STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345234	A. BUILDING _____ B. WING _____	C 03/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON HEALTH AND REHAB CENTER	1555 WILLIS AVENUE LUMBERTON, NC 28358

(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 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 164		3/31/17

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

Electronically Signed | 04/10/2017

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F 164	Continued From page 1 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to maintain the privacy of 1 of 9 sampled residents (Resident #5) on the 700 hall during incontinence rounds. Findings included: Review of the Quarterly Minimum Data Set dated 03/07/17 revealed Resident #5 was cognitively aware and was totally dependent on one staff member for hygiene and toileting needs. Resident #5 was always incontinent of bowel and bladder. In an observation on 03/28/17 at 6:05 AM the door to Resident #5's room was open and the lights were on. The soiled linen/trash cart was outside the door at an angle. Resident Care Specialist (RCS) #1 was in the room providing care to Resident #5. Soiled linens and a soiled brief were on the floor. The privacy curtain between the beds was not pulled and Resident #5 was in full view of the roommate. The privacy curtain between the door and the bed was also not pulled allowing for full viewing of Resident #5, who was not covered and was lying unclothed on the bed, by anyone in the hallway. After entry into the room by the surveyor, RCS #1 pulled the privacy curtain between the two beds. Resident # 5 remained unclothed and the door to the room remained open. RCS #1 pulled out a folded brief that was under Resident #5's buttocks and threw it on the floor along with another brief. She picked up the soiled linens and soiled briefs that	F 164	Criteria 1 Resident care specialist #1 was re-educated regarding providing for resident privacy and dignity. She was re-educated by the Director of Clinical Education on 3/30/2017. Resident Care Specialist #1 did not return to work prior to re-education. Criteria 2 All other direct care staff will be re-educated by Director of Clinical Education to ensure privacy of all residents to include ensuring dignity of all residents. All education will be completed on or before March 31, 2017. Criteria 3 Director of Clinical Education and/or any Department Head in her absence will randomly monitor 5 staff members alternating shifts to include weekends to ensure privacy is provided to ensure resident dignity. Monitoring will begin week of April 3rd - April 7. 2017. Staff will be monitored weekly for a minimum of 3 months and then until no longer deemed necessary. Criteria 4	

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F 164	Continued From page 2 were on the floor and disposed of them in the hallway and then re-entered the room, closing the door behind her. In an interview on 03/28/17 at 7:37 AM RCS #1 stated she should have pulled the privacy curtain and closed the door prior to providing care to Resident #5. In an interview on 03/29/17 at 10:50 AM Resident #5, when asked if it bothered him that privacy was not provided to him during care, stated "Not really, I'm used to it." He did not explain his comment any further. In an interview on 03/29/17 at 11:02 AM the Staff Development Coordinator (SDC) stated RCS's should always provide privacy for each resident prior to care by closing the door, pulling the curtain between the beds, and closing the window blinds if appropriate. Residents should also be covered during care so they would not be exposed. In an interview on 03/29/17 at 1:29 PM RCS #2 stated privacy curtains should always be pulled and the door closed when giving care. In an interview on 03/29/17 at 1:37 PM RCS #3 stated curtains should be pulled for privacy during care. In an interview on 03/29/17 at 1:47 PM the Director of Nursing (DON) stated she expected the privacy curtains to be pulled in front of the door and the door to be closed. She indicated she also expected the curtain between the beds to be pulled and the blinds to be closed. She stated she expected resident's bodies to not be	F 164	The results of the monitoring will be brought to the QAPI committee to ensure quality assurance and process improvement. The monitoring will be completed no less than 3 consecutive months and then until no longer deemed necessary. Immediate QAPI meeting held 3/29/2017 to review the findings during complaint survey and the plan for correction and process improvement.	

