit, and dysphagia. The summary further indicated Resident #39 had family visitors most days, chose own routine, and liked Western stories and Reader's Digest magazines. Resident #39 was noted to require maximum assistance to participate in activities and the resident would continue to be invited to activities and in room stimulations provided. A review of a care plan indicated Resident # 39 was at risk for Activity intolerance for late effects of Stroke. A goal on the care plan specified the resident was to attend activities that were brief or non-fatiguing once a week for 3 months. Another care plan goal stated the resident to propel self	F 248	F248 SS=D 483.15(f)(1) This plan of correction is the facility's credible allegation of compliance. A new activity plan was developed for Resident # 39 based on his current interests to provide in room activities four times per week. It includes but is not limited to music, wrestling and western movies. He will continue to be encouraged to attend out of room activities as well. Plan of care was updated to reflect these changes. Staff were educated on facilities expectation to provide sensory stimulation during and after care by providing conversation, opening blinds, turning on TV/ radio and setting up room per resident□s preference. "Audit was conducted of all current resident'□s activity plans and attendance records. A new attendance format was initiated to track activities. All resident□'s activities plan of care was reviewed and updated to provide residents with activities of individualized preference. Activity attendance logs will be monitored weekly by the Administrator and Activity Director for 1 month then monthly x 3 months. Results of audits will be reported to the QAPI Committee monthly x 4 months. Any identified changes needed to QAPI plan or continuance of plan will be modified	

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F 248	Continued From page 4 about facility daily and interact with peers. The interventions included on the resident's Activity Care Plan included; providing the activity schedule to Resident #39 and encouragement to engage in group activities. Another intervention on the care plan included initiation of conversation with resident as frequently as possible. The Care plan was reviewed 12/21/16 with no updated goals or interventions. A review of report of in-room visitation by activity staff revealed the resident had 1 10 minute visit the week of 10/31/16-11/5/16; 1 10 minute visit the week of 11/7/16-11/12/16; one visit for 10 minutes week of 11/14/16/-11/18/16; 1 visit for 10 minutes week of 11/21/16-11/28/16. Resident #39 was hospitalized between the dates of 11/28/16-12/9/16. The resident had no in-room visits by activity staff recorded for dates 12/12/16through 12/23/16 The report further revealed that Resident #39 had 2 visits the week of 12/27/16- 12/31/16 of 5 minutes and 6 minutes. On 1/3/17 at 3:49 p.m. an interview was conducted with one of Resident # 39's family members due to the resident's difficulty with speech. During the interview it was stated that the resident had been hospitalized in late November and had returned to the facility much weaker. The family member stated that Resident #39 was unable to attend activities and the family member was unable to recall any in-room activities since the resident returned to the facility. On 1/5/17 at 9:15 a.m. Resident #39 was observed lying in bed and the privacy curtain was pulled past three quarters the length of the bed, the lights in the room cut down low, and the	F 248	accordingly by QAPI committee. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of state and federal law.	

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television was off.

On 1/5/17 at 12:03 p.m. Resident #39 was observed lying in bed in the same position, the privacy curtain remained pulled past the resident's view to the room, the room remained in low light, and the television was off.

On 1/5/17 at 2:19 p.m. Resident #39 was observed sitting in bed with head tilted forward, blinds on window opened, but no television on. The resident was alone in room.

The Resident #39 was observed on 1/6/17 at 11:47 a.m. lying in bed in room with window blinds closed, lights in the room turned off, and the television turned off. The resident had no visitors.

On 1/4/17 at 4: 16 p.m. an interview was conducted with Nurse Aide (NA) #2 who stated that Resident # 39 required assistance with all activities of daily living. It was also stated that Resident #39 was able to be transferred into a chair but did not attend activities at this time due to increased weakness following hospitalization.

An interview was conducted on 1/4/17 at 4:30 p.m. with Nurse # 3 who stated the resident used to go outside with assistance from family when the weather was warmer. Nurse # 3 further stated the resident did attend activities at times but mostly interactions were provided by the resident's family in the room of Resident # 39.

