STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING ______ B. WING ______	C 01/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 000	INITIAL COMMENTS On 1/31/17 F 312 was amended.	F 000		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) 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, staff interviews and record reviews the facility failed to provide perineal care for 2 of 5 dependent residents reviewed for activities of daily living. (Resident #8 and Resident #7) Findings included: 1. Resident #8 was admitted to the facility on 6/3/16 with cumulative diagnoses ' which included dementia. Review of the quarterly Minimum Data Set dated 12/09/16 revealed Resident #8 was severely cognitively impaired and dependent on staff for care. The MDS coded the resident as always incontinent of urine and bowel. Review of the care plans revealed a problem onset of 6/16/16 as a potential for a urinary tract infection related to urinary incontinence and dependency in activities of daily living related to cognitive loss. The approach included perineal care frequently and as needed when incontinent. Observation of incontinence care on 1/11/17 at 2:15 PM performed by Nursing Assistant (NA) #4 and NA #5 revealed Resident #8 had experienced an incontinent episode of urine and stool. The resident was positioned on her right side. NA #4 cleansed the rectal area and buttocks with pre-moistened adult wipes then barrier cream was	F 312	F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. The plan of correction is prepared and submitted solely because of requirements under state and federal law. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Perineal Care Policy was reviewed by the Administrator and Director of Nursing on 01/18/17 and again on 02/01/17. The identified licensed and unlicensed staff were educated regarding proper perineal care to ensure that care is provided appropriately, per policy. The	2/7/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/07/2017

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 312	Continued From page 1 applied. A clean brief was applied. The perineal area and the pubic area was not cleansed. Interview on 1/11/17 at 2:28 PM with NA #4 stated it was " just an oversight. " NA #4 revealed she should have cleansed between the resident ' s legs. Interview on 1/12/17 at 1:18 PM with the Director of Nurses (DON) revealed her expectation for incontinence care was to have staff separate the resident ' s legs and cleanse the labia in a front to back motion. 2. Resident #7 was readmitted to the facility on 11/6/16 with cumulative diagnoses which included adult failure to thrive. Review of the quarterly Minimum Data Set assessment dated 12/16/16 revealed Resident #7 required cueing from staff for recall. The resident was coded as frequently incontinent of bowel and bladder as well as dependent on staff for toileting and personal hygiene. Review of the written care plan (date unknown) included a problem of urinary incontinence related to cognitive deficit and impaired mobility. The approach included to provide incontinent care approximately every 2 hours and whenever necessary. Observation on 1/11/17 at 1:05 PM revealed the Treatment Nurse and Nursing Assistant (NA) #3 transferred Resident # 7 from the chair to the bed using a mechanical lift. Once in bed Resident #7 had experienced an incontinent episode of urine. NA #3 used pre-moisture adult wipes to cleanse the sides of the resident ' s groin and anterior pubic area. But did not open the resident ' s legs to clean her labia in a front to back method. Interview on 1/11/17 at 2 PM with NA #3 revealed Resident #7 required total care except for feeding. When an inquiry was made about the incontinence care provided to the resident, NA #3	F 312	education included return demonstration on incontinent residents and/or mannequin. This education was provided by the Director of Nursing (DON) and/or RN Supervisor and was completed on 02/03/17. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents who require assistance from staff for incontinence care have the potential to be affected. On 01/19/17 the DON, Unit Managers (UM), and RN Supervisors began education for all licensed nursing and unlicensed nursing staff (certified nursing assistant), to include weekend and PRN staff on the perineal care policy. The education included return demonstration on incontinent residents and/or mannequin. Of the 61 licensed nursing staff, 40 have completed the in-service as of 02/07/17. Of the 69 unlicensed staff, 54 have completed the in-service as of 02/07/17. All licensed and unlicensed staff will be required to complete the in-service prior to working his/her next scheduled shift. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not	

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F 312	Continued From page 2 indicated that was her " usual routine. " Interview on 1/12/17 at 1:18 PM with the Director of Nurses (DON) revealed her expectation for incontinence care was to open the resident ' s legs and cleanse the labia in a front to back motion.	F 312	recur: All licensed nursing staff and unlicensed nursing staff (certified nursing assistant) will be educated on proper perineal care in accordance with the perineal care policy and procedure demonstrated by the DON, UM and RN Supervisors. Education included review of the perineal care policy, procedures review, demonstration and return demonstration. This was completed on 02/06/17. All licensed and unlicensed staff will be required to complete the in-service prior to working his/her next scheduled shift. The DON, UM, RN Supervisors and/or SDC will review the perineal care policy and return demonstration annually with all licensed and unlicensed nursing staff to ensure the staff provide proper perineal care for incontinent residents. All licensed and unlicensed nursing staff hired after 02/07/17 will be educated by the DON, UM, RN Supervisors and/or SDC during his/her scheduled orientation on the facility□s perineal care policy. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The SDC, UM, RN Supervisor and/or DON will conduct random observations of perineal care on six residents (two per unit) by licensed nursing staff on a weekly basis times four weeks, then three residents (one per unit) on a weekly basis	

