STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD HILLS NURSING AND REHABILITATION CENTER	1016 FLETCHER STREET WILKESBORO, NC 28697

(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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		10/3/18

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

Electronically Signed | 09/26/2018

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, and staff interviews the facility failed to maintain the dignity of 1 of 3 residents by allowing staff to talk about the resident s bowel incontinence while providing care to the resident (Resident #77). The findings included: Resident #77 admitted to the facility on 07/27/18 with diagnoses that included: hemiplegia and hemiparesis following an infarction, diastolic heart failure, atrial fibrillation, major depressive disorder, bipolar disorder, and others. Review of the comprehensive minimum data set (MDS) dated 08/03/18 revealed that Resident #77 was moderately cognitively impaired and required extensive assistance of 2 staff members with toileting. The MDS further revealed Resident #77 was always incontinent of bowel and no behaviors or rejection of care was noted during the reference period. An observation and interview were conducted with Resident #77 on 09/10/18 at 10:59 AM. Resident #77 was up in a rock n go wheelchair in her room. Resident #77 recalled an event that occurred approximately a week earlier on 3rd shift when Nursing Assistant (NA #2) was mean to her. She stated that NA #2 and NA #3 had come in to provided incontinent care to her because she had a bowel movement. Resident #77 stated that when NA #2 and NA #3 came in to change her she overheard NA #2 say to NA #3 "she is so nasty" look at what is all over her hand.	F 550	Westwood Hill Nursing and Rehabilitation Acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Westwood Hills Nursing and Rehabilitation□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Westwood Hills Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 550 The plan of correcting the specific deficiency: The position of Westwood Hills Nursing and Rehabilitation regarding the process that led to this deficiency for F550 was	

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F 550	Continued From page 2 Resident #77 stated that her left hand was paralyzed, and she had no use of it and because she had an incontinent episode of bowel she was scratching herself and when she heard NA #2 say that to NA #3 she felt like she was being scolded like a child. She added that NA #2 and NA #3 did clean her up and then exited her room. Resident #77 stated she had reported the incident to the facility management. An interview was conducted with NA #2 on 09/11/18 at 4:43 PM. NA #2 confirmed that she worked on the unit where Resident #77 resided and routinely cared for her. NA #2 stated that about a week ago she and NA #3 had entered Resident #77's room to provide incontinent care on 3rd shift. NA #2 stated that when she pulled back Resident #77's covers she had an incontinent bowel movement and her hand was in her vagina and she stated to NA #3 "that is nasty" and they proceeded to clean Resident #77 up and wash her hands before exiting the room. NA #2 stated that when they washed Resident #77's hand off "it was nasty and covered with all kinds of stuff." She added that she did not think Resident #77 heard her say that was nasty and if she did hear she did not indicate that she had heard it. NA #2 stated that they cleaned Resident #77 up and left the room and finished her shift. She added that she was expected to treat the resident with dignity and respect and have good bedside manner. She added that she had been trained that if she had conflict with a resident to get another staff member to assist the resident. An interview was conducted with NA #3 on 09/12/18 at 3:18 PM. NA #3 confirmed that she worked 3rd shift with NA #2 on the unit where Resident #77 resided. NA #3 confirmed that	F 550	that a staff member failed to follow the policy and protocol related to dignity by talking about the resident□s bowel movement while providing care to the resident. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: The employee concerning resident #77 was retrained on September 7, 2018, by the Director of Nursing and Assistant Director of Nursing regarding speaking to residents in an appropriate manner. This training was based on the F550 tag. In addition, a retraining was provided to all staff by the Staff Development Coordinator, Director of Nursing, or Department Head managers, on staff treatment of residents, to include speaking to residents, or in speaking about residents, in patient care areas, in a dignified manner. This will be completed by October 3, 2018. This inservice will continue to be a part of the orientation process for all newly hired employees. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The monitoring of staff speaking to residents in a dignified manner will be accomplished by individual interviews of 10 random interviewable residents by the Social Workers or Activity Director. They will be questioned concerning the staff treating them with dignity. The Dignity Audit Tool will be utilized and will be completed weekly x4, then monthly x 3.	

