STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING ______ B. WING ______	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	**1303 HEALTH DRIVE NEW BERN, NC 28560**

(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
E 000	Initial Comments An unannounced Recertification and complaint survey was conducted on 10/14/19 through 10/18/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #YB3Z11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from10/14/19 through 10/18/19. Event ID# YB3Z11. 18 of the 59 complaint allegations were substantiated resulting in deficiencies.	F 000		
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, staff and resident interviews, and record review the facility failed to keep a call bell within reach for 1 of 2 residents reviewed for accommodation of needs. (Resident #62) Findings included: Resident #62 was admitted to the facility on 5/16/18. His active diagnosis included atrial fibrillation, coronary artery disease, and hemiplegia or hemiparesis. Resident #62's minimum data set assessment	F 558	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. Immediate corrective action taken for this alleged deficient practice includes: 1. The call bell was placed in reach for resident #62.	11/15/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/10/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 558

Continued From page 1

dated 9/12/19 revealed he was assessed as moderately cognitively impaired. He had no behaviors documented. Resident #62 required extensive assistance with bed mobility and personal hygiene. He was totally dependent on staff for dressing and toilet use. He was independent with eating.

Resident #62's care plan dated 9/26/19 revealed the interventions included to place his call bell within reach.

During observation on 10/15/19 at 9:25 AM Resident #62 was observed in bed. Resident #62's call bell was observed to be clipped to the fitted sheet on the top corner at the head of the bed. He was observed to be unable to reach the call bell and did not have the strength to pull the call bell by the cord from the mattress.

During an interview on 10/15/19 at 9:25 AM Resident #62 stated he was unable to reach the call bell and could not pull the call bell from the sheet to be in his reach.

During observation on 10/15/19 at 1:57 PM Resident #62's call bell was in the same location.

During an interview on 10/15/19 at 1:57 PM Resident #62 stated the call bell had not been moved even with staff coming in his room.

During observation on 10/15/19 from 4:37 PM through 4:39 PM Resident #62 was observed in his room attempting to reach his call bell unsuccessfully. The call bell was still in the same location.

During an interview on 10/15/19 at 4:39 PM

F 558

Residents with potential to be affected:

1. All residents have the potential to be affected. The Interdisciplinary Team, consisting of the Administrator, Director of Health Services, Minimum Data Set Nurses, Administrative Nurses, and Social Work completed an audit of the building to ensure all residents had their call light within reach on 10/16/2019.

Measures put into place to ensure that the alleged deficient practice does not recur include:

1. Rounding sheets developed and distributed to Interdisciplinary team that includes observing if residents have their call light in place in their room, and it is within reach. The rounding sheets are reviewed in morning meeting daily. The Interdisciplinary team consists of social work, dietary, housekeeping, business office, nursing and Administrator, and other key departments. The rounding sheets are completed by the Interdisciplinary Team / Nurse Managers five times per week for four weeks then once a week for four weeks them monthly thereafter.

2. The RN Clinical Competency Coordinator will educate all personnel on the importance of placing call bells within reach of residents. This will be completed by 11/15/2019. This education has been added to the general orientation for new hires.

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F 558	Continued From page 2 Resident #62 stated he was trying to get his call bell to ask for water but could not get to it. He concluded it had been out of reach all day and staff had not placed it in his reach because they were out of his room too fast. During an interview on 10/15/19 at 4:51 PM Nurse Aide #2, upon observing the call bell, stated Resident #62's call bell was out of his reach. The nurse aide stated she provided activities of daily living care on Resident #62 around 3:45 PM. She further stated she was in a rush and did not notice the call bell was out of Resident #62's reach and she would place it in his reach. She further stated Resident #62 could use his call bell. During an interview on 10/16/19 at 12:04 PM the Director of Nursing #1 stated call bells should be attached somewhere within the resident's reach if they were able to use the call system. She further stated Resident #62, could use his call bell and he should not have had his call bell out of reach for the whole day.	F 558	Monitoring put in place to assure the alleged deficient practice does not recur includes: 1. The Director of Nursing will present the findings from the rounding sheets to morning meeting daily for one month. The Director of Nursing will also bring the findings of the rounding sheets to the Quality Assurance/Performance Improvement Committee meetings for review of any additional needs monthly for three months of consecutive compliance has been established, and then quarterly thereafter to ensure to the alleged deficient practice does not recur. Date of Compliance: 11/15/19	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		11/15/19

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F 578	Continued From page 3 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, physician, resident representative and staff interviews the facility failed to enter a portable Do Not Resuscitate (DNR) advanced directive order into the medical record for 1 of 2 residents (Resident #78) reviewed for advanced directives placing Resident #78 at risk for undesired cardio(heart)-pulmonary(breathing) resuscitation (CPR) in the event of cardiac arrest.	F 578	Immediate corrective action taken for this alleged deficient practice includes: 1. On 11/16/19, the Administrator contacted PruittHealth Hospice and confirmed code status as DNR/ Do Not Resuscitate. An order was obtained and placed in the MatrixCare system that changed the resident□s face sheet code	