On 1/5/17 at 2:26 p.m. an interview was conducted with Activities Director. During the interview it was stated that activities were provided for various levels of cognition, physical abilities, and based on interests of residents. It

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F 248	Continued From page 6 was further stated that if resident was unable to attend group activities, then in in-room activities and one on one visits were provided. The Activities Director stated that the facility had I-pods to use with residents. A review of the list of residents who had been assigned an I-pod did not include Resident #39. Another interview was conducted with Activities Director on 1/6/17 at 12:00 p.m. During the interview it was stated that Resident #39 had not been offered the use of an I-pod, a plan had not been put into place to assist the resident to use the I-pod to listen to music or stories. The Activities Director stated that the in-room visits that occurred with Resident #39 once a week were not adequate activity and that more could have been done to provide Resident #39 an individualize activity program.	F 248		
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 label resident's personal care items which included 2 hair brushes in the bathroom of resident room #207, an emesis basin in the bathroom of resident room #208, a plastic graduate used to measure liquids and emesis basis in the bathroom of resident room #314, a tube of toothpaste, a razor and soaps in the bathroom of resident room #401 and failed to	F 253	F253 483.15(h) (2) This plan of correction is the facility's credible allegation of compliance. Rooms #207,208,314,401,409 items were labeled accordingly and stored properly. All resident□s rooms were checked to	2/3/17

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F 253	Continued From page 7 label a can of shave cream and an emesis basin with a sink stopper on the top of it in the bathroom of resident room #409 (on 3 of 4 resident hallways); failed to repair smoke prevention doors with broken and splintered laminate and wood on the lower edges of the doors (on 4 of 4 resident hallways); failed to repair the double doors to the therapy department with broken and splintered laminate and wood on the lower edges of the double doors (on 1 of 4 hallways); failed to repair a loose toilet with a bolt missing and repair base molding that had pulled away from the wall next to the toilet in the bathroom of resident room #212 (on 1 of 4 resident hallways) and failed to repair base molding that had pulled away from the wall in the bathrooms of resident rooms #209 and #314 (on 2 of 4 resident hallways). The findings included: 1. a. Observations on 01/04/17 at 11:05 AM in the bathroom of resident room #207 revealed 2 hair brushes on a shelf under the mirror with no resident name on them. Observations on 01/04/17 at 4:25 PM in the bathroom of resident room #207 revealed 2 hair brushes on a shelf under the mirror with no resident name on them. Observations on 01/05/17 at 3:05 PM in the bathroom of resident room #207 revealed 2 hair brushes on a shelf under the mirror with no resident name on them. b. Observations on 01/03/17 at 11:10 AM the bathroom of resident room #208 revealed an emesis basin on a shelf under the mirror with no resident name on it. Observations on 01/04/17 at 4:26 PM in the	F 253	ensure all items for residents were labeled and stored properly. Staff was in-serviced on proper labeling and storage of resident personal care items. Management team was assigned rooms for monitoring. Rounds will be made three times weekly to assure compliance. Results of rounds will be given to Administrator and DON. DON will report results of rounds to QAPI Committee monthly x 3 months. Smoke prevention doors for 100, 200, 300, 400 halls and therapy room doors were sanded and repaired. Room # 212 commode and base molding was repaired. Base molding was repaired 209 and 314. Staff was educated to report any repairs needed to maintenance promptly and to write these in the communication book. All other doors in facility were inspected for rough spots and splintering that could cause safety concerns. All doors identified were repaired of rough spots and splintering. All facility toilets and base moldings were checked and repairs made accordingly. Maintenance director will conduct weekly rounds of doors, toilets and base molding with repairs made as needed weekly x 1 month then monthly x 3 months.	