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F 312	Continued From page 3	F 312	times four weeks and then three residents (one per unit) monthly times three months and document via the audit tool. The SDC, UM, RN Supervisor and/or DON will conduct random observations of perineal care on six residents (two per unit) by unlicensed nursing staff on a weekly basis times four weeks, then three residents (one per unit) on a weekly basis times four weeks and then three residents (one per unit) monthly times three months and document via the audit tool. The results of these observations will be reported to the Quality Assurance and Performance Improvement Committee monthly for three months or until a pattern of compliance is achieved. Include dates when corrective action will be completed. Date of compliance: 02/07/17	
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based	F 315		2/7/17

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F 315	Continued From page 4 on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to stabilize Resident #6 ' s urinary catheter to prevent trauma or dislodgement. This was evident in 1 of 1 resident reviewed with a urinary catheter. Findings included: Resident #6 was admitted to the facility on 4/3/15 with cumulative diagnoses which included Alzheimer ' s disease. Review of the January 2017 physician orders included an indwelling urinary catheter due to a	F 315	F315 NO CATHETER, PREVENT UTI, RESTORE BLADDER 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. The plan	

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F 315	Continued From page 5 stage 4 pressure ulcer (advanced pressure sore). Review of the quarterly Minimum Data Set assessment dated 10/7/16 revealed Resident #6 was severely cognitively impaired and dependent on staff for care. Review of the care plan with a problem onset dated 12/20/16 included the used of an indwelling urinary catheter due to a stage 4. The approach included to secure the tube to my (referring to Resident #6) thigh to prevent pulling. Observation on 1/11/17 at 11:10 AM during the wound care performed by the Treatment Nurse revealed the urinary catheter was not stabilized. There was a sticky tape like substance around the catheter. After the wound care, Resident #6 was repositioned. The urinary catheter tube was not stabilized. Observation on 1/11/16 at 1 pm revealed the urinary catheter tube was not stabilized. Observation on 1/11/17 at 3:45 PM with the Treatment Nurse revealed the sticky tape like substance around the catheter was removed by the treatment nurse. The urinary catheter tube was not stabilized. Observation of the urinary catheter on 1/12/17 at 9:35 AM with Restorative aide (RA) #1 and Nursing Assistant (NA) #1 revealed the catheter was not stabilized. Interview on 1/12/17 at 9:37 AM with RA #1 and NA #1 was held. NA #1 indicated the nurse was responsible for taping (stabilizing) the urinary catheter in place. Interview on 1/12/17 at 1:10 PM with the Treatment Nurse and the Director of Nurses (DON) was held. The Treatment Nurse indicated she did not believe the urinary catheter needed to be stabilized because the drainage tubing was not kinked, the urinary catheter was draining and the drainage bag was not pulling or tugging. The DON indicated her expectation was for facility	F 315	of correction is prepared and submitted solely because of requirements under state and federal law. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #6 foley catheter was stabilized via a CATH-SECURE strap on 01/12/17. The Urinary Catheter Care policy was reviewed by the Administrator and Director of Nursing on 01/18/17 and again on 02/03/17. The identified licensed and unlicensed staff were educated regarding proper catheter stabilization, per policy. The education included return demonstration on a resident with a foley catheter. This education was provided by the Director of Nursing (DON) and was completed on 02/03/17. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents who have an indwelling foley catheter have the potential to be affected. All residents were reviewed for an indwelling foley catheter and five residents were noted to have an indwelling foley catheter. These residents were assessed for catheter stabilization on 02/03/17 and	

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F 315	Continued From page 6 nurses to stabilize the urinary catheter.	F 315	5 of 5 indwelling foley catheters were stabilized per policy. On 01/19/17 the DON, Unit Managers (UM), and RN Supervisors began education for all licensed nursing and unlicensed nursing staff (certified nursing assistant), to include weekend and PRN staff on the Urinary Catheter Care policy. The education included return demonstration on catheter stabilization on residents with an indwelling foley catheter and/or mannequin. Of the 61 licensed nursing staff, 40 have completed the in-service as of 02/07/17. Of the 69 unlicensed staff, 54 have completed the in-service as of 02/07/17. All licensed and unlicensed staff will be required to complete the in-service prior to working his/her next scheduled shift. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: All licensed nursing staff and unlicensed nursing staff (certified nursing assistant) will be educated on catheter stabilization in accordance with the Urinary Catheter Care policy demonstrated by the DON, UM and RN Supervisors. Education included review of the CATH SECURE stabilization device, where to obtain device, how to apply device and what to do is device has become dislodged. The Urinary Catheter Care policy and return demonstration will be completed annually	

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F 315	Continued From page 7	F 315	with all licensed and unlicensed nursing staff to ensure the staff provide proper catheter stabilization to residents with an indwelling foley catheter. All licensed and unlicensed nursing staff hired after 02/07/17 will be educated by the DON, UM, RN Supervisors and/or SDC during his/her scheduled orientation on the facility□s Urinary Catheter Care policy. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The SDC, UM, RN Supervisor and/or DON will conduct observations of catheter stabilization on all residents with an indwelling foley catheter five times per week four weeks, then three times a week for four weeks and then one time a week for three months and document via the audit tool. The results of these observations will be reported to the Quality Assurance and Performance Improvement Committee monthly for three months or until a pattern of compliance is achieved. Include dates when corrective action will be completed. Date of compliance: 02/07/17	