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F 578	Continued From page 4 Findings included: Resident #78 was admitted to the facility 7/30/19 with diagnoses including chronic respiratory failure with hypoxia (low blood oxygen) and cardiac arrythmia (irregular heart beat). Review of a significant change Minimum Data Set (MDS) assessment dated 9/19/19 indicated Resident #78 was severely impaired for daily decision making. A nursing progress note dated 10/9/19 at 9:21 AM indicated Resident #78 was admitted to Hospice Service on 10/7/19. Review of the current care plan for Resident #78 with a start date 8/12/19 indicted a focus area of Full Code with a goal of will receive life saving procedures through next review and interventions including administer CPR in event of cardiac arrest. An additional focus area of Resident #78 is receiving Hospice Services included a goal dated 10/7/19 of will live meaningful end of life free from pain and noxious(unpleasant) symptoms with interventions including observe for signs and symptoms of respiratory depression. Review of the electronic medical record for Resident #78 indicated a current physician's order for Full Code status dated 8/30/19. Further review of the electronic medical record revealed a portable DNR advanced directive order dated 10/7/19 with a box, checked indicating no expiration, signed by Resident #78's Hospice Physician, had been scanned in to Resident #78's medical record but no DNR order had been entered in to the system.	F 578	status to Do Not Resuscitate. Residents with potential to be affected: All residents have the potential to be affected. Measures put into place to ensure that the alleged deficient practice does not recur include: The Clinical Competency Coordinator RN in-serviced nursing staff on proper procedure for documentation and tracking code status, and how to improve communication between hospice and the facility. The Director of Health Services or designee will monitor code status changes on all admissions and discharges daily for one month. Each new admission□s face sheet and discharge/admission paperwork will be reviewed for code status documentation/advance directives. The Director of Health Services or designee will use a spreadsheet to account for this auditing. Monitoring put in place to assure the alleged deficient practice does not recur includes: The Director of Health Services or designee will then track and trend the code status of 5 residents a week for one week, and subsequently 5 residents a month for three (3) months until compliance is achieved and sustained.	

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F 578	Continued From page 5 On 10/15/19 at 12:03 PM an interview with Hospice Social Worker who was visiting with Resident #78 in the facility indicated Resident #78's current code status was DNR. On 10/15/19 at 2:09 PM interview with Nurse #7 indicated she was familiar with Resident #78 and responsible for her care on the 7AM-3PM shift. She further indicated Resident #78 was receiving hospice services and her current code status in the electronic medical record was Full Code. She went on to say if she discovered Resident #78 with no heart beat or not breathing, she would begin CPR. On 10/15/19 at 4:24 PM telephone interviews with the Hospice Administrator and the Hospice Director of Nursing indicated on 10/7/19 the Hsopice Nurse #6 spoke at length with Resident #78's Representative (RP) regarding the hospice process and code status. They further indicated Resident #78's RP indicated at that time it was his wish that Resident #78 be a DNR code status. They went on to say Nurse #6 provided the facility with both the DNR order and medication prescriptions on 10/7/19. The Hospice Administrator stated Hospice staff were supposed to be able to enter orders directly into the facility's system, but they had not received their user names and passwords and could not do so. She went on to say the portable DNR advanced directive provided to the facility served as a physician's order and no other order was required. On 10/16/19 at 11:23 AM telephone interview with Resident #78's Hospice Physician indicated the portable DNR advanced directive form for	F 578	The Director of Nursing will present the analysis of the code status review to the Quality Assurance/Performance Improvement Committee meetings for review monthly until three months of consecutive compliance has been established, then quarterly thereafter to ensure the alleged deficient practice does not recur. Date of compliance: 11/15/2019	

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F 578	Continued From page 6 Resident #78 dated 10/7/19 signed by him and provided to the facility was a physician's order, the only physician's order and he would have expected the facility to honor it and treat it as such. On 10/16/19 at 9:10 AM telephone interview with Nurse #6 indicated she had a long conversation with Resident #78's RP on 10/7/19. She went on to say he indicated to her it was his wish that Resident #78 be a DNR code status. She went on to say she obtained an order from Resident #78's Hospice Physician on 10/7/19 and brought the DNR order signed by him to the facility on 10/7/19. She stated she provided the portable DNR advanced directive order form and medication prescriptions to Nurse #7 as she was not able to enter orders into the facility's system. She further indicated Medical Records #1 took the DNR order, stating the order needed to be scanned into the system. On 10/15/19 at 3:41 PM interview with the Administrator #1 indicated she believed the problem to be the facility recently transitioned to computerized records and the DNR order dated 10/7/19 for Resident #78 had been scanned into her medical record without an order being entered by mistake. She went on to say Nurse #7 who was on duty at the time Nurse #6 provided the DNR order form and medication prescriptions would have been responsible for those orders. In a follow up interview on 10/16/19 at 8:48 AM Nurse #7 indicated she did not recall receiving the DNR order on 10/7/19 for Resident #78, just the medication prescriptions which she entered into the computer system. On 10/15/19 at 2:26 PM an interview with the	F 578		

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F 578	Continued From page 7 DON #1 indicated she was not aware Resident #78 had a portable DNR advanced directive. She went on to say Resident #78 was under the care of the Hospice Physician and of course the facility would have honored the DNR order dated 10/7/19 if they had been aware of it. She stated the DNR order dated 10/7/19 from the Hospice Physician must have gotten scanned into Resident #78's medical record without an order being placed into the system. She stated this was a huge problem because Resident #78 would have received undesired CPR in the event of cardiac arrest. On 10/16/19 at 11:01 AM telephone interview with Resident #78's RP indicated it was his desire that Resident #78 be a DNR code status and he had communicated that information to Nurse #6 at a meeting he had with her on 10/7/19. On 10/18/19 at 12:11 PM interview with the DON indicated Resident #78's DNR order was given to facility staff on 10/7/19 and the order should have been entered into Resident #78's medical record immediately. She further indicated Resident #78's code status had been corrected on 10/15/19 to reflect her wishes and Resident #78's code status was now DNR.	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment for the area of as	F 641	Immediate corrective action taken for this alleged deficient practice includes:	11/15/19

