| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345505 | A. BUILDING _____ B. WING _____ | 03/03/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CAROLINA REHAB CENTER OF CUMBERLAND | 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 |

| (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 |
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| F 242 SS=D | 483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br><br>(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident, staff interviews and records review, the facility failed to offer showers as scheduled for 1 of 40 sampled residents. (Resident #40).<br><br>The findings included:<br><br>Resident #40 was admitted to the facility 02/09/2008 with the diagnosis of Alzheimer Disease. The quarterly Minimum Data Set (MDS) dated 01/06/2017 indicated Resident #40 was severely cognitively impaired with no signs of behaviors. Resident #40 was coded as totally dependent for her hygiene and bathing.<br><br>A review of the Dogwood Unit Shower List dated 08/31/2016 indicated Resident #40 shower days were Mondays, Wednesdays and Fridays on second shift. | F 242 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.<br><br>F242<br><br>How corrective action will be accomplished for each resident found to have been affected by the deficient | 4/3/17 |

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

Electronically Signed | 03/27/2017

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| F 242 | Continued From page 1<br>A review of the Task: ADL - Bathing (Prefers Shower) Sheet (this is the printed sheet from the Nursing Assistants electronic kiosk data entry) for Resident #40 dated the month of February 2017 indicated no refusals and no showers/baths done on 02/3/2017 - Friday, 02/10/2017 - Friday and 02/20/2017 - Monday.<br><br>A review of the nursing progress notes from 02/01/2017 to present made no mention of Resident #40 refusing her showers or baths.<br><br>In an interview on 03/01/2017 at 4:30 PM, Resident #40's family member stated the resident was not given showers on her scheduled shower days of Mondays, Wednesdays and Fridays. She stated she visited every day and the staff would tell her if it had not been done. The family member stated having showers was important to Resident #40. The family member also explained she had discussed these issues previously with the Administrator and the DON and the resident was care planned for the showers/baths.<br><br>In an interview on 03/2/2017 at 3:36 PM, Nursing Assistant (NA) #1 stated there were some days all showers were not given and the NAs tried to give bed baths. She continued by saying, "there are days we are short staffed." NA #1 reported any refusals to the nurse and she documented them on her kiosk. She knew of no refusals for Resident #40. She stated if she did not record the shower in the kiosk, she did not give the shower.<br><br>In an interview on 03/03/2017, the Director of Nursing (DON) stated it was her expectation that Resident #40 receive her showers as scheduled and if she refused, the staff should attempt to try | F 242 | practice □ Resident #40 was offered a shower and preference reviewed with resident representative (daughter) upon notification to ensure preferences were met going forward.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice □ All in house Residents will be reviewed to ensure showers schedules reflect preferences and are given as scheduled.<br><br>Measures to be put in place or systemic changes made to ensure practice will not re-occur- Nurses and CNA□s will be in-serviced by Director of Nursing/SDC or designee on making sure resident□s choice of showers are honored. DON, Unit Manager or Designee will complete an audit of all residents to ensure that their shower preferences have been acknowledged and scheduled. This audit will be completed 5 x weekly for 4 weeks for all residents and monthly x 3 months. Any deficient practice will result in re-education and/or discipline as needed.<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- All audits will be presented to the QA Committee monthly x3 to ensure continued compliance and revisions to the plan if needed. | |

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| F 242 | Continued From page 2<br>again later but should report it to the Charge Nurse on shift. | F 242 | | |
| F 282 SS=G | 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to follow the care plan by not keeping 1 of 2 sampled residents in a visible area when in wheelchair, resulting to a left femur fracture. (Resident # 236). Findings included:<br><br>Resident # 236 was admitted to the facility on 4/14/2016 with diagnoses of Peripheral Vascular Disease, Hypertension, Alzheimer's disease, muscle weakness, difficulty walking and adult failure to thrive. The most current Minimum Data Set (MDS) dated 12/23/2016 revealed the resident's cognition was severely impaired; she needed extensive assistance with 1 person for bed mobility and extensive assistance with 2 persons for transfer.<br><br>Resident # 236's Care Area Assessment (CAA) worksheet dated 1/4/2017 documented "During this look back period, resident has been out of bed at least 4 out of 7 days. Staff to continue to attempt to engage resident in activities of choice. Resident has had falls since admission, but no | F 282 | F282<br><br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #236 discharged on February 18, 2017.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: The Director of Nursing/Unit Manager or designee will review/update all fall care plans for current interventions. Nurses and CNAs will receive education on following the care plan interventions related to falls. The DON/Unit Manager or designee, will interview 15 CNAs weekly on care planned fall interventions, then twice a month x 6 months. Any deficient practice will result in re-education and/or disciplinary action as needed. | 4/3/17 |