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F 550	Continued From page 3 about a week ago she and NA #2 had gone into Resident #77's room on 3rd shift to provide incontinent care. NA #3 stated that when they pulled Resident #77's covers back she had had her hand in her vagina and NA #2 made the comment "that was nasty." NA #3 stated that she was not sure if Resident #77 heard the comment that NA #2 made or not, but they had cleaned her up and then exited the room. NA #3 added that she had been trained to treat the resident with respect and dignity. An interview was conducted with the Director of Nursing (DON) on 09/13/18 at 10:17 AM. The DON stated that when the incident with Resident #77 and NA #2 was reported she was suspended from duty until further notice. She added that if NA #2 returned to work she would be required to complete a customer service book. The DON stated that she expected her staff to not say things out loud where residents could hear them, and they should always be respectful.	F 550	Any areas of concern will be addressed immediately with the Administrator or Director of Nursing. Retraining will occur with the employee. The Quality Assurance Committee will review the results of the Dignity Audit Tool monthly and give recommendations for follow up as needed or appropriateness for continued compliance in this area and to determine the need for and or frequency of continued QA monitoring. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to maintain a resident's mobility by placing the resident in a wheelchair that the resident could not propel for 1 of 1 residents sampled in a rock n go wheelchair	F 558	F558 The plan of correcting the specific deficiency The position of Westwood Hills Nursing	10/3/18

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F 558	Continued From page 4 (Resident #77). The findings included: Resident #77 admitted to the facility on 07/27/18 with diagnoses that included: hemiplegia and hemiparesis following an infarction, diastolic heart failure, atrial fibrillation, major depressive disorder, bipolar disorder, and others. Review of the comprehensive minimum data set (MDS) dated 08/03/18 revealed that Resident #77 was moderately cognitively impaired and required extensive assistance of 1 staff member with locomotion on and off the unit. The MDS indicated Resident #77 used a wheelchair daily. An observation and interview were made of Resident #77 on 09/10/18 at 10:54 AM. Resident #77 was up in a rock n go wheelchair at the nurse's station. She stated that she could not propel herself down to her room and the Assistant Director of Nursing (ADON) was observed to push Resident #77 in the rock n go wheelchair down to her room. Once in her room Resident #77 indicated that she was able "to go all over in the wheelchair I had." An interview was conducted with Nursing Assistant (NA) #1 on 09/11/18 at 2:09 PM. NA #1 confirmed that she routinely cared for Resident #77 on 1st shift. She stated that Resident #77 was not able to propel herself in the rock n go wheelchair and the staff pushed her wherever she wanted to go, especially out to smoke. NA #1 further stated that when Resident #77 was in her old wheelchair she was able to take herself outside to smoke and back with no assistance.	F 558	and Rehabilitation regarding the process that lead to this deficiency was failure to place resident in a wheelchair rock n go that the resident could not propel. According to the therapist, there was no scoot chair available to try the resident in . The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Resident # 77 was placed in a scoot chair on 9/13/2018 by the therapist to attempt to increase patient□s safety and independence, however, upon further evaluation of Resident#77□s abilities in this chair, it was determined that this was not the most effect to meet her mobility needs. On 9/20/2018, the Occupational Therapist changed resident to a high back reclining wheel chair with lateral trunk support placed on the left side to prevent leaning, with success. The resident now has increased abilities to self-propel and states improved comfort and easier mobility with this wheelchair. All therapy staff were in-serviced by the rehab manager or regional director on determining the potential for improved mobility for residents in rock-n-go chairs. This was completed by 10/03/2018. This training will be incorporated into orientation for the new therapy staff. All residents using this type of chair were evaluated by the rehab manager for mobility, if appropriate in these chairs, were reassessed by the rehab manager or regional manager for possible chairs to promote self-propelling. This was completed on 9/26 and 9/27/2018. Any resident who could not propel themselves	