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F 641	Continued From page 8 needed use of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications (Resident #28). Findings included: Resident #28 was admitted to the facility on 4/25/19 with diagnoses that included dementia and hypertension. The May 2019 Medication Administration Record revealed administration of Haldol 5 milligrams/ 1 milliliter intramuscularly every 6 hours as needed for agitation on 5/1/19 and 5/6/19. Resident #28's MDS assessment dated 5/6/19, an admission assessment, revealed he was assessed in Section N, question N0450 as receiving an antipsychotic during the 7-day look back period on a routine basis only. During an interview on 10/16/19 at 4:36 PM MDS Nurse #1 stated routine administration on an antipsychotic was a coding error on Resident #28's MDS assessment dated 5/6/19. She explained residents are normally on routine administration of antipsychotics. During an interview with the Administrator on 10/18/19 at 11:17 AM she indicated Resident #28's MDS assessment should have been coded correctly for medications.	F 641	1. Resident #28�s Minimum Data Set Assessment was opened on 10/16/19 and amended to reflect accurate coding for antipsychotic medication use. Residents with potential to be affected: All residents using antipsychotic medication have the potential to be affected by the alleged deficient practice. Director of Health Services and Nurse Managers reviewed all MDS assessments for residents who are ordered any antipsychotic medication to ensure the coding was done correctly. Measures put into place to ensure that the alleged deficient practice does not recur include: The Minimum Data Set Coordinators, Nurse Managers and Director of Health Services were educated regarding proper coding of antipsychotic medications by the Regional Clinical Reimbursement Consultant (RN) on 10/16/19. The Director of Nursing and/or Nurse Managers will review 3 assessments weekly for 4 weeks to ensure accuracy in coding antipsychotic medication use. Thereafter, they will review 3 assessments a month for three (3) months to ensure continued compliance. Monitoring put in place to assure the alleged deficient practice does not recur includes:	

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F 641	Continued From page 9	F 641	The Administrator or Director of Nursing will present the findings of the monitoring program at the monthly Quality Assurance/Performance Improvement meetings for three (3) months and quarterly thereafter until compliance has been achieved and sustained. Date of Compliance: 11/15/2019	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		11/15/19

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F 656	Continued From page 10 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to develop a resident centered care plan which included individualized interventions for falls (Resident # 27) and staff failed to implement resident specific interventions of using a fall mat (Resident #5) for 2 of 26 care plans reviewed. The findings included: 1. Resident #27 was admitted to the facility on 2/16/11. Her diagnoses included hypertension, diabetes and Alzheimer's dementia. Resident #27's quarterly Minimum Data Set (MDS) dated 7/30/19 revealed she was severely cognitively impaired. She was totally dependent for all activities of daily living and had range of motion limitations on both sides of both the upper and lower extremities. The care plan which was updated on 7/30/19 revealed Resident #27 was at risk for falls related	F 656	Immediate corrective action taken for this alleged deficient practice includes: Resident #27□s care plan was reviewed by the IDT team and all necessary changes were made. Resident #5□s care plan was also reviewed by the IDT team and all necessary changes were made. Residents with the potential to be affected: All residents have the potential to be affected by the alleged deficient practice. The Interdisciplinary Team, which includes but is not limited to Social Services, Dietary, Activities, Nursing, and Administrative members, will review all care plans for residents residing in the facility to ensure they are person-centered and meet regulatory requirements.	

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F 656 Continued From page 11

to Alzheimer's disease with significantly impaired cognition, glaucoma with impaired vision and impaired mobility. The approaches included but were not limited to: Place call bell within reach and answer promptly; Keep personal items within reach; Provide cues for safety awareness; provide adequate lighting and assist with reading small print as needed.

During an observation on 10/16/19 at 8:25 AM Resident #25 was in her bed laying on her back. Her arms were positioned on her chest about 4 inches below her chin with her hands closed in a fist like position.

During an observation on 10/17/19 at 08:28 AM Resident #25 was in her bed laying on her back. Her arms were positioned on her chest with her fist closed and about 4 inches below her chin. She was wearing splints on both hands.

On 10/17/19 at 10:35 AM Nursing Assistant (NA) #12 stated Resident #27 was not able to talk except she may occasionally respond verbally or nod her head in response to a yes or no question. She stated Resident #27 was not able to use her arms to reach for things due to her arms not being able to bend at the elbow. She stated Resident #27 was not able to use a call bell due to her mental inability to understand when or how to use it.

On 10/17/19 at 12:40 PM Nurse #7 stated Resident #27 was not able to use a call bell due to her dementia and was not physically able to reach for anything due to contractures in her upper arms. Nurse #7 stated the staff check on her frequently to be sure her needs are met. The nurse added Resident #27 would at times speak

F 656

Measures put into place to ensure that the alleged deficient practice does not recur include:

Four (4) Resident care plans will be reviewed by the Interdisciplinary Team weekly for one (1) month to ensure they are person-centered and reflective of actual care provided and resident need, as well as appropriate interventions for falls. Thereafter, 4 care plans will be reviewed monthly for (3) months until compliance is achieved. The Interdisciplinary Team includes Unit Managers, Social Work, Administrator, Clinical Competency Coordinator Registered Nurse, Registered Nurse Navigator, Dietary, and other department heads. The facility implemented a process change to increase the efficacy of the care planning process. Each department director responsible for their respective part of the care plan, will complete it, the Minimum Data Set nurse and/or Director of Health Services will review the care plan to ensure each section is completed.

The Clinical Competency Coordinator provided education for the licensed staff in the facility to ensure they are aware of where to find the care plans and how to edit them if necessary.