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F 164	Continued From page 3 exposed by the RCS.	F 164		
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 observation, record review and staff interviews the facility failed to provide incontinent care using front to back cleansing technique for 3 of 4 sampled residents (Resident #6, Resident #7, and Resident #8) observed for incontinent care. Findings included: 1. Review of the Quarterly Minimum Data Set (MDS) dated 02/13/17 revealed Resident #6 was admitted to the facility on 12/08/15 with diagnoses of heart failure, hypertension and Alzheimer's disease. Resident #6 was severely cognitively impaired, always incontinent of bowel and bladder and was totally dependent on two persons for toileting and hygiene needs. In an observation on 03/28/17 at 6:25 AM Resident Care Specialist (RCS) #1 entered Resident #6's room to provide incontinence care. RCS #1 pulled back Resident #6's brief revealing a moderate amount of urine. RCS #1 used disposable wipes and cleansed Resident #6's perineum using a motion from the lower perineum toward the top of the perineum three times using the same wipe each time. Resident #6's buttocks were cleansed from the lower buttocks toward the lower back and a clean brief was placed.	F 312	Criteria 1 Resident care specialist #1 re-educated March 29, 2017 by Clinical Director of Education regarding proper procedure for providing incontinent care, ensuring return demonstration more than once. RCS checked off by Director of Clinical Education following the procedure step by step for accuracy to ensure comprehension of providing incontinent care to the male and female resident. Criteria 2 All other Resident Care Specialists will be re-educated regarding the policy and procedure for providing incontinent care to residents on or before Friday, March 31, 2017. The Director of Clinical Education is completing the re-education. Criteria 3 Director of Clinical Education and/or another Registered Nurse in her absence will randomly monitor 5 resident care specialists weekly to ensure incontinent	3/31/17

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F 312	Continued From page 4 2. Review of the Annual MDS dated 02/28/17 revealed Resident #7 was readmitted to the facility on 04/07/15 with diagnoses of Alzheimer's disease, hypertension and anxiety disorder. Resident #7 had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. Resident #7 was always incontinent of bladder and bowel and was totally dependent on one person for toileting and hygiene needs. In an observation on 03/28/17 at 6:40 AM RCS #1 entered Resident #7's room to provide incontinence care. RCS #1 pulled back Resident #7's brief revealing a moderate amount of urine. RCS #1 used disposable wipes and cleansed Resident #7's perineum three times using the same wipes in a motion from the lower perineum toward the top of the perineum. Resident #7's buttocks were cleansed using a motion from the lower buttocks to the lower back and a clean brief was placed. 3. Review of the Quarterly MDS dated 12/23/16 revealed Resident #8 was admitted to the facility on 04/15/15 with diagnoses of hypertension, heart failure and neurogenic bladder. Resident #8 was severely cognitively impaired and was always incontinent of bowel and bladder. Resident #8 was totally dependent on one person for hygiene and needed the extensive assistance of one person for toileting needs. In an observation on 03/28/17 at 6:52 AM RCS #1 entered Resident #8's room to provide incontinence care. RCS #1 pulled back Resident #8's brief revealing a moderate amount of urine. RCS #1 used disposable wipes and cleansed Resident #8's buttocks using a lower back to	F 312	care is provided by policy/procedure following infection control practices. Monitoring will be begin week of Monday, April 3, 2017 and will continue weekly for no less than 3 months to ensure quality improvement and compliance. Criteria 4 The plan of correction will be brought to the QAPI committee 3/29/2017 for recommendations and to review the steps of correction. The results of the monitoring will be brought to the QAPI committee for a minimum of 3 consecutive months and then until no longer deemed necessary based on the results of the monitoring.	

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F 312	Continued From page 5	F 312		

lower buttocks motion five times using three different wipes returning stool with each wipe. She then wiped three times using one disposable wipe in a lower back to lower buttocks motion and on the last swipe no stool was visible on the wipe. RCS #1 then proceeded to cleanse Resident #8's perineum. The labia were spread and stool was noted on the wipe. RCS #1 cleansed the perineum using a motion from the top of the perineum to the bottom of the perineum. A clean brief was placed on Resident #8.

In an interview on 03/28/17 at 7:37 AM RCS #1 stated the purpose of cleansing with a front to back motion was to keep the perineal area from getting contaminated. She indicated if the area was contaminated the resident could get an infection. RCS #1 indicated that she thought she had cleansed each resident using a front to back motion.