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F 253	Continued From page 8 bathroom of resident room #208 revealed an emesis basin on a shelf under the mirror with no resident name on it. Observations on 01/05/17 at 3:07 PM in the bathroom of resident room #208 revealed an emesis basin on a shelf under the mirror with no resident name on it. c. Observations on 01/03/17 at 11:12 AM the bathroom of resident room #314 revealed a clear plastic graduate used to measure liquids and an emesis basin with no resident name on them. Observations on 01/04/17 at 4:28 PM in the bathroom of resident room #314 revealed a clear plastic graduate used to measure liquids and an emesis basin with no resident name on them. Observations on 01/05/17 at 3:09 PM in the bathroom of resident room #314 revealed a clear plastic graduate used to measure liquids and an emesis basin with no resident name on them. d. Observations on 01/03/17 at 12:30 PM in the bathroom of resident room #401 revealed a tube of toothpaste, soaps and a razor with the blade uncovered on a shelf under the mirror in the bathroom had no resident name on them. Observations on 01/04/17 at 4:29 PM in the bathroom of resident room #401 revealed a tube of toothpaste, soaps and a razor with the blade uncovered on a shelf under the mirror in the bathroom had no resident name on them. Observations on 01/05/17 at 3:12 PM in the bathroom of resident room #401 revealed a tube of toothpaste, soaps and a razor with the blade uncovered on a shelf under the mirror in the	F 253	Results of audits and repairs made will reviewed by the QAPI Committee monthly x 4 months. Any identified changes needed to QAPI plan or continuance of plan will be modified accordingly by QAPI committee. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of state and federal law.	

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bathroom had no resident name on them.

e. Observations on 01/03/17 at 12:35 PM in the bathroom of resident room #409 revealed a can of shave cream and an emesis basin turned bottom up with a sink stopper on top of it on a shelf under the mirror in the bathroom had no resident name on them.

Observations on 01/04/17 at 4:30 PM in the bathroom of resident room #409 revealed a can of shave cream and an emesis basin turned bottom up with a sink stopper on top of it on a shelf under the mirror in the bathroom had no resident name on them.

Observations on 01/05/17 3:15 PM in the bathroom of resident room #409 revealed a can of shave cream and an emesis basin turned bottom up with a sink stopper on top of it on a shelf under the mirror in the bathroom had no resident name on them.

During an interview on 01/06/17 at 11:23 AM with Nurse Aide #4 she stated resident's personal care items were supposed to be labeled with their name on them and staff should use a black marker to write the name on each item.

During a tour and interview on 01/06/17 at 11:28 AM with the Director of Nursing she stated it was her expectation for resident's personal care items to be labeled with the resident's name. She confirmed the 2 hair brushes in the bathroom of resident room #207 had no resident names on them, the emesis basin in the bathroom of resident room #208 had no resident name on it and should be discarded, the clear plastic graduate and the emesis basin were not labeled

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with a resident name and should be discarded in the bathroom of resident room #314 and the tube of toothpaste, soaps and razor were not labeled with the resident name and confirmed the blade on the razor was not covered and should have had the safety cover in place to prevent injury in the bathroom of resident room #401. She also confirmed the can of shave cream and the emesis basin in the bathroom of resident room #409 was not labeled with a resident name and she stated staff should not have left the sink stopper on top of the emesis basin on the shelf under the mirror in the bathroom.

During an interview on 01/06/17 at 12:07 PM with the Administrator she stated it was her expectation for staff to label resident's personal care items.

2. a. Observations on 01/03/17 at 11:04 AM on the 100 resident hall revealed a double set of smoke prevention doors with broken and splintered laminate and wood on the edges of the lower half of both doors that were rough to the touch.

Observations on 01/04/17 at 4:16:31 PM on the 100 resident hall revealed a double set of smoke prevention doors with broken and splintered laminate and wood on the edges of the lower half of both doors that were rough to the touch.

Observations on 01/05/2017 3:36 PM on the 100 resident hall revealed a double set of smoke prevention doors with broken and splintered laminate and wood on the edges of the lower half of both doors that were rough to the touch.

b. Observations on 01/03/17 at 11:25 AM on the

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200 resident hall revealed a double set of smoke prevention doors with broken and splintered laminate with deep gouges in the wood on the edges of the lower half of both doors that were rough to the touch.

Observations on 01/04/17 at 4:17 PM on the 200 resident hall revealed a double set of smoke prevention doors with broken and splintered laminate with deep gouges in the wood on the edges of the lower half of both doors that were rough to the touch.

Observations on 01/05/17 at 3:37 PM on the 200 resident hall revealed a double set of smoke prevention doors with broken and splintered laminate with deep gouges in the wood on the edges of the lower half of both doors that were rough to the touch.

c. Observations on 01/03/17 at 12:42 PM on the 300 resident hall revealed a double set of smoke prevention doors with broken and splintered laminate and wood on the edges of the lower half of both doors and a strip of molding was broken off on the lower half of the left door.