Monitoring put in place to assure the alleged deficient practice does not recur includes:

The Administrator or designee will bring the results of the auditing tools to the

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F 656	Continued From page 12 a word like yes or no but she was not able to answer most questions appropriately. On 10/17/19 at 2:14 PM MDS nurse #1 stated she was aware Resident #27 had upper extremity immobility and contractures. MDS nurse #1 said she was aware Resident #27 was severely cognitively impaired so she was not able to use a call bell, she was not able to read and she was not able to reach for items if they were place near her. MDS nurse #1 stated she put those things in the care plan because "she had always done it that way." During an interview with the Director of Nursing (DON) #1 she stated the resident's care plan was not reflective of the resident and the interventions were not appropriate for Resident #27 because she had upper arm contractures and was severely cognitively impaired. The DON said Resident #27 was not able to use a call bell and was not able to read. 2. Resident #5 was admitted to the facility on 8/31/18 with diagnoses including left hemiparesis (weakness on one side of the body) after a stroke and contracture (shortening) of the left knee among others. A quarterly Minimum Data Set (MDS) assessment dated 10/2/19 indicated Resident #5 was severely impaired for daily decision making and needed extensive assistance of one person for bed mobility and extensive assistance of two people for transfers. It further indicated Resident #5 had one fall with injury since his prior MDS assessment. Review of a care plan for Resident #5 updated 10/2/19 indicated a focus area of at risk for falls	F 656	monthly Quality Assurance/Process Improvement committee meetings for three (3) months until compliance is achieved and sustained. Date of compliance: 11/15/2019	

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F 656	Continued From page 13	F 656		

and fall related injuries due to left hemiparesis and attempts to get up unassisted with a goal of will have no falls or fall related injuries and interventions including mat to floor at bedside.

On 10/15/19 at 8:18 AM an observation of Resident #5 revealed he was in bed with no fall mat in place at his bedside.

On 10/15/19 at 9:11 AM an observation of Resident #5 indicated he remained in his bed with no fall mat at his bedside.

On 10/17/19 at 6:30 AM Resident #5 was observed in his bed with no fall mat at his bedside.

On 10/17/19 at 6:30 AM interview with Nurse #5 indicated he had been responsible for the care of Resident #5 on the 11PM-7AM shift. Nurse #5 stated he did not know if Resident #5 was supposed to have a fall mat at his bedside and he was not able to find a fall mat in Resident #5's room.

On 10/17/19 at 7:30 AM in an interview Director of Nursing #1(DON #1) indicated she did not know if Resident #5 was supposed to have a fall mat at his bedside as she could not find Resident #5's care plan. She stated she did not know what happened to the care plan yesterday after it was returned to her. She further indicated Nurse #5 told her he could not find Resident #5's care plan but had put a fall mat beside Resident #5's bed after he was questioned about it.

On 10/17/19 at 7:41 AM the DON #1 stated she found Resident #5's care plan which indicated Resident #5 should have a fall mat beside his

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F 656	Continued From page 14 bed. She went on to say that Resident #5 had changed rooms on 10/1/19 and she thought perhaps his fall mat had been left in his old room when he moved. On 10/18/19 at 12:04 PM an interview with the DON #1 indicated Resident #5 should have had a fall mat in place beside his bed. She stated this was a care planned intervention to protect Resident #5 from injury if he should fall. She stated staff in the facility caring for residents needed to be familiar with care planned interventions for those residents and consistently implementing the interventions. She further indicated it was important for staff to have ready access to the care plans.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		11/15/19

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F 657	Continued From page 15 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to remove the intervention of a fall mat on a resident's care plan and failed to update the code status on a resident's care plan for 2 of 26 care plans reviewed. (Resident #33, Resident #5) Findings included: 1. Resident #33 was admitted to the facility on 11/9/15. Her active diagnosis included hypertension and diabetes mellitus. Resident #33 minimum data set assessment dated 8/12/19 revealed she was assessed as moderately cognitively impaired. She was assessed to have had two or more falls with no injury. Resident #33's care plan dated 9/2/19 revealed she was care planned to have a fall mat to the floor beside the bed. During observation on 10/15/19 at 8:04 AM Resident #33 was observed in bed. No fall matt was in place beside the resident's bed. During observation on 10/16/19 at 9:08 AM Resident #33 was observed in bed. No fall matt	F 657	Immediate corrective action taken for this alleged deficient practice includes: 1. The care plan for resident #33 was amended to remove the fall mat as an intervention for falls. Resident #5s care plan was addressed for code status to ensure accuracy. Residents with the potential to be affected: All residents with a history of falls or who are at risk of falls have the potential to be affected by this alleged deficient practice. Measures put into place to ensure that the alleged deficient practice does not recur include: The Interdisciplinary Team has been educated by the Clinical Reimbursement Coordinator regarding Care plan revision and timing on 10/16/2019. The Director of Health Services or Nurse Managers will review all falls areas of care plans for residents residing in the facility to ensure accurate information is	

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was in place beside the resident's bed.

During an interview on 10/16/19 at 9:38 AM Nurse Aide #3 stated Resident #33 did not have a fall mat.

During an interview on 10/16/19 at 9:41 AM Nurse #1 stated Resident #33 did not have a fall mat and she did not believe she was supposed to have a fall mat.

During an interview on 10/16/19 at 9:43 AM the Director of Nursing #1 stated Resident #33 did have a fall mat at one time, but it was taken away quickly because it was found to be a fall hazard when Resident #33 tripped on the fall mat. She stated this fall happened in July. The Director of Nursing further stated there should have been a conversation in the weekly fall meeting that the fall mat did not work and MDS Nurse #1 should have physically looked at the room and taken the intervention off the care plan for Resident #33's safety so that staff would not replace the fall mat.

During an interview on 10/16/19 at 9:51 AM MDS Nurse #1 stated she updated care plans with each minimum data set assessment and as needed. She further stated Resident #33 had a fall mat at one time and it was taken away, but she could not recall when or why. She further stated whoever removed the fall mat should have removed the intervention from the care plan. She stated she was unaware of who the staff member was that removed the fall mat.
2. Resident #5 was admitted to the facility on 8/31/18 with diagnoses including left hemiparesis (weakness on one side of the body) after a stroke and contracture (shortening) of the left knee among others.

F 657

included. The Director of Health Services and Nurse Managers will ensure that any change in code status is properly reflected in the resident care plan.

Monitoring put in place to assure the alleged deficient practice does not recur includes:

The Administrator or Case Mix Directors will bring the results of the care plan auditing tool to the monthly Quality Assurance/Process Improvement meetings for three (3) months to review and to ensure compliance is achieved and sustained, then quarterly thereafter to ensure the alleged deficient practice does not recur.