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F 558	Continued From page 5 An observation was made of Resident #77 on 09/11/18 at 2:28 PM. Resident #77 was brought by staff to the nurse's station to use the telephone to call her family. Once Resident #77 had finished her conversation she hung the phone up and attempted to roll herself in the rock n go wheelchair back down the hallway using her right hand but was unable to move more than an inch. A staff member returned Resident #77 to her room as she requested. A continuous observation was made of Resident #77 on 09/13/18 from 9:16 AM to 9:22 AM. The staff was observed to push Resident #77 in her rock n go wheelchair up to the nurse's station. Resident #77 was observed to try and propel herself back down the hallway towards her room for the next 6 minutes and was unsuccessful. She remained in the same spot but had managed to turn the chair in the correct direction. A passing staff member returned Resident #77 to her room. An interview was conducted with the Physical Therapist (PT) on 09/13/18 at 9:34 AM. The PT stated that when Resident #77 admitted to the facility she brought her wheelchair from home and it was unsafe and she had several falls from it. Because of those falls the PT stated Resident #77 was placed in the rock n go wheelchair approximately 3 weeks ago. The PT further explained that the best option for Resident #77 was a scoot chair, but the facility did not have one. The PT stated that facility had a scoot chair, but it was in use by another resident and they had talked about ordering one but was not sure if that had happened or not. She added that in the wheelchair she brought from home Resident #77 was able to propel herself 50-100 feet independently. She added that she had witnessed	F 558	appropriately in these chairs, were reassessed by the rehab manager or regional manager for possible chairs to promote self-propelling. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Residents utilizing Rock n Go seating will be reviewed monthly x3 by the rehab manager/designee for self propelling if appropriate. Anyone that requires different seating to promote self propelling will be treated thru the therapy department for a more suitable device. The Rock n Go Audit tool will be utilized. The Quality Assurance Committee will review the results of the audits monthly and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QA monitoring. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	

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F 558	Continued From page 6 Resident #77 propel the rock n go wheelchair but stated "it was not as far or as well as she did in her old wheelchair." The PT stated that she was addressing the underlying impairments and at this time and "we are doing the best we can with what we have to keep her safe." An interview was conducted with the Therapy Director (TD) on 09/13/18 at 9:40 AM. The TD stated they had ordered some new wheelchairs that were more appropriate for Resident #77 and they would be delivered to the facility soon. An interview was conducted with the Director of Nursing (DON) on 09/13/18 at 10:45 AM. The DON stated she was not aware of any wheelchair that was needed for Resident #77. She added if therapy felt like Resident #77 needed a different wheelchair they should have communicated that to me and I would have made one available to her. An interview was conducted with the Administrator on 09/13/18 at 11:38 AM. The Administrator stated that when Resident #77 admitted to the facility her family brought a wheelchair that was not appropriate, and we gave her another one. The Administrator stated she had not been approached about needing a scoot chair for Resident #77 and if she had been she would have made one available to her. She added she wished she would have been made aware because the facility had chairs available for use.	F 558		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		10/3/18

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F 641	Continued From page 7 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code a received antipsychotic for one of one residents receiving injectable antipsychotic (Resident #42) and failed to code a resident's life expectancy of less than 6 months on two MDS assessments for 1 of 1 resident on Hospice (Resident #50). Findings Included: 1. Resident #42 was admitted to the facility on 04/03/18 with diagnoses that included Alzheimer's disease, dementia with behavioral disturbance, major depressive disorder, anxiety disorder, obsessive-compulsive disorder and schizophrenia among others. A review of Resident #42's most recent Minimum Data Set (MDS) Assessment dated 07/09/18 revealed Resident #42 to be cognitively impaired and required supervision with bed mobility, transfer, walk in room/corridor, locomotion on unit and eating; limited assistance with dressing, toilet use and personal hygiene and totally dependent with bathing. Further review of Resident #42's quarterly MDS revealed he was coded as "Antipsychotics were not received" A review of physician orders on 09/12/18 at 2:22 PM revealed a physician order for RisperDAL CONSTA 25mg/2mL, and antipsychotic, at a dose of "inject 2mL intramuscularly every two weeks. The active date of this medication appeared to be 04/05/18.	F 641	F641 The plan of correcting the specific deficiency The position of Westwood Hills Nursing and Rehabilitation regarding the process that lead to this deficiency for F641 was that a staff member failed to accurately code a received antipsychotic for one of the residents receiving injectable antipsychotic. The nurse was not aware the resident had the injectable antipsychotic. The MDS nurse failed to code a resident□s life expectancy of less than 6 months on two MDS assessments for 1 resident on Hospice. The nurse was unaware of the RAI manual guidance on coding less than 6 months if on Hospice. On 9/13/2018 a corrected modification was completed by the MDS nurse, including the injectable antipsychotic. On 9/13/2018 modified assessments (4/18/18 & 7/18/18) were completed by the MDS nurse, to include the coding for the life expectancy of less than 6 months. There were no other hospice residents to compare coding. This was confirmed by the MDS nurse. There was one other resident with an injectable antipsychotic. This coding was audited by the MDS nurse on 9/13/2018, and it was correct The procedure for implementing the acceptable plan of correction for the	