Observations on 01/04/17 at 4:18 PM on the 300 resident hall revealed a double set of smoke prevention doors with broken and splintered laminate and wood on the edges of the lower half of both doors and a strip of molding was broken off on the lower half of the left door.

Observations on 01/05/17 at 3:37 PM on the 300 resident hall revealed a double set of smoke prevention doors with broken and splintered laminate and wood on the edges of the lower half of both doors and a strip of molding was broken

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off on the lower half of the left door.

d. Observations on 01/03/17 at 12:43 PM on the 400 resident hall revealed a double set of smoke prevention doors with broken and splintered laminate with deep gouges in the wood on the edges of the lower half of both doors that were rough to the touch.

Observations on 01/04/17 at 4:19 PM on the 400 resident hall revealed a double set of smoke prevention doors with broken and splintered laminate with deep gouges in the wood on the edges of the lower half of both doors that were rough to the touch.

Observations on 01/05/17 at 3:38 PM on the 400 resident hall revealed a double set of smoke prevention doors with broken and splintered laminate with deep gouges in the wood on the edges of the lower half of both doors that were rough to the touch.

3. Observations on 01/03/17 at 12:44 PM of the doors to the therapy department revealed a double set of doors with broken and splintered laminate and wood on the edges of the lower half of both doors that were rough to the touch.

Observations on 01/04/17 at 4:20 PM of the doors to the therapy department revealed a double set of doors with broken and splintered laminate and wood on the edges of the lower half of both doors that were rough to the touch.

Observations on 01/05/17 at 3:40 PM of the doors to the therapy department revealed a double set of doors with broken and splintered laminate and wood on the edges of the lower half

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of both doors that were rough to the touch.

4. Observations on 01/03/17 at 12:45 PM in the bathroom of resident room #212 revealed the toilet was loose and bolt on the left base of the toilet was missing and the base molding at the floor next to the toilet was pulled away from the wall.

Observations on 01/04/17 at 10:23 AM in the bathroom of resident room #212 revealed the toilet was loose and bolt on the left base of the toilet was missing and the base molding at the floor next to the toilet was pulled away from the wall.

Observation on 01/05/2017 3:40 PM in the bathroom of resident room #212 revealed the toilet was loose and bolt on the left base of the toilet was missing and the base molding at the floor next to the toilet was pulled away from the wall.

5. a. Observation on 01/03/17 at 12:46 PM in the bathroom of resident room #209 revealed the base molding at the floor next to the toilet was pulled away from the wall.

Observation on 01/04/17 at 4:25 PM in the bathroom of resident room #209 revealed the base molding at the floor next to the toilet was pulled away from the wall.

Observations on 01/05/17 at 3:42 PM in the bathroom of resident room #209 revealed the base molding at the floor next to the toilet was pulled away from the wall.

b. Observation on 01/03/17 at 12:47 PM in the

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bathroom of resident room #314 revealed the base molding at the floor next to the toilet was pulled away from the wall.

Observation on 01/04/17 at 10:08 AM in the bathroom of resident room #314 revealed the base molding at the floor next to the toilet was pulled away from the wall.

Observations on 01/05/17 at 4:31 PM in the bathroom of resident room #314 revealed the base molding at the floor next to the toilet was pulled away from the wall.

During an interview on 01/06/17 at 11:15 AM with Housekeeper #2 she explained during the week if housekeeping staff saw repairs that needed to be made they were expected to report them to maintenance staff. She stated on weekends they usually wrote down repairs that needed to be made in a maintenance book and there was always maintenance staff on call and they were available after hours for repairs. She further stated they were expected to report if toilets were loose or if base molding had pulled away from the wall but she did not recall any resident rooms where repairs needed to be made.