Date of Compliance: 11/15/2019

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The current physician order for Resident #5 dated 8/30/19 indicated a code status of Full Code, meaning cardiopulmonary resuscitation (CPR) should be started in the event of cardiac (heart) or respiratory (breathing) arrest.

A quarterly Minimum Data Set (MDS) assessment dated 10/2/19 indicated Resident #5 was severely impaired for daily decision making.

A care plan for Resident #5 revised on 10/2/19 indicated a focus area of advanced directives, do not resuscitate (DNR), with an approach of no CPR in the event of cardiac arrest.

On 10/16/19 at 8:51 AM interview with Nurse #7 indicated she was responsible for the care of Resident #5 on the 7AM-3PM shift. She stated she was familiar with Resident #5 and his code status was Full Code. She stated she always went by the physician orders in the electronic record as they were the most current and accurate.

On 10/16/19 at 8:55 AM interview with the facility's MDS nurse indicated the care plan for Resident #5 revised on 10/2/19 was the current and only care plan for him. She stated she was responsible for the care plan focus area of advanced directives and she was not sure which was correct for Resident #5, the Full Code order in the electronic record or the DNR in the care plan.

On 10/16/19 at 9:39 AM interview with Administrator #1 indicated care plans were used to direct the care for residents and needed to be accurate. She further indicated to her knowledge

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F 657	Continued From page 18 Resident #5 was a Full Code, but she would clarify the information with Resident #5's Representative. On 10/16/19 at 10:07 AM an interview with Social Worker #2 indicated she had just spoken with Resident #5's Representative and the desire was for his code status to be Full Code. On 10/18/19 at 12:04 PM an interview with Director of Nursing #1 indicated Resident #5's care plan should be a current and accurate reflection of his needs and wishes as it was used to direct the care provided to him.	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff and nurse practitioner interviews, the facility failed to provide incontinent care and fingernail care for 4 of 11 dependent residents reviewed for Activities of Daily Living (ADL) care (Residents #6, #25, #9, #12). Findings included: 1. Resident #6 was admitted to the facility on 9/23/16 with diagnoses which included dementia and diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment dated 7/08/19 indicated Resident #6	F 677	Immediate corrective action taken for this alleged deficient practice includes: 1. Resident #6 was immediately changed and provided incontinence care from her incontinent episode using proper procedures. Nurse Aide #8 was re-educated on proper incontinence care procedure on 10/15/19. Residents with the potential to be affected: The Minimum Data Set coordinator provided a list of dependent residents to	11/15/19

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was severely cognitively impaired and was coded as totally dependent on staff for toileting. The resident was incontinent of bowel and bladder and wore briefs.

Review of Resident #6's care plan dated 10/07/19 revealed she was care planned for ADL/self-care performance deficit related to dementia, chronic respiratory failure, decreased range of motion to lower bilateral extremities, and weakness. The interventions included incontinence care after each incontinent episode using adult pads for containment.

An interview on 10/15/19 at 10:13 AM with Nurse Aide (NA) #8 revealed she was responsible for taking care of Resident #6 during the 7:00 AM to 3:00 PM shift on 10/15/19. NA #8 stated her shift began at 7:00 AM but she had not provided Resident #6 with any incontinence care since her shift began. NA #8 stated Resident #6 was total care and required staff to change her brief.

An observation on 10/15/19 at 10:25 AM of NA #8 providing incontinence care revealed Resident #6's brief and incontinence insert were saturated from front to back with urine and stool and a strong odor of urine and feces was noted when brief was opened. The pad under the resident was saturated, the bottom fitted sheet was wet up to and under the resident's pillow, and portions of the top sheet over the resident were also wet with urine.

An interview on 10/15/19 at 3:52 PM with NA #8 revealed she had last checked on Resident #6 at 2:19 PM but had not changed her at that time since she wasn't very wet, and she had not provided any incontinence care on the resident

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the Director of Health Services RN. These are the residents with the potential to be affected by the alleged deficient practice.

Measures put into place to ensure that the alleged deficient practice does not recur include:

1. The Director of Health Services and/or Nurse Managers will audit 4 residents a day for 4 weeks to observe ADL care and ensure staff are using proper procedure for incontinence care and nail care. The Director of Health Services and/or Nurse managers will use the rounding checklist to document findings of incontinence care, nail care and ADL care. The Director of Health Services and/or Nurse Managers will audit 5 residents weekly thereafter for 4 weeks, and monthly for 3 months to ensure compliance is achieved.
The Clinical Competency Coordinator began in-servicing certified nursing assistants and licensed nurses about proper procedures regarding Activities of Daily Living, such as incontinence care and nail care, which will be complete by 11/15/2019.

Monitoring put in place to assure the alleged deficient practice does not recur includes:

1. The Administrator or Director of Nursing will review the auditing of ADL�s completed by the Director of Health Services and bring the findings of these audits to the monthly Quality Assurance and Performance Improvement

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since 10:25 AM. NA #8 stated only her insert was wet and not her brief and she usually waited until brief was wet before changing the resident.

An observation on 10/15/19 at 3:58 PM of NA #8 providing incontinence care for Resident #6 revealed her insert and brief were saturated and there was a strong odor of urine. NA #8 stated that the residents were supposed to be checked every 2 hours and changed if wet and she had not changed Resident #6 every 2 hours during the day of 10/15/19.

An interview on 10/15/19 at 4:09 PM with the Director of Nursing (DON) revealed that the residents should be checked every 2 hours and changed as needed when they were wet. She further revealed the NA should have checked on Resident #6 at least once before 10:30 AM.

An interview on 10/15/19 at 4:27 PM with the Administrator revealed the residents should be checked every 2 hours and changed as needed.
2. Resident #25 was admitted to the facility on 4/9/13 with diagnoses which included dementia, osteoporosis and anxiety disorder.