In an interview on 03/28/17 at 11:02 AM the Staff Development Coordinator (SDC) stated the correct way to provide incontinence care for a female resident was to cleanse the perineal area using one wipe for the left side, one wipe for the right side and one wipe for the middle. A front to back motion should always be used. She indicated if a back to front motion was used it could cause a urinary tract infection or another type of infection.

In an interview on 03/29/17 at 1:29 PM RCS #2 stated that when providing incontinence care a front to back motion should always be used to prevent an infection.

In an interview on 03/29/17 at 1:37 PM RCS #3 indicated an RCS should wipe from the front to

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F 312	Continued From page 6 the back when providing incontinent care to a resident. In an interview on 03/29/17 at 1:47 PM the Director of Nursing (DON) stated it was her expectation that when incontinence care was provided, cleansing should be done using the front to back method. She indicated washing back to front was unacceptable and could cause an infection.	F 312		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide the correct	F 322	Criteria 1	3/31/17

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F 322	Continued From page 7 gastrostomy tube feeding rate for 1 of 2 sampled residents (Resident #3) whose tube feeding was observed. Findings included: Resident #3's Admission Minimum Data Set (MDS) dated 01/20/17 revealed a readmission date of 01/13/17 with diagnoses of diabetes mellitus, gastrostomy, pressure wounds, and Alzheimer's disease. Resident #3 had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. Resident #3 was totally dependent on staff for her nutritional needs and received 51% or more of calories through gastrostomy tube feedings. Review of the Physician's Orders dated 03/16/17 revealed an order to discontinue the enteral feed order every shift for (Brand name) at 65 cc/hr (cubic centimeters/hour) by g (gastrostomy) tube via continuous pump x (times) 20 hours/day (providing) 1300 ml/1950 kcal (milliliters/kilocalories). The rate of the g tube feeding was to be increased to 70 cc/hr (to provide) 1400 ml/2100 kcal. Review of Resident #3's Enteral Medication Administration Record (MAR) for March 2017 revealed an enteral feeding order for (Brand name) to infuse at 70 cc/hr beginning 03/16/17 at 2300. The MAR was divided into spaces for each shift of nurses to sign off that the order was carried out on each shift each day. The order was initialed by Nurse #1 on 03/26/17 second shift, Nurse #2 on 03/27/17 first shift, and Nurse #3 on 03/27/17 second shift. In an observation on 03/26/17 at 3:45 PM (second shift) Resident #3 was lying in bed with	F 322	Resident #3's enteral feeding pump adjusted by the Director of Nursing 3/27/2017 at approximately 4:30 pm to reflect the correct physician orders. 100% audit of all enteral feeding resident were audited 3/27/2017 by Director of Nursing Services to ensure all other feeding pumps were set to accurately reflect the physician order. No others found to be affected. Criteria 2 All licensed nurses will be re-educated on or before March 29, 2017 to ensure all nurses validate enteral feeding pumps against the physician order every shift. All education will be completed on or before March 31, 2017. All licensed nurses will be educated to ensure any enteral feeding order whether an initial order or a change in order will be communicated on the 24 hour report board and the order entry nurse will have ownership to change the pump to the ensure following of physician orders. All education will be completed by March 31, 2017 by the Director of Clinical Education. Criteria 3 Director of Nursing and/or another Registered Nurse, in her absence, will audit all residents with enteral feedings daily X 5 days beginning 3/27/2017 and then weekly, beginning April 3, 2017 for a minimum of 3 consecutive months to ensure accuracy of physician orders.	