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| F 282 | Continued From page 3<br>falls noted during this look back period. Safety precautions being followed per facility protocol. Resident has fall mats beside bed and bed is lowered."<br><br>Resident # 236's care plan dated 2/28/2017 documented "the resident is at risk for falls due to confusion, deconditioning, advanced dementia, history of falls, prefers to sit on the mat." The care plan documented the following interventions: "Get resident up before lunch time and in common areas, keep resident in visible area when in wheel chair."<br><br>On 1/30/2017 a nurse's note at 12:38 PM documented "Patient was found on floor mat next to bed during day shift. Patient had pain to right femur, notified doctor. Received order for x- ray."<br><br>Review of the resident's incident report dated 1/30/2017 revealed under description "Patient was found sitting on her floor mat next to her wheelchair. Patient was asked if she put herself there and she nodded "yes." I asked the patient if she was hurting anywhere and she said "no."<br><br>Review of the x-ray report dated 1/31/2017 revealed the resident had a left hip fracture.<br><br>During the interview with Nurse Assistant (NA) # 1 on 3/2/2017 at 10:13 AM, she reported she was assigned to take care of the resident on 1/30/2017. She reported after dressing up the resident she took her to the day room and went on a half hour break. She further added when she came back from her break she was told by Resident # 236's roommate that resident # 236 earlier fell on the floor while she was gone on her | F 282 | Measures to be put in place or systemic changes made to ensure practice will not re-occur: Nurses and CNAs will receive education on following the care plan interventions related to falls. The DON/Unit Manager or designee, will interview 15 CNAs weekly on care planned fall interventions, then twice a month x 6 months. Any deficient practice will result in re-education and/or disciplinary action as needed.<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Risk Quality Assurance Meeting x 3 months and Quarterly Quality Assurance meeting X 2 for further resolution if needed. | |

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| F 282 | Continued From page 4 | F 282 | | |

break. NA#1 further stated she was not aware of the staff member who wheeled the resident back to her room and left her unattended while sitting up on the wheelchair because the resident had no safety awareness and she would stand and try to walk. She added the resident had unsteady gait and was not to transfer herself independently due to her history of falls. NA #1 also reported the resident was to be kept near nurse's station and day room where the staff were to keep an eye on her at all times. She also stated before going on her break she told Nurse # 1 to keep an eye on Resident # 236.

During the interview with Nurse # 1 on 3/2/2017 at 1:30 AM, she reported on 1/30/2017 she was passing by the resident's room and saw the resident lying on the floor. She added the resident was sitting earlier on her wheel chair in her room when she fell on the floor and it appeared the resident was attempting to get back on her bed when she fell on the floor. Nurse # 1 reported the resident had history of getting up from the wheel chair and walking but because of unsteady gait she would fall. She also indicated the resident was reminded not to transfer without assistance from wheel chair to bed but the resident was forgetful.
During the interview on 3/2/2017 at 2:33 PM, The resident's roommate reported she was in the room on 1/30/2017 when the resident fell to the floor from her wheel chair. She reported the resident was attempting to get back to her bed when she fell on the floor. She added she reported the fall to the staff who was passing by her room to come and help the resident.

During the interview on 3/3/2017 at 11:00 PM, the Director of Nursing (DON) reported the resident

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| F 282 | Continued From page 5<br>was found on the floor next to her bed but they were unable to determine the staff that wheeled the resident back to her room from the day room. The DON further reported that her expectation was for the staff not to have left the resident unattended sitting in the wheel chair in her room. | F 282 | | |
| F 323 SS=G | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews, the facility failed to keep 1 of 2 sampled residents in a | F 323 | F323 | 4/3/17 |