The annual Minimum Data Set dated 7/27/19 revealed Resident #25 was severely cognitively impaired. She required total assistance for all activities of daily living (ADLs) including bathing. She was always incontinent of bladder and bowel.

The care plan updated on 7/27/19 revealed Resident #25 was care planned for dementia with significantly impaired cognition. The interventions included to anticipate and meet all needs and to assist with ADLs to meet needs.

committee meetings for 3 months until compliance s achieved and sustained, then quarterly thereafter to ensure the alleged deficient practice does not recur.

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On 10/16/19 at 8:15 AM an observation of Resident #25's fingernails on both hands revealed they contain debris under the nail. The debris was black in color and was observed under each of the fingernails.

On 10/17/19 at 2:51 PM Resident #25 was observed and her fingernails on both hands continued to contain black debris under the nails.

On 10/17/19 at 2:51 PM Nursing Assistant (NA) #9 stated she gave Resident #25 a bath that morning. She stated she washed Resident #25's hands and fingernails with a wash cloth. She then stated she did clean the resident's fingernails with the wash cloth. She also said she did not use any other tool to clean the resident's fingernails. NA #9 observed Resident #25's fingernails and stated they were dirty. During the interview NA #9 removed nail cleaning sticks from her pocket and stated she would clean the resident's fingernails with the nail cleaning stick.

The Director of Nursing was interviewed on 10/18/19 at 9:00 AM and said nail care was considered part of the resident's daily hygiene which should be performed as part of the daily bath.
3. Resident # 9 was admitted to the facility on 11/30/2018 with diagnoses which included chronic pain syndrome and bipolar disorder.

A quarterly Minimum Data Set (MDS) dated 10/08/2019 revealed Resident # 9 required total assistance with all activities of daily living and was cognitively intact. The MDS further revealed the resident had contractures of the upper and lower extremities.

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The care plan dated 7/9/2019 and revised 10/8/2019 revealed a plan which focused on Resident # 9's self- care deficit with the interventions to provide nail care as needed.

An observation on 10/14/2019 at 3:27 pm revealed Resident #9 sitting in a reclining chair in the hallway outside of her room. There was a blackish color substance under all of her fingernails.

Resident # 9 was observed on 10/15/2019 at 10:48 am to be resting in bed with her eyes open. There continued to be a blackish substance under all her fingernails.

On 10/17/2019 at 12:30 pm Resident #9 was sitting in a reclining chair in the hall way. The resident continue to have a blackish substance under all her fingernails.

An interview with Resident # 9 on 10/17/2019 at 1:12 pm revealed nail care for her was completed every Thursday by the Activity director. Resident # 9 also stated the Nurse Aides did not perform nail care for her.

During an interview with Nurse Aide (NA) #7 on 10/15/2019 at 2:05 pm revealed nail care was normally completed with daily baths and as needed. NA #7 also stated the resident's nails would be checked after meals and a manicure stick would be used to clean the nails. The NA #7 further stated she had never known Resident # 9 to refuse nail care.

An interview with Nurse # 1 on 10/15/2019 at 11:00 am revealed nail care should be completed before and after meals and as part of the daily

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(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 677	Continued From page 23	F 677		

bathing process. Nurse #1 also stated if nail care was refused the nurse would be informed and nail care would have been offered by the nurse.

The Administrator revealed during an interview on 10/18/2019 at 2:20 pm the staff should have followed the frequency of nail care to make sure the fingernails were clean and tidy.

4. Resident # 12 was admitted to the facility on 5/9/2017 with the diagnoses which included unspecified dementia with behavior disturbances, heart failure, and muscle weakness.

A quarterly Minimum Data Set (MDS) dated 7/9/2019 revealed Resident # 12 was cognitively impaired and required extensive assistance with all activities of daily living (ADL) except for meals which required supervision.

The care plan dated 10/24/2018 and revised on 7/19/2019 revealed a plan which focused on Resident # 12's self-care deficit with the intervention to provide nail care as needed.

An observation on 10/14/19 at 11:25 am revealed the Resident #12's right hand had dried food particles under the fingernails and the right pointer fingernail was broken with a jagged edge.

On 10/15/2019 at 10:47 am Resident #12 was resting in bed with her hands outside of the covers. The resident's fingernails on both hands had a dried yellowish substance under the nails and the right pointer fingernail still had a jagged edge.

During an observation of Resident #12 on 10/16/2019 at 3:34 pm, the resident was resting

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F 677	Continued From page 24 in bed with her eyes open. The nails on both hand continued to have a dried yellowish substance under the nails. An interview on 10/15/2019 at 2:05 pm with Nurse Aide (NA) # 3 revealed nails are normally done on day shift and as needed. NA# 3 also stated Resident #12 sometimes refuses to have her nails cut, but there was no certain time for cleaning the nails. NA # 3 also stated the nails should be cleaned throughout the day and especially after meals. During an interview with the Nurse Practitioner (NP) on 10/17/2019 at 2:20 pm, she revealed dirty fingernails could contain bacterial under the nails that could cause an infection. The NP further revealed that she expected the staff to clean the resident's fingernails or soak the fingernails first for easier cleaning. The Administrator revealed during an interview on 10/18/2019 at 2:20 pm the staff should have followed the frequency of nail care to make sure the fingernails were clean and tidy. The Administrator also stated any refusals should had been documented by the nurses.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		11/15/19

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F 690	Continued From page 25 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff and nurse practitioner interviews, and record review the facility failed to provide sanitary catheter care to prevent contamination when cleaning a urinary catheter by wiping the catheter tubing towards the resident instead of away from the resident for 1 of 2 residents reviewed for catheter care. (Resident #62) Findings included:	F 690	Immediate corrective action taken for this alleged deficient practice includes: 1. NA #1 was re-educated on proper catheter care on 10/17/19. Residents with potential to be affected: 1. All residents who receive catheter care have the potential to be affected by the alleged deficient practice.	