During an environmental tour and interview on 01/06/17 at 11:44 AM with the Maintenance Director he stated the facility did not utilize a work order system but he had a book for staff to write down any repairs that needed to be made and the book was kept in the charge nurse's office. He stated the book was accessible to staff 24 hours a day and he and another maintenance worker were on call 24 hours a day. He stated he oriented all new staff to write down any repairs that needed to be made in the notebook but if

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there was a safety concern or emergency he expected for staff to call him or his co-worker immediately. He confirmed there were no special projects in progress in the facility but they were doing preventive maintenance and routine repairs. During the tour he confirmed he had not noticed the damage to the smoke prevention doors or the doors to the therapy department and also confirmed the laminate and wood was broken and splintered and rough to touch. He stated no one had reported the doors needed to be repaired but that was something he expected for staff to report. He also confirmed the toilet was loose in the bathroom of resident room #209 because a bolt was missing that secured the toilet to the bathroom floor and no one had reported it but staff should have reported it. He also confirmed the base molding was pulled away from the wall at the floor in the bathrooms of resident rooms #209, #212 and #314 and no one had reported it to him but they should have reported it.

During a tour and interview on 01/06/17 at 12:07 PM with the Administrator she stated it was her expectation for staff to report damage to doors, loose toilets and base molding that was pulled away from the walls in bathrooms. She stated they had hall ambassadors to monitor resident hallways and they also needed to report repairs that needed to be made. She stated she expected for maintenance staff to monitor more carefully and make the repairs that needed to me made. She stated she also expected for staff on resident hallways to report damage or repairs that needed to be made and she expected for housekeeping staff to report repairs that needed to be made. She further stated it was a group effort for everyone to report.

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F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to follow occupational therapy recommendations to place hand rolls in a resident's contracted left hand to prevent further decline in range of motion for 1 of 1 sampled resident with a contracture (Resident #61). The findings included: Resident #61 was admitted to the facility on 11/05/15 with diagnoses that included end stage renal disease, hemiplegia with contractures of left hand and left wrist. A document titled "OT (Occupational Therapy) Progress and Discharge Summary" dated 01/01/16 specified Resident #61 was discharged from therapy services because he was unable to meet goals but was able to tolerate a wash cloth in his left hand. The most recent annual Minimum Data Set (MDS) dated 11/09/16 specified the resident had short and long term memory impairment and moderately impaired cognitive skills for daily	F 318	F318 SS=D 483.15(e)(2) This plan of correction is the facility's credible allegation of compliance. Resident # 61 was referred to OT and placed on caseload for contracture management and positioning. Staff were educated to report any resident identified as having a contracture or decline in ROM promptly to therapy department and MDS Coordinator. All residents identified with contractures and decline in ROM was screened by PT and OT and placed on caseload if needed. Going forward, all residents in facility will be screened by therapy on a quarterly basis to correspond with MDS schedule. Resident will be placed on caseload as needed. All new orders and change in treatment plan will be communicated to	2/3/17

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F 318	Continued From page 17 decision making. The MDS also specified the resident had impaired range of motion on one side of upper and lower extremity and required extensive assistance with activities of daily living. A Care Area Assessment (CAA) dated 11/09/16 specified the resident was dependent on staff for activities of daily living and did not reference the resident's contractures. A care plan updated on 11/16/16 indicated Resident #61 had a problem related to mobility because of contractures. The care plan did not specify approaches to address the contractures. On 01/03/17 at 12:54 PM observations were made of Resident #61. Resident #61 had his left elbow bent, with his hand resting across his chest. Resident #61's left fingers were clinched and he was unable to open his hand upon request. There was no wash cloth or palm protector in the left hand. On 01/04/17 at 11:10 AM Nurse #1 was interviewed and reported Resident #61 had a contracture to his left hand and was to have a wash cloth in place to his hand. On 01/06/17 at 9:45 AM observations were made of Resident #61. Resident #61 had his left elbow bent, with his hand resting across his chest. Resident #61's left hand was clinched and he was unable to open his hand. There was no wash cloth or palm protector in the left hand. On 01/06/17 at 9:50 AM nurse aide (NA) #1 was interviewed, she stated she was assigned to Resident #61 and had completed his morning care. She was unaware the resident was to have	F 318	nursing staff in writing as well as verbal. Therapy Director will communicate any changes made to resident□s treatment plan to DON and MDS Coordinator via communication form. Therapy Director will complete audit monthly of quarterly screens to assure compliance. Results of audit will then be reported to the QAPI Committee monthly x 3 months. Any identified changes needed to QAPI plan or continuance of plan will be modified accordingly by QAPI committee Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of state and federal law. .	