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| F 323 | Continued From page 6<br>visible area when in wheelchair, resulting to a left femur fracture. (Resident # 236). Findings included:<br><br>Resident # 236 was admitted to the facility on 4/14/2016 with diagnoses of Peripheral Vascular Disease, Hypertension, Alzheimer's disease, muscle weakness, difficulty walking and adult failure to thrive. The most current Minimum Data Set (MDS) dated 12/23/2016 revealed the resident's cognition was severely impaired; she needed extensive assistance with 1 person for bed mobility and extensive assistance with 2 persons for transfer.<br><br>Resident # 236's Care Area Assessment (CAA) worksheet dated 1/4/2017 documented "During this look back period, resident has been out of bed at least 4 out of 7 days. Staff to continue to attempt to engage resident in activities of choice. Resident has had falls since admission, but no falls noted during this look back period. Safety precautions being followed per facility protocol. Resident has fall mats beside bed and bed is lowered."<br><br>Resident # 236's care plan dated 2/28/2017 documented "the resident is at risk for falls due to confusion, deconditioning, advanced dementia, history of falls, prefers to sit on the mat." The care plan documented the following interventions: "Keep environment free of hazards, anticipate and meet the resident's needs, get resident up before lunch time and in common areas, keep resident in visible area when in wheel chair."<br><br>On 1/30/2017 a nurse's note at 12:38 PM documented "Patient was found on floor mat next to bed during day shift. Patient had pain to right | F 323 | How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #236 discharged on February 18, 2017.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: The Director of Nursing/Unit Manager or designee will audit all patients with falls going forward to ensure care planned interventions are in place.<br><br>Measures to be put in place or systemic changes made to ensure practice will not re-occur: Nurses will receive education on Nursing Policy 1201 Falls Management Program. Nurses and CNAs will receive education on following the care plan interventions related to falls. The DON/Unit Manager or designee, will interview 15 CNAs weekly on care planned fall interventions, then twice a month x 6 months. Any deficient practice will result in re-education and/or disciplinary action as needed.<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Risk Quality Assurance Meeting x 3 months and Quarterly Quality Assurance meeting X 2 for further resolution if needed. | |

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| F 323 | Continued From page 7 | F 323 | | |

femur, notified doctor. Received order for x- ray."

Review of the resident's incident report dated 1/30/2017 revealed under description "Patient was found sitting on her floor mat next to her wheelchair. Patient was asked if she put herself there and she nodded "yes." I asked the patient if she was hurting anywhere and she said "no."

On 1/31/2017 a nurse's note at 1:39 PM documented "Patient complained of hip pain during shift. X- Ray to left hip and femur was ordered. Findings: left hip fracture. Doctor was aware and told me to call the agency that was responsible for taking care of the resident. The nurse practitioner advise to continue giving the patient pain medication."

Review of the x-ray report dated 1/31/2017 revealed the resident had a left hip fracture.Orthopedics report dated 2/1/2017 documented "The resident presents with pain and fracture on the left side. She states that the symptoms have been acute traumatic and began on 2/1/2017. She indicated the injury occurred at the nursing home. The resident states that the symptoms began as the result of a fall on the hip. The symptoms occur constantly with intermittent worsening. Currently the patient states that the symptoms are severe. The pain is described as discomforting and piercing. She rates her best pain as 10/10. She rates her worst pain as 10/10. She rates her current pain 10/10. The symptoms are aggravated by no specific activity and movement. Resident # 236 states that the symptoms are relieved by no specific activity." Orthopedics report under diagnostics subheading documented "displaced intertrochanteric fracture

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| F 323 | Continued From page 8 | F 323 | | |

of the left femur with slight superior migration of the femoral shaft. No other acute abnormality noted."

During the interview with Nurse Assistant (NA) # 1 on 3/2/2017 at 10:13 AM, she reported she was assigned to take care of the resident on 1/30/2017. She reported after dressing up the resident she took her to the day room and went on a half hour break. She further added when she came back from her break she was told by Resident # 236's roommate that resident # 236 earlier fell on the floor while she was gone on her break. NA#1 further stated she was not aware of the staff member who wheeled the resident back to her room and left her unattended while sitting up on the wheelchair because the resident had no safety awareness and she would stand and try to walk. She added the resident had unsteady gait and was not to transfer herself independently due to her history of falls. NA #1 also reported the resident was to be kept near nurse's station and day room where the staff were to keep an eye on her at all times. She also stated before going on her break she told Nurse # 1 to keep an eye on Resident # 236.

During the interview with Nurse # 1 on 3/2/2017 at 1:30 AM, she reported on 1/30/2017 she was passing by the resident's room and saw the resident lying on the floor. She added the resident was sitting earlier on her wheel chair in her room when she fell on the floor and it appeared the resident was attempting to get back on her bed when she fell on the floor. Nurse # 1 reported the resident had history of getting up from the wheel chair and walking but because of unsteady gait she would fall. She also indicated the resident was reminded not to transfer without assistance