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F 690	Continued From page 26 Review of the policy and procedure for indwelling urinary catheter care and management dated 11/11/16 utilized by the facility read in part, "To avoid contaminating the urinary tract, always clean by wiping away from-never toward-the urinary meatus." Resident #62 was admitted to the facility on 5/16/18. His active diagnosis included a history of urinary tract infections and obstructive uropathy. Resident #62's medical record revealed on 2/23/19 Resident #62 was sent to the hospital for altered mental status. Review of the discharge summary from the hospital dated 2/28/18 revealed he was diagnosed with a urinary tract infection present upon admission to the hospital. On 4/1/19 Resident #62 was seen by the urologist and was diagnosed with a urinary tract infection. On 4/17/19 Resident #62 was sent to the hospital for change in mental status. Review of the discharge summary from the hospital dated 4/22/19 revealed Resident #62 was diagnosed with a urinary tract infection upon admission to the hospital. On 5/19/19 Resident #62 was sent to the hospital for shortness of breath and chills. Review of the discharge summary dated 5/24/19 revealed he was assessed to have an acute urinary tract infection upon admission to the hospital Resident #62 minimum data set assessment dated 9/12/19 revealed he was assessed as moderately cognitively impaired. He was assessed to have the use of a urinary catheter. Resident #62's care plan dated 9/26/19 revealed the interventions included to provide urinary catheter care per policy.	F 690	Measures put into place to ensure that the alleged deficient practice does not recur include: 1. The Clinical Competency Coordinator will in-service all licensed and certified nursing staff members on how to provide appropriate catheter care by 11/15/19. The Director of Health Services or Nurse Managers will audit 3 episodes of catheter care weekly for 4 weeks, and then will monitor 3 instances of catheter care per month. The purpose of these audits is to ensure education was effective and catheter care is performed as trained. Monitoring: The Director of Nursing or Clinical Competency Coordinator will present the findings from the catheter care audits to morning meeting weekly for one month. The Director of Nursing will also bring the findings of the catheter care audit to the Quality Assurance/Performance Improvement Committee meetings for review of any additional needs monthly until three months of consecutive compliance has been established, then quarterly thereafter to ensure the alleged deficient practice does not recur. Compliance date: 11/15/2019	

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F 690	Continued From page 27 During observation on 10/17/19 at 7:45 AM Nurse Aide #1 was observed to provide catheter care to Resident #62. The nurse aide secured Resident #62's penis in her left hand and used her right hand to wipe the catheter tubing. She first wiped away from his penis with a washcloth and then without stopping contact with the catheter tubing, wiped back towards his penis and ended by coming in contact with the head of his penis. She used the same technique to rinse the catheter. During an interview on 10/17/19 at 8:27 AM Nurse Aide #1 stated she should not have wiped towards Resident #62's penis and that was not how she was trained. She further stated she did it because she was nervous and cleaning a catheter in that way increased risks for urinary tract infections. During an interview on 10/17/19 at 8:30 AM the Director of Nursing stated Nurse Aide #1 should not have wiped towards the urethra when providing catheter care because of the increased risk for urinary tract infections that created. During an interview on 10/17/19 at 10:54 AM Nurse Practitioner #1 stated when providing catheter care staff should wipe away from the urethra in order to prevent the spreading of bacteria.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		11/15/19

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F 761 Continued From page 28

appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews, the facility failed to keep unattended medications in a secured medication cart for 1 of 4 medication carts observed. (100 hall medication cart).

Findings included:

During observation on 10/17/19 at 4:05 PM the 100 hall medication cart was observed unlocked and unattended. The medication cart lock was observed in the unlocked position. At 4:07 PM a nurse aide was observed to take a cup from the medication cart. At 4:07 PM a nurse aide walked past the unlocked medication cart. At 4:08 PM a visitor walked by the unlocked medication cart. At 4:09 PM Treatment Nurse #1 came to the cart

F 761

Immediate corrective action taken for this alleged deficient practice includes:

1. Nurse #2s med cart was immediately locked on 10/17/19 and Nurse #2 was educated on the requirement to lock the medication cart when not in use.

Residents with the potential to be affected by the alleged deficient practice:

1. All residents have the potential to be affected by the alleged deficient practice.

Measures put into place to ensure that the alleged deficient practice does not recur

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F 761	Continued From page 29 and saw that it was unlocked and locked it. During an interview on 10/17/19 at 4:09 PM Treatment Nurse #1 stated the medication cart should have been locked because it was out of view of Nurse #2. She concluded the medication cart belonged to Nurse #2 and the cart had been left unlocked. During an interview on 10/17/19 at 4:09 PM Nurse #2 stated medication carts were to be locked when unattended and the 100 hall medication cart should have been locked. During an interview on 10/17/19 at 4:20 PM the Director of Nursing #1 stated medication carts should be locked when unattended and Nurse #2 should have locked her cart.	F 761	include: The Interdisciplinary team will conduct daily rounds on both units of the facility to ensure all medication and treatment carts are locked when not in use. This will be documented daily on a checklist. All licensed personnel will be in-serviced on the requirement of locking medication carts when not in use, and on medication storage, by 11/15/2019. Monitoring put into place to ensure alleged deficient practice does not recur: The Clinical Competency Coordinator or Director of Nursing will present the findings from the rounds to morning meeting weekly for one month. The Clinical Competency Coordinator or designee will also bring the findings of the rounds to the Quality Assurance/Performance Improvement Committee meetings for review monthly until three months of consecutive compliance has been established, then quarterly thereafter to ensure the alleged deficient practice does not recur. Compliance date: 11/15/2019	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		11/15/19