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F 322	Continued From page 8 the head of the bed elevated. The (Brand name) tube feeding was infusing at 65 cc/hr. In an observation on 03/27/17 at 2:22 PM (first shift) Resident #3 was lying in bed with the head of the bed elevated. The (Brand name) tube feeding was infusing at 65 cc/hr. In an observation of medication administration on 03/27/17 at 3:37 PM (second shift) Resident #3 was lying in bed with the head of the bed elevated. The (Brand name) tube feeding was infusing at 65 cc/hr. Nurse #3 stopped the feeding and proceeded with medication administration. When finished providing the medication, Nurse #3 restarted the pump and the (Name brand) tube feeding began infusing at 65 cc/hr. In an observation on 03/27/17 at 4:23 PM (second shift) Resident #3 was lying in bed with the head of the bed elevated. The (Brand name) tube feeding was infusing at 65 cc/hr. In an observation and interview with the Director of Nursing (DON) on 03/27/17 at 4:25 PM, the DON verified that the tube feeding for Resident #3 was infusing at 65 cc/hr. When she was asked to check the Enteral MAR with Nurse #3 to verify the rate she stated the rate should be at 70 cc/hr. She then went to Resident #3's room and adjusted the pump so that it was infusing at 70 cc/hr. In a telephone interview on 03/28/17 at 1:52 PM Nurse #3 stated it was her process to check for each of the six resident rights which included the right dose. She indicated she was unaware that the rate for Resident #3's tube feeding had been	F 322	Criteria 4 The results of the monitoring will be brought to the QAPI meeting monthly to ensure quality of care and compliance with the plan of correction. The monitoring will be completed no less than 3 consecutive months and then until no longer deemed necessary. Immediate QAPI meeting held with review of the plan of correction held 3/27/2017.	

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F 322	Continued From page 9	F 322		

changed. She stated she just missed that the rate should have been 70 cc/hr and not 65 cc/hr. Nurse #3 stated if the order had been on the MAR and not the Enteral MAR she would have seen it. She indicated the print on the computer MAR/Enteral MAR was very fine and she could not really see it.

In a telephone interview on 03/28/17 at 1:57 PM Nurse #2 stated she had not checked Resident #3's pump to make sure the tube feeding was infusing at the correct rate. She indicated if she had realized the rate had changed she would have adjusted it.

In an interview on 03/28/17 at 2:13 PM Nurse #2 stated the rate of the tube feeding for Resident #3 should have been 70 cc/hr. She indicated she had not seen the order because it was on a different page than the regular MAR, however she stated that she had initialed that she had verified and completed the order as written. She stated she only glanced at the order and did not read it. Nurse #2 indicated she would never put a resident in harm's way and had just missed the order. She indicated if she had seen that the Enteral MAR showed the rate should have been 70 cc/hr she would have gone to look at the order or asked someone about it.

In an interview on 03/29/17 at 1:47 PM the DON stated she expected all physician orders to be followed including tube feeding orders. She indicated she expected the nurses to verify the order was correct and then to sign them off. The DON stated tube feedings provided nutrition and hydration to residents and was very important as it helped to stabilize weight and if a resident had wounds it would assist in wound healing. She

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F 322	Continued From page 10 stated it was very important that the orders be followed.	F 322		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide the ordered calories and protein for 1 of 2 sampled residents (Resident #3) whose tube feeding was reviewed. Findings included: Resident #3's Admission Minimum Data Set (MDS) dated 01/20/17 revealed a readmission date of 01/13/17 with diagnoses of diabetes mellitus, pressure wounds, and Alzheimer's disease. Resident #3 had short and long term memory problems and was severely impaired in cognitive skills for daily decision making.	F 325	Criteria 1 Resident #3's enteral feeding pump adjusted by the Director of Nursing 3/27/2017 at approximately 4:30 pm to reflect the correct physician orders. 100% audit of all enteral feeding resident were audited 3/27/2017 by Director of Nursing Services to ensure all other feeding pumps were set to accurately reflect the physician order. No others found to be affected.	3/31/17

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F 325	Continued From page 11	F 325		

Resident #3 was totally dependent on staff for her nutritional needs and received 51% or more of calories through gastrostomy tube feedings.

Review of the Physician's Orders dated 03/16/17 revealed an order for Glucerna 1.5 at 70cc/hr (cubic centimeters/hour) by g tube via continuous pump times 20 hours/day.

Review of Resident #3's weights by pound revealed the following :

12/23/16 115.3
01/13/17 138.0
01/18/17 136.0
01/24/17 131.0
01/31/17 120.0
02/08/17 115.0
02/14/17 116.0
02/21/17 117.0
02/28/17 115.0
03/07/17 116.0
03/14/17 114.0
03/21/17 115.0
03/27/17 117.8

Review of the Nutrition Note dated 01/18/17 revealed Resident #3's weight on readmission to the facility after a feeding tube was placed on 01/09/17 was 138 pounds and the weight gain was likely related to an increase in total intake and fluids. Edema had been noted in the hospital. Resident #3 received 41 grams of protein and 1130 ml (milliliters) of fluid and 750kcal (kilocalories) from Glucerna 1.5 infusing at 25 ml/hr. Feedings had been held temporarily due to concerns with the new tube which may have affected weight and there were also edema changes.