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| F 323 | Continued From page 9<br>from wheel chair to bed but the resident was forgetful.<br>During the interview on 3/2/2017 at 2:33 PM, The resident's roommate reported she was in the room on 1/30/2017 when the resident fell to the floor from her wheel chair. She reported the resident was attempting to get back to her bed when she fell on the floor. She added she reported the fall to the staff who was passing by her room to come and help the resident.<br>During the interview on 3/2/2017 at 3:00 PM, the Nurse Practitioner reported the resident was already declining in her health when she fell on 1/30/2016 and sustained a left hip fracture. She also added the orthopedic specialist did not recommend surgery on the resident because of the resident being frail and declining in her health.<br><br>During the interview on 3/3/2017 at 11:00 PM, the Director of Nursing (DON) reported the resident was found on the floor next to her bed but they were unable to determine the staff that wheeled the resident back to her room from the day room. The DON further reported that her expectation was for the staff not to have left the resident unattended sitting in the wheel chair in her room. | F 323 | | |
| F 353 SS=D | 483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS<br><br>483.35 Nursing Services<br><br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care | F 353 | | 4/3/17 |

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| F 353 | Continued From page 10<br>and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br>[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(a) Sufficient Staff.<br>(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br><br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br><br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br><br>(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident, | F 353 | F353 | |

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| F 353 | Continued From page 11<br>family and staff interviews, the facility failed to provide sufficient nursing staff to offer showers as scheduled for 1 of 40 sampled residents (Resident #40).<br><br>Findings included:<br>1. Cross refer F242. Based on resident, staff interviews and record review, the facility failed to offer showers as scheduled for 1 of 40 sampled residents. (Resident #40).<br><br>Interview with the Director of Nursing on 3/3/2017 at 2:30 PM revealed her expectations of nursing staffing were the residents' care would be provided as care planned and with choices. | F 353 | How corrective action will be accomplished for each resident found to have been affected by the deficient practice  Resident #40 was offered a shower and preference reviewed with resident representative (daughter) upon notification to ensure preferences were met going forward. The Director of Nursing/Unit Manager or designee will reallocate CNA resources among the 3 units to ensure the facility has adequate nursing staff to provide showers.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice  The Director of Nursing/Unit Manager or designee will audit staffing assignment sheets daily to assure adequate staffing to meet resident needs and to adjust assignments according to resident needs Monday  Friday for a month and weekly X 2 months.<br><br>Measures to be put in place or systemic changes made to ensure practice will not re-occur  The Administrator will interview 10% of resident census weekly x 4 weeks and monthly thereafter to assure showers are being given as scheduled. Any deficient practice will result in re-education and/or discipline as needed. Administrator will in-service the DON and designees on expectations of nursing staffing for care to be provided as care planned and with choices. | |

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| F 353 | Continued From page 12 | F 353 | How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- The results of these audits will be reviewed in weekly Quality Assurance Risk Meetings X3 months and Quarterly Quality Assurance Meetings X1 for further problem resolution. | |
| F 356 SS=C | 483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION<br><br>483.35<br>(g) Nurse Staffing Information<br>(1) Data requirements. The facility must post the following information on a daily basis:<br><br>(i) Facility name.<br><br>(ii) The current date.<br><br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br><br>(A) Registered nurses.<br><br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law)<br><br>(C) Certified nurse aides.<br><br>(iv) Resident census.<br><br>(2) Posting requirements.<br><br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. | F 356 | | 4/3/17 |

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| F 356 | Continued From page 13<br><br>(ii) Data must be posted as follows:<br><br>(A) Clear and readable format.<br><br>(B) In a prominent place readily accessible to residents and visitors.<br><br>(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to post nursing staffing information in the facility on 1 of 6 days of the survey.<br><br>The findings included:<br><br>During the initial tour of the facility on 02/26/2017 at 4:00 PM nursing staffing information was not found.<br><br>In an interview held on 02/26/2017 at 5:20 PM with the Front Desk Receptionist, she stated the information was normally posted on the desk at the entrance in the clear display case. She stated, "I have not seen it all day."<br><br>During general observation tour on 02/26/2017 at 7:30 PM nursing staffing information was not found to be posted in the facility. | F 356 | F356<br><br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice: No residents affected by deficient practice.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: DON and designees are to be educated by regional nurse consultant on posted nurse staffing and census.<br><br>Measures to be put in place or systemic changes made to ensure practice will not re-occur: Administrator and/or DON will | |