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F 812	Continued From page 30 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide a barrier between ready to eat foods and the server's bare hand for 1 of 2 staff who assisted residents with their meals. Findings included: During an observation of resident dining on 10/14/2019 at 1:20 pm the Medical Record Assistant (MRA) was observed as she assisted a resident with putting condiments on a sandwich. The MRA used a fork and a knife to cut the sandwich into quarter sections which caused a section of the bun to separate from the sandwich. The MRA used her bare hand to return the section of the bun back into place on the sandwich. On 10/14/2019 at 1:30 pm during an interview with the Medical Records Assistant, she revealed that she would assist the residents with meals when needed. She also stated that she did not know if she had touched the bun and that she	F 812	Immediate corrective action taken for this alleged deficient practice includes: 1. On 10/18/19, the Medical Records Assistant who was assisting residents with eating lunch obtained a pair of gloves to ensure proper sanitation while assisting the resident. She was then in-serviced personally by the Clinical Competency Coordinator regarding food sanitation. Residents with the potential to be affected by the alleged deficient practice: 1. All residents have a potential to be affected by the alleged deficient practice. Measures put into place to ensure that the alleged deficient practice does not recur include: The Clinical Competency Coordinator RN will in-service all nursing staff and	

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F 812	Continued From page 31 probably did. The Medical Record Assistant further stated touching the resident's food with her bare hands was a contamination issue. The Administration stated during an interview on 10/18/2019 at 12:00 pm, the staff should not be touching the resident's food with bare hands and gloves should have been used.	F 812	personnel authorized to assist with residents during meals about food safety and sanitation. This began on 10/14/19 and will complete by 11/15/2019. The Clinical Competency Coordinator or Nurse Navigator will observe food service 3 times weekly at various meal times for 1 month to ensure staff assisting residents are following proper protocol to avoid food contamination. Then, the Clinical Competency Coordinator or designee will continue to monitor food service 5 times a month for 3 months until compliance is achieved. Monitoring put into place to ensure alleged deficient practice does not recur: The Clinical Competency Coordinator or Director of health Services will present the findings from the dining observations to morning meeting weekly for one month. The Clinical Competency Coordinator or Director of Health Services will also bring the findings of the dining observations to the Quality Assurance/Performance Improvement Committee meetings for review monthly until three months of consecutive compliance has been established, and quarterly thereafter to ensure the alleged deficient practice does not recur. Compliance date: 11/15/2019	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		11/15/19

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F 880	Continued From page 32 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; (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	F 880		

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F 880	Continued From page 33 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 observation, staff interviews, and record review the facility failed utilize personal protective equipment when entering a contact isolation room for 2 of 2 residents reviewed for infections. (Resident #9, Resident #3). Findings included: 1. Review of the policy and procedure for contact precautions for the facility dated 5/18/18 revealed staff were to don a gown and gloves before entering the resident's room to comply with contact precautions.	F 880	Immediate corrective action taken for this alleged deficiency: 1. The Clinical Competency Coordinator began in-servicing all personnel on 10/16/19 regarding contact precautions and personal protective equipment. All in-servicing will be complete by 11/15/19. Nurse #1 and Direct Care Aide #1 were re-educated on 10/16/2019 by the Clinical Competency Coordinator on an individual basis regarding contact precautions and infection control procedure.	

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Review of the personal protective equipment in nursing to prevent spread of multidrug resistant organisms article from the Centers for Disease Control and Prevention (CDC) updated 7/26/19 revealed if a resident was on contact precautions, staff were required to use gown and gloves on every entry to the resident's room. This was the recommendation in use at the facility.

Resident #9 was admitted to the facility on 11/30/18. Her active diagnosis included a wound infection by the bacteria acinetobacter baumannii complex (a highly contagious and multidrug resistant bacteria).

During observation on 10/16/19 at 8:14 AM a sign was observed at Resident #9's door. The sign indicated Resident #9 was on contact precautions. Hand hygiene was to be performed before entering or leaving the room. Gloves were to be worn when entering the room and when touching the patient's intact skin, surfaces, or articles in close proximity. Gowns were to be worn when entering the resident's room and whenever anticipating that clothing would touch patient items or potentially contaminated environmental surfaces.

During observation on 10/16/19 at 8:15 AM Nurse #1 was observed to enter Resident #9's room and provide Resident #9 her morning medications. The nurse did not don a gown or gloves. The nurse was observed to move the bedside table with her hand and then gave Resident #9 her medications. The nurse's clothing was observed to come in contact with the bed and side rail. The nurse then pulled Resident #9's sheet up to the resident's chest. The resident requested more

F 880

Residents with potential to be affected:

1. All residents have the potential to be affected by the alleged deficient practice.

Measures put into place to ensure that the alleged deficient practice does not recur include:

1. The Clinical Competency Coordinator will complete an infection control audit by completing a checklist of room rounds to ensure all Personal Protective Equipment is present outside the room, sign is present, and all staff is using equipment per infection control guidelines. The Clinical Competency Coordinator or Nurse Managers will observe 5 partners entering and exiting resident rooms with isolation to validate infection control procedures are in place, weekly for one (1) month, then 5 partners per month for three (3) months until compliance is achieved. If anyone observes improper infection control precautions being utilized, the Clinical Competency Coordinator or Nurse Manager will complete corrective action through individual in-servicing to ensure understanding of infection control practices.

Monitoring put in place to assure the alleged deficient practice does not recur:

The Administrator or Clinical Competency Coordinator will review the auditing of ADL□s completed by the Director of Health Services and bring the findings of

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blankets. The nurse went to the chair in the room and took a blanket from the chair and then placed the blanket on the resident. The nurse's clothing again met the blanket, bed, and bedside table. The nurse then moved the bedside back, washed her hands, and left the room.

During an interview on 10/16/19 at 5:02 PM Nurse #1 stated she did not need to don a gown and gloves because the infection was in the resident's urine.

During an interview on 10/16/19 at 3:42 PM the Infection Control Nurse stated Resident #9 had acinetobacter