Criteria 2

All licensed nurses will be re-educated on or before March 29, 2017 to ensure all nurses validate enteral feeding pumps against the physician order every shift. All education will be completed on or before March 31, 2017. All licensed nurses will be educated to ensure any enteral feeding order whether an initial order or a change in order will be communicated on the 24 hour report board and the order entry nurse will have ownership to change the pump to the ensure following of physician orders. All education will be completed by March 31, 2017 by the Director of Clinical Education.

Criteria 3

Director of Nursing and/or another Registered Nurse, in her absence, will audit all residents with enteral feedings daily X 5 days beginning 3/27/2017 and then weekly, beginning April 3, 2017 for a minimum of 3 consecutive months to ensure accuracy of physician orders.

Criteria 4

The results of the monitoring will be brought to the QAPI meeting monthly to ensure quality of care and compliance with the plan of correction. The monitoring will be completed no less than 3 consecutive months and then until no longer deemed necessary. Immediate QAPI meeting held with review of the plan

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F 325	Continued From page 12 Review of the Nutrition RD (Registered Dietician) Assessment dated 01/18/17 revealed Resident #3 had the following estimated nutrient needs: approximate calories- 1860-2170, approximate protein- 78-93 grams, and approximate fluid- 1860-2170ml (milliliters). Review of the Nutrition Note written by the RD and dated 03/15/17 revealed Resident #3's weight on 03/14/17 was 114 pounds. Resident #3's weight ranged from 114-117 pounds since 02/21/17. A stage 2 pressure ulcer was noted to be improving. The Glucerna 1.5 formula at 65 cc/hr (cubic centimeters/hour) for 20 hrs with 160 ml of water flush every 4 hours and 1 scoop of protein powder twice each day provided approximately 37.5 kcal/kg (kilocalories/kilogram). Consider increasing feeding to 70 ml/hr for 40 kcal/kg which will provide approximately 115.5 grams of protein and 1063 ml free water from feeding; continue current flush of 960 ml for total of 2023 ml fluid plus (fluid) with and between medications. Review of the Physician's Orders dated 03/16/17 revealed an order to discontinue the enteral feed order every shift for Glucerna 1.5 at 65 cc/hr (cubic centimeters/hour) by g (gastrostomy) tube via continuous pump x (times) 20 hours/day (providing) 1300 ml/1950 kcal (milliliters/kilocalories). The rate of the g tube feeding was to be increased to 70 cc/hr (to provide) 1400 ml/2100 kcal. Review of Resident #3's Enteral Medication Administration Record (MAR) for March 2017 revealed an enteral feeding order for Glucerna 1.5 to infuse at 70 cc/hr beginning 03/16/17 at 11:00 PM.	F 325	of correction held 3/27/2017.	

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In an observation on 03/26/17 at 3:45 PM Resident #3 was lying in bed with the head of the bed elevated. The Glucerna 1.5 tube feeding was infusing at 65 cc/hr.

In an observation on 03/27/17 at 2:22 PM Resident #3 was lying in bed with the head of the bed elevated. The Glucerna 1.5 tube feeding was infusing at 65 cc/hr.

In an observation on 03/27/17 at 4:23 PM Resident #3 was lying in bed with the head of the bed elevated. The Glucerna 1.5 tube feeding was infusing at 65 cc/hr.

In an observation and interview with the Director of Nursing (DON) on 03/27/17 at 4:25 PM, the DON verified that the tube feeding for Resident #3 was infusing at 65 cc/hr. When she was asked to check the Enteral MAR with Nurse #3 to verify the rate she stated the rate should be at 70 cc/hr. She then went to Resident #3's room and adjusted the pump so that it was infusing at 70 cc/hr.