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F 318	Continued From page 18 a wash cloth in his contracted left hand. The NA reported that she relied on the computer kiosk for individual resident instructions. The NA reviewed Resident #61's computerized care instructions during the interview and reported the instructions for Resident #61 did not specify the resident was to have a wash cloth in his left hand. On 01/06/17 at 9:55 AM Nurse #1 was observed telling NA #1 that Resident #61 should have a wash cloth in his left hand at all times. The Occupational Therapist was no longer employed at the facility and unable to be reached for an interview. On 01/06/17 at 10:00 AM the Director of Nursing (DON) was interviewed and stated she expected staff to follow therapy recommendations. The DON explained that the facility had experienced problems with communication between therapy and nursing. She added that the therapy recommendations made in January 2016 had not been communicated to nursing. The DON also reported that if a resident had a contracture she would expected the nurse aides to apply a wash cloth to prevent further decline in the contracture.	F 318		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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	F 371		2/3/17

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F 371	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review the facility failed to store an ice scoop in clean conditions and monitor and report a nourishment refrigerator outside safe temperature range (below 41 degrees Fahrenheit) for 1 of 1 nourishment rooms. The findings included: On 01/03/17 at 10:00 AM an initial tour of the facility's nourishment room was made with the Dietary Manager (DM). The observations revealed an ice scoop stored in a plastic container with the tip down. The tip of the ice scoop was noted to be inserted into a small amount of accumulated water. Closer observation revealed the water had floating particles. The DM was interviewed and reported the scoop was used to serve residents ice. The DM also reported the scoop was supposed to be cleaned daily and as needed but had not been cleaned yet that day. A temperature log taped on the outside of the nourishment room refrigerator for the month of January was reviewed. The document specified refrigerator temperatures should be between 32-41 degrees Fahrenheit. The document read in part, "If temperatures are above what they are supposed to be, alert supervisor and recheck temperature in 30 minutes." Further review of the log revealed: 01/01/17 at 9:20 AM the refrigerator was 45	F 371	F371 SS=E 483.35(i) This plan of correction is the facility's credible allegation of compliance. All ice scoops were replaced to allow for proper drainage and drying. All refrigerators were inspected by outside contractor to ensure all refrigerators were in good repair and cooling properly. Dietary staff were in-serviced on proper procedure for checking and reporting temperatures and cleaning and storage of ice scoops. Audits will be completed by Dietary Manager weekly x 4 weeks then monthly x 3 months. Results will be reported to the QAPI Committee monthly x 3 months. Any identified changes needed to QAPI plan or continuance of plan will be modified accordingly by QAPI committee. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by	

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F 371	Continued From page 20 degrees Fahrenheit. 01/02/17 at 9:20 AM the refrigerator was 48 degrees Fahrenheit On 01/03/17 at 10:00 AM during the observation of the refrigerator with the Dietary Manager present, revealed the refrigerator temperature was 44 degrees Fahrenheit. On 01/04/17 at 9:32 AM the temperature of the refrigerator was checked and noted to be 44 degrees Fahrenheit. On 01/05/17 at 3:36 PM the temperature of the refrigerator was 42 degrees Fahrenheit. On 01/06/17 at 9:19 AM the Dietary Manager (DM) was interviewed about the nourishment room refrigerator. She stated she was not aware of the temperature being outside the safe parameters. The DM observed the nourishment room refrigerator and the internal temperature was 42 degrees Fahrenheit. The DM was asked to take the temperature of milk stored in the refrigerator for residents. The internal temperature of the milk was 41.7 degrees Fahrenheit. The DM stated the milk should be less than 41 degrees Fahrenheit. The DM used a digital thermometer for the reading and asked if she could try the taking the temperature with another thermometer. On 01/06/17 at 9:21 AM the DM used a dial thermometer to measure the temperature of the refrigerator. The temperature was 39 degrees Fahrenheit. During the observation, the DM was interviewed and stated she did not believe there was a	F 371	provisions of state and federal law.	