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F 641	Continued From page 8 A review of Resident #42's medication administration record (MAR) revealed Resident #42 received two doses of RisperDAL CONSTA between the admission MDS and the quarterly MDS dated 07/09/18. During an interview with MDS nurse #1 revealed she overlooked the administered dose of RisperDAL CONSTA. She reported she looked over it most likely due to Resident #42 not having received the antipsychotic during the 7 day look back period. She reported she should have checked question 0450, "Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent" as "yes - Antipsychotics were received on a routine basis only". During an interview with the Director of Nursing on 09/13/18 at 11:38 AM revealed she expected MDS assessments to be completed correctly. She reported Resident #42's quarterly MDS assessment dated 07/09/18 should have reflected that he had received an antipsychotic medication since his admission or previous assessment. 2. Resident #50 was admitted to the facility on 10/22/10 with diagnoses that included mental retardation, epilepsy, psychosis and others. Review of the medical record revealed on 04/11/18 the physician signed a Certification of	F 641	specific deficiency cited: The MDS nurses were retrained on the MDS coding of antipsychotics and hospice residents coded as a resident□s life expectancy of less than 6 months per the RAI manual by the MDS nurse consultant on 9/25/2018. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: MDS Coding Audits will be performed by the Director of Nursing or Assistant Director of Nursing for the correct coding of antipsychotics and hospice coding monthly x 3. Any issues will be identified and corrected by the RAI manual and retraining of the MDS nurses will occur if needed by the MDS consultant. The MDS Coding Tool for Hospice and Antipsychotics will be utilized. The Quality Assurance Committee will review the results of the audits monthly and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QA monitoring. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	

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F 641	Continued From page 9	F 641		

Terminal Illness for Hospice services. The letter read in part, "this patient (Resident #50) is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course."
Resident #50 started receiving Hospice services in April 2018 according to the medical record.

A significant change Minimum Data Set (DMS) dated 04/18/18 specified the resident was on Hospice but did not have less than 6 months to live.

The most recent quarterly MDS dated 07/18/18 specified the resident was receiving Hospice services. Section J1400 was coded as the resident did not have less than 6 months to live.

On 09/13/18 at 9:31 AM the MDS Nurse was interviewed and explained that she thought she had to have something in writing signed by the physician stating a resident was terminally ill before she could code it on the MDS. The MDS Coordinator reviewed the medical record and the physician signed Certification of Terminal Illness but stated it was not in the medical record when she completed the MDS.

In a second interview with the MDS Nurse on 09/13/18 at 12:36 PM she reviewed the RAI manual for coding section J1400 and was unaware that initiation of Hospice services meant the section should be coded as yes that a resident had less than 6 months to live.

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F 880	Continued From page 10	F 880		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(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; §483.80(a)(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; (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;	F 880		10/3/18

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	345205	A. BUILDING _____ B. WING _____	09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD HILLS NURSING AND REHABILITATION CENTER	1016 FLETCHER STREET WILKESBORO, NC 28697

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F 880	Continued From page 11 (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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff and Medical Doctor interviews the facility failed to follow their policy when discontinuing isolation precautions for clostridium difficile (Cdiff) and failed to develop a policy that was consistent with facility practice which affected 1 of 1 resident on isolation precautions (Resident #137). The findings included:	F 880	F880 The plan of correcting the specific deficiency The position of Westwood Hills Nursing and Rehabilitation regarding the process that led to this deficiency for F880 was	