In a telephone interview on 03/28/17 at 1:52 PM Nurse #3 stated it was her process to check for each of the six resident rights which included the right dose. She indicated she was unaware that the rate for Resident #3's tube feeding had been changed. She stated she just missed that the rate should have been 70 cc/hr and not 65 cc/hr. Nurse #3 stated if the order had been on the MAR and not the Enteral MAR she would have seen it. She indicated the print on the computer MAR/Enteral MAR was very fine and she could not really see it.

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In a telephone interview on 03/28/17 at 1:57 PM Nurse #2 stated she had not checked Resident #3's pump to make sure the tube feeding was infusing at the correct rate. She indicated if she had realized the rate had changed she would have adjusted it.

In an interview on 03/28/17 at 2:13 PM Nurse #2 stated the rate of the tube feeding for Resident #3 should have been 70 cc/hr. She indicated she had not seen the order because it was on a different page than the regular MAR, however she stated that she had initialed that she had verified and completed the order as written. She stated she only glanced at the order and did not read it. Nurse #2 indicated she would never put a resident in harm's way and had just missed the order. She indicated if she had seen that the Enteral MAR showed the rate should have been 70 cc/hr she would have gone to look at the order or asked someone about it.

In an interview on 03/29/17 at 12:59 PM the Registered Dietician (RD) stated when a resident first received a feeding tube the formula was started at a low rate and was increased as tolerated by the resident. She indicated she felt the weight gain in the hospital was due to intravenous fluid and the g tube feedings and the weight was now stabilized. The RD indicated Resident #3's nutritional needs were being met. She indicated that although Resident #3 was doing well, she had recommended an increase in the tube feeding rate to help maintain her weight and to help with wound healing and felt it would be beneficial to provide an added boost of calories and protein.

In an interview on 03/29/17 at 1:47 PM the DON

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F 325	Continued From page 15 stated she expected all physician orders to be followed including tube feeding orders. The DON stated tube feedings provided nutrition and hydration to residents and was very important as it helped to stabilize weight and if a resident had wounds it would assist in wound healing. She stated it was very important that the orders be followed. The DON stated Resident #3's weight was stabilized and did not feel the weight loss was due to not receiving the correct nutrition, but due to fluid loss after the hospitalization.	F 325		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (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); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 441		3/31/17

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F 441	Continued From page 16 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 441		

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F 441	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to perform hand washing between residents while providing care for 9 of 9 Residents (Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10, Resident #11, Resident #12 and Resident #13) and failed to handle dirty linen and soiled briefs in a sanitary manner by placing them on the floor for 1 of 1 residents (Resident #5). Findings included: 1. Review of the Infection Prevention Manual for Long Term Care Hand Hygiene policy, revised 09/2015 and provided by the facility, revealed under Policy: "Handwashing/hand hygiene is generally considered the most important single procedure for preventing healthcare associated infections." In an observation of care rounds on 03/28/17 beginning at 6:05 AM Resident Care Specialist (RCS) #1 was observed in Resident #5's room wearing gloves while providing care. When care was completed she removed her gloves and threw them in the trash. She then put on clean gloves without washing her hands and proceeded to Resident #9's room. RCS #1 checked Resident #9's brief for incontinence. She used disposable wipes to clean the wet mattress and provided incontinent care to the resident. RCS #1 removed her gloves and disposed of them in the trash. She did not wash her hands. She proceeded to Resident #6's room and put on gloves outside the doorway. RCS #1 provided incontinent care and then removed her gloves and threw them in the trash outside of the room. She did not wash her hands prior to putting on	F 441	Criteria 1 Resident Care Specialist #1 re-educated regarding Washing of hands on March 28, 2017 and soiled linen handling, soiled brief/pad storage, and transporting of those soiled items on March 29, 2017 by Director of Clinical Education. Resident care specialist #1 demonstrated proper Handwashing for the Director of Clinical Education on 3/28/2017, with resident care specialist entering resident rooms and practicing her technique to ensure comprehension of policy/procedure. Resident care specialist #1 was able to repeat and demonstrate proper technique when handling soiled items, i.e. linens and/or briefs/pads/trash. Walking rounds completed by clinical leadership on 3/28/2017 found no other affected residents. Observation found all soiled linens handled properly and handwashing completed as expected. Criteria 2 All other staff members to be re-educated on or before March 31, 2017 regarding policy and procedure for hand washing and the handling of soiled linens and briefs/pads/trash, etc. The Director of Clinical Education will complete the education for all staff members.	