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F 371	Continued From page 21 problem with the temperature of the refrigerator. She stated she had not been notified of the temperatures being outside safe ranges and would have expected staff tor report a concern to her.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		2/3/17

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F 441	Continued From page 22 (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, record reviews, and staff interviews the facility failed to follow isolation precautions for 1 of 1 residents on enteric contact precautions. (Resident #130). The findings included: A review of facility policy from the facility's Infection Control Manual was undated. The policy was titled Multi-Resistant Organisms stated "prevention, containment and eradication measures including use of contact precautions are indicated to prevent the spread of resistant microorganisms that have been identified within the facility." The policy also stated "if use of common equipment or items is unavoidable, they should be adequately cleaned and disinfected before use on another resident." Concerning C-diff the policy stated, "Excellent environmental cleaning should be done with recommended 'wet times' to inactivate the spore. A 1:10 solution of bleach will also be effective against this organism in its spore state." "Infection of Infection Control Manual entitled "Multidrug-Resistant Organisms" which was included in materials provided by DON for Infection Control policy included information under heading Contact Precautions: Gloves should be worn to enter the room of a resident who is infected or colonized. A gown must be	F 441	F441 483.65 Infection Control This plan of correction is the facility's credible allegation of compliance. Resident # 130 room was deep cleaned with appropriate Clorox solution to include floor and hard surfaces. Cubicle curtain and linens that could hold spores were replaced. All staff directly caring for this resident were in-serviced on isolation precautions and PPE equipment to be worn anytime entering room. No other residents identified on isolation at this time. All resident have the potential to be affected by Infection control practices. All staff were in-serviced on infection control policies and procedures taking care of residents on isolation, importance of adhering to these policies and procedures and importance of proper hand washing. Staff were also in-serviced on proper cleaning and use of equipment on isolation residents. Housekeeping staff were in-serviced by HealthCare Services Group on proper	

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F 441	Continued From page 23 worn to enter the room of an infected/colonized resident if substantial contact with the resident or environmental surfaces is anticipated, especially if the resident is incontinent, has diarrhea, a colostomy, or wound drainage not contained by a dressing. Gowns and gloves should be removed before leaving the resident's room and hands must be washed with an antiseptic soap or waterless hand rub. There was no information in the policy about " double gloving." Resident #130 was admitted to the facility on 10/30/16 with diagnosis that included Urinary Tract Infection, Depression, Bipolar Depression, Heart Failure, Atrial fibrillation, and anemia. The Minimum Data System admission assessment dated 11/14/16 indicated the resident had slight cognitive impairment. The resident was assessed as needing limited assistance of one person for bed mobility, eating and toileting; extensive assistance for transfers, locomotion on unit, dressing and personal hygiene; and was totally dependent for bathing. The resident did not resist care. Enteric Contact Precautions were put in place for resident # 130 after stool sample collected and facility received notification of positive c-diff results on 11/16/16. A record review revealed the resident had completed a round of antibiotics and enteric precautions in November. The symptom of loose stool was again documented by Nurse #2 in medical record again on 12/08/16. Resident # 130 was ordered on 12/08/16 Vancomycin 125mg by mouth to continue until 12/23/16. Resident #130 continued to have symptoms of C-diff and the antibiotic order was extended until 1/5/17 and	F 441	cleaning and disinfecting of isolation rooms in addition to deep cleaning of all resident rooms and areas. Audit will be completed by DON on staff adhering to infection control policies and procedures weekly x 1 month then monthly x 3 months. Quality Control Inspections will be completed by HCS account manager five times weekly for six weeks then monthly times three months. Audit will be completed by HCS District Manager of chemicals used, isolation, deep cleaning following quality inspection guidelines weekly times six weeks then month times three months. Results of audits will be reported to QAPI Committee by DON and HCS account manager monthly x 3 months. Any identified changes needed to QAPI plan or continuance of plan will be modified accordingly by QAPI committee. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies.	

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enteric precautions remained in place for resident #130 through 1/5/17.

On 1/3/17 at 10:00 a.m. Personal Protective Equipment observed in small rolling cart placed outside of the door to room for Resident #130. A sign with Enteric Contact Precautions with instructions for use of PPE and Handwashing guidelines was posted on the wall over the cart of PPE and near the door of the room for Resident # 130.