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F 880	Continued From page 12 Review of a facility policy titled Clostridium Difficile (C. Difficile) dated 9/2014 and revised 08/24/15 read in part, Duration and Discontinuation of Transmission Based Precautions: It is the policy of this facility that transmission-based precautions will be discontinued when: · Resident is asymptomatic, without diarrhea or fecal incontinence · Seventy-two (72) hours after resident completed antibiotic Resident #137 admitted to the facility on 08/21/18 and discharged from the facility on 09/10/18 with diagnoses that included: enterocolitis due to C-Diff, ulcerative colitis, and irritable bowel syndrome. Review of a physician order dated 08/21/18 read, isolation precautions for C-Diff. Review of Resident #137 ' s bowel movement record from 09/04/18 through 09/10/18 revealed that Resident #137 had loose stool on 09/06/18. Review of the Medication Administration Record (MAR) dated 09/01/18 through 09/30/18 revealed that the antibiotic prescribed to treat Resident #137 ' s C-Diff was completed on 09/07/18. Review of Resident #137 ' s medical record revealed no order to discontinue isolation precautions. An observation and interview were conducted with Resident #137 on 09/10/18 at 9:56 AM. There was no isolation precaution sign on the door and there was no personal protective equipment (PPE) available. She was observed to	F 880	that the nursing department failed to follow the facility policy and procedures for residents with C Diff infections, by removing the resident off isolation precautions when antibiotics were complete. The staff were unaware of the written policy guidelines. According to the policy, isolation precautions should have been removed 72 hours after the resident was off her antibiotics. The resident was discharged home on the day, 72 hours after her antibiotics were complete. She had no symptoms of D-Diff upon discharge. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: The resident roster was reviewed, on 9/10/2018, by the Director of Nursing and no other residents were on isolation in the facility. Retraining of the Clostridium Difficile policy and procedures was provided by the Staff Development Coordinator or Director of Nursing to the licensed nursing staff. This training involved the isolation guidelines for C Diff and when to remove resident off isolation precautions. This training will be completed by October 3, 2018. This inservice will be included in the orientation process for new licensed staff. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:	

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F 880	Continued From page 13 be in the bathroom and stated, "honey I am having some loose stools, but I will be out in a bit." An observation was made on 09/10/18 at 12:38 PM of Nursing Assistant (NA) #1 delivering Resident #137 her lunch tray, NA #1 did not don any PPE prior to entering the room. NA #1 returned at 1:18 PM to pick up Resident #137 ' s lunch tray and again did not don any PPE before entering the room. An interview was conducted with the Director of Nursing (DON) on 09/10/18. The DON stated that Resident #137 had completed her antibiotic on Friday 09/07/18 and she instructed the staff to remove her isolation precautions and the PPE from Resident #137 ' s room. The DON stated that her loose stools had resolved, and she had completed her antibiotic course and she believed that the precautions could be stopped. An interview was conducted with the Medical Director (MD) on 09/11/18 at 10:13 AM. The MD stated that generally he advised the facility to discontinue precautions when the residents have finished their treatment of antibiotics unless they were not clinically getting better. The MD stated that Resident #137 had irritable bowel syndrome and we believed her loose stools were coming from that and not from C-Diff. He added that retesting Resident #137 was not necessary because the toxin would still show positive for several weeks after the completion of treatment. The MD was not aware the facility ' s policy stated to continue the precautions for 72 hours after treatment. He added that he was aware that some of the infection control practices recommend the 72 hours after treatment but was	F 880	All residents with C Diff infections will continue to be added to the infection control Surveillance Log daily as they occur by the Staff Development Nurse/Infection Control Nurse or Director of Nursing. The SDC along with the DON or designee will audit the surveillance log for stop dates for the isolation precautions for any resident with C Diff. The first Surveillance Log audit will be for Oct 1, 2018, and 2 months after. Any issues will be addressed at that time with retraining of staff. The Quality Assurance Committee will review the results of the Surveilance Log audits monthly and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QA monitoring. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	

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F 880	Continued From page 14	F 880		

not aware that the facility ' s policy indicated that. The MD stated that there was no need to continue the isolation after the completion of treatment unless symptoms persisted and clinically the resident was not improving. He added that he would have to get with the facility administration to see if they could amend or change the policy.

An interview was conducted with NA #1 on 09/13/18 at 9:17 PM. NA #1 stated that Resident #137 was able to take herself to the bathroom and would report to the staff when she had a bowel movement so that the staff could document it. She added that Resident #137 used to be on isolation but that when she returned to work on Monday the PPE and sign had been removed. NA #1 stated that if there was a sign on the door then she would apply the PPE but if there is no sign on the door then she did not have too.

An follow up interview was conducted with the DON on 09/13/18 at 10:17 AM. The DON again stated that the MD had always advised them to remove the precautions when treatment had been completed and there were no active symptoms and that was what we did with Resident #137. She stated the facility ' s policy was not very clear and very confusing, so she had reached out to her home office and discovered that the facility was considering rewriting the policy. The DON stated that they did one part of the policy by stopping the isolation precautions when Resident #137 was asymptomatic but did not wait the 72 hours after her antibiotic was completed.