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| F 356 | Continued From page 14<br><br>On 02/26/2017 at 7:45 PM, a daily nursing staff information sheet was received from the Director of Nursing. She stated the information had not been posted but was now posted at the entrance in the clear display case.<br><br>In an interview with the Director of Nursing (DON) on 03/03/2017 she stated it was her expectation the nursing staff information sheet would be posted daily. She explained there was a new scheduler hired and everyone was not posting the information appropriately. She confirmed it should be posted in the clear display case on the desk at the entrance of the facility. | F 356 | conduct audit of daily nurse staffing summary for completeness weekly for 4 weeks; every other week for 4 weeks and monthly X 1.<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the audits will be reviewed at Weekly Risk Quality Assurance Meeting and Quarterly Quality Assurance meeting X 1 for further resolution if needed. | |
| F 441 SS=D | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: | F 441 | | 4/3/17 |

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| F 441 | Continued From page 15<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which 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; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. | F 441 | | |

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| F 441 | Continued From page 16<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and record review the facility failed to implement practices to prevent cross contamination for 1 of 1 sampled residents. (Resident # 352).<br><br>The findings included:<br><br>Resident # 352 was admitted to the facility 02/23/2017 with the diagnoses of Left Groin Cellulitis and Necrotizing Fasciitis with Abscess, Hypertension, Diabetes, Duodenal Ulcer with Hemorrhage, Anemia, Gastro-esophageal Reflux Disease and Kidney Disease.<br><br>Resident #352 was admitted with surgical wounds x 3 of the left groin area. Observed wound care of Resident #352 on 3/02/2017 at 3:13 PM of the surgical wounds x 3 to the left groin area linked with sponges and attached to the wound vacuum. The wound vacuum was attached to suctioning.<br><br>Review of a Service Concern Report dated 2/27/2017 revealed a concern of Family Member of Resident #352 revealed she was concerned about Resident # 352 because he was in a room with a resident (Resident #19) on isolation. The Family Member was referred to the Director of Nursing (DON). The action taken revealed "DON explained the isolation situation, but after discussion, the family member did not voice an understanding." The Family Member was offered a room change and Resident #352 was moved to | F 441 | F441<br><br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #352 was removed from isolation room and placed in appropriate room on 02/27/17.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All current nurses will receive education on Policy number 405 Transmission Based Precautions.<br><br>Measures to be put in place or systemic changes made to ensure practice will not re-occur: All new Licensed Nurses will receive education in orientation on Policy number 405 Transmission Based Precautions. DON and/or designee for each unit will conduct audit of all residents on isolation precautions to ensure proper placement weekly for 4 weeks and monthly X 3 months. Any deficient practice will be corrected immediately with education and/or disciplinary action as needed.<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits | |

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| F 441 | Continued From page 17<br>another room. The Family Member "concern was resolved."<br><br>An interview with Resident #352 on 02/27/2017 at 3:39 PM revealed Resident #352 had been moved to another room because his family had concerns regarding him being in a room with Resident #19. He stated he did not understand why, but his Family Member took care of the issue.<br><br>An interview with the Infection Control Nurse and the Unit Manager of 200 hall on 3/2/2017 at 3:00 PM revealed Resident #19 was on Contact Isolation related to his treatment for Methicillin Resistant Staphylococcus Aureus (MRSA) since his admission (01/31/2017).<br><br>An interview with the DON, on 3/2/17 at 11:31 AM was conducted. She explained the Admissions Director responsibility is bed assignment to the various units.<br><br>An interview with the Admissions Director on 3/2/201 at 11:35 AM revealed she did not know Resident #352 was a new surgical wound and that he could not be placed with another Resident that had a wound on isolation. The Admissions Director stated usually the nurses will let her know if there needs to be a room change.<br><br>An interview with the Infection Control Nurse on 3/2/2017 at 4:00 PM revealed there policy regarding isolation would allow cohorts of similar residents. The Infection Control Nurse was aware Resident #352 had a surgical wound. She was also aware Resident #19 had Methicillin Resistant Staphylococcus Aureus (MRSA) and was on contact isolation. The Infection Control | F 441 | will be reviewed at Weekly Risk Quality Assurance Meeting and Quarterly Quality Assurance meeting X 1 for further resolution if needed. | |

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| F 441 | Continued From page 18<br>Nurse explained "I was not here on Friday and did not know, he (Resident #352) was placed there." She stated someone had failed to let admissions know the surgical wound should not be placed in the room with the resident that had MRSA. During the interview she revealed her responsibility included monitoring wounds, antibiotics, isolation and she usually was a contact person for the Admissions Director. She explained when she was informed of the event she assessed the other residents that were on isolation and made sure there were no other concerns identified or that may have been over looked. The Infection Control Nurse stated she needed to complete staff re-education about mixing residents with wounds and infections. The Infection Control Nurse also stated there needed to be "improvement in communication between admissions, infection control, and the nursing staff." | F 441 | | |