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F 441	Continued From page 18 clean gloves. RCS #1 proceeded to Resident #10's room to check for incontinence. Resident #10's brief was pulled down and appeared dry. The brief was straightened and put back on Resident #10. RCS #1 removed her gloves and disposed of them in the hallway trash. She put on clean gloves without washing her hands. RCS #1 proceeded to Resident #11's room and felt the brief which was dry. The brief was rearranged and RCS #1 took off her gloves and disposed of them in the room. She did not wash her hands before proceeding to Resident #12's room. RCS #1 put on gloves outside the door of Resident #12. She touched the brief and stated it was dry. She removed her gloves and without washing her hands proceeded to Resident #7's room. RCS #1 put on clean gloves and proceeded to provide incontinent care to Resident #7. When incontinent care was completed she removed her gloves and disposed of them in the trash. She did not wash her hands. RCS #1 then went to Resident #8's room and provided incontinent care after putting on clean gloves. When incontinent care was completed RCS #1 disposed of her gloves in the trash and did not wash her hands. RCS #1 proceeded to Resident #13's room and put on clean gloves. She checked Resident #13's brief and it was dry. She removed her gloves and did not wash her hands. Care rounds were completed at 7:04 AM and no hand washing was performed during the observation. In an interview on 03/28/17 at 7:37 AM RCS #1 stated the purpose of hand washing was to disinfect the hands so diseases were not taken from person to person. She indicated she did not wash her hands at any time during her care rounds because she was nervous. She stated she should have washed her hands after	F 441	Criteria 3 Licensed nurses on duty will monitor 2 staff members each shift to ensure hand washing policy/procedures are followed. The Director of Clinical Education and/or a Department Head or Assistant will randomly monitor 5 staff members each week alternating shifts to include weekends to ensure hand washing policy/procedures are followed and the soiled linen collection and transfer policy is followed. The monitoring will begin the week of April 3, 2017 and will continue for a minimum of 3 consecutive months and then until no longer deemed necessary. Criteria 4 The QAPI committee met to review the plan of correction and make any recommendations to ensure quality of care on 3/29/2017. The results of the monitoring will be brought to the QAPI committee for a minimum of 3 consecutive months and then until no longer deemed necessary based on the results of the monitoring.	

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providing care to each resident.

In an interview on 03/29/17 at 11:02 AM the Staff Development Coordinator (SDC) stated RCS #1 had received a hand washing in-service in December. She indicated staff were expected to wash their hands before and after care was provided to residents.

In an interview on 03/29/17 at 1:29 PM RCS #2 stated hand washing should be done before and after providing care to residents.

In an interview on 03/29/17 at 1:37 PM RCS #3 indicated hands should always be washed before and after care was provided to a resident.

In an interview on 03/29/17 at 1:47 PM the Director of Nursing (DON) stated she expected hand washing to be done between each resident. She indicated hand sanitizer was also available in the hallways for staff to use. She stated RCS #1 should have washed her hands between each resident during her rounds.

2. In an observation on 03/28/17 at 6:05 AM soiled linen was seen on the floor in Resident #5's room. The linen was not in a bag. RCS #1 was in the room providing care to Resident #5. She threw 2 soiled briefs onto the floor. The briefs were not in a bag. When care was completed the soiled linens and briefs were thrown in the soiled linen and trash receptacle.

In an interview on 03/28/17 at 7:37 AM RCS #1 stated she should not have thrown soiled linen and soiled briefs onto the floor. She indicated she should have placed them in a plastic bag and then disposed of them.

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F 441	Continued From page 20 In an interview on 03/29/17 at 1:29 PM RCS #2 stated soiled linens and trash should never be thrown on the floor. In an interview on 03/29/17 at 1:37 PM RCS #3 indicated plastic bags should be taken into the room before care so soiled linen and trash could be put in them. In an interview on 03/29/17 at 1:47 PM the DON stated she expected soiled linen and soiled briefs to be placed in plastic bags and then tied up and taken out of the room. She indicated they should never be thrown on the floor.	F 441		