On 1/3/17 at 11:16 a.m. Nurse # 2 observed while in the room of Resident 130. Nurse # 2 had repositioned the roommate of Resident # 130. It was observed that Nurse # 2 was not wearing a gown or gloves. Nurse #2 exited the room of Resident # 130 without stopping to wash hands prior to leaving that room.

On 1/4/17 at 2:04 p.m. a member of the housekeeping staff was observed to enter the room of Resident # 130 to put clean laundry into the closet. The housekeeping staff member touched the doorknob of the closet in room of Resident # 130 and exited without washing hands. The signage for the Contact Precautions and the PPE remained in place at the door of the room for Resident # 130.

On 1/4/17 at 3:55 p.m. Nursing Assistant # 2 observed entering the room of Resident # 130. Nursing Assistant # 2 opened the closet of Resident # 130 in order to put supplies into the closet. Then Nursing Assistant #2 exited the room of Resident # 130 without washing hands.

On 1/5/17 at 6:19 a.m. Nursing Assistant # 3 observed while weight of Resident # 130 was

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	345138	A. BUILDING _____ B. WING _____	C 01/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

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measured with a lift scale. There was a designated sling to be used to weight Resident # 130. The sling was stored in dresser used by Resident # 130. The lift scale was pushed out of the room of Resident # 130. The lift was not disinfected prior to leaving the room of Resident # 130. Nursing Assistant #3 stated that the lift was to be used to weight other residents who needed to be weighed that day.

On 1/6/17 at 10:55 a.m. Housekeeper # 1 observed mopping the floor near the bed of Resident # 130. The floor was mopped with solution of water and Quat disinfectant. Review of the label from the Quat disinfectant revealed that it was to be used for general cleaning. The label described the solution as being a disinfectant, virucidal, fungicidal, Mold and Mildew controller. The label of the Quat disinfectant listed to be effective against several bacteria, but Clostridium Difficile not listed on the label.

An interview was conducted on 1/3/17 at 11:16 a.m. with Nurse # 2. During the interview it was stated that gown and gloves were not needed when entering the room of Resident # 130 if care was provided to the roommate of Resident # 130. Nurse # 2 also stated as part of the interview that Infection Control in-service training was conducted at time of orientation to the facility and repeated annually.

An interview was conducted on 1/6/17 with Housekeeper # 1 at 10:57 a.m. It was stated during the interview that a solution of Quat disinfectant was used to mop the floor in rooms of all residents. It was further stated that a spray solution of Quat disinfectant was used to clean toilet area, sink, side rails, and all surfaces in the

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room of Resident # 130. Housekeeper # 1 stated that the isolation procedure to be followed was to wear gloves and gown when in the room with contact precautions. The used gloves and gowns were to be removed prior to leaving the room, and disposed of trash bin in the room. The used gloves and isolation gowns were transported out of the building in a closed plastic bag and put into the dumpster. During interview with Housekeeper #1 it was stated that Quat disinfectant "killed everything." That the spray could be used on all surfaces in the room including toilet, sinks, door knob, bed side rail and that she didn't need to use bleach solution to clean the isolation room.

An interview was conducted on 1/6/17 at 11:01 a.m. with Environmental Services Manager. It was stated during that interview that rooms of residents requiring isolation precautions should be cleaned with a solution of Clorox and water. It was stated by the Environmental Services Manager that he was aware that Resident # 130 was on enteric precautions at that time. During the interview it was reported that the disinfectant on the cart of the Housekeeping staff was Quat.

An interview was conducted with the Director of Nursing on 1/6/17 at 3:40 p.m. The Director of Nursing stated it was expected for the staff to follow contact precautions which included application of gloves and gown whenever the room of resident on isolation/contact precautions was entered. It was further stated that it was the expectation that staff removed PPE and washed hands prior to exiting the room of a resident with isolation/contact precautions. The Director of Nursing also stated that it was expected that Clorox and water solution be used for cleaning

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F 441	Continued From page 27 the room of residents where contact precautions were in place. The Spice Program Infection Control Training had been completed by the Director of Nursing who was the interim Infection Control Nurse, also. During the interview with the Director of Nursing it was stated that Infection Control training was mandatory for all employees at time of hire and annually thereafter. The most recent Infection Control Training was conducted in October 2016.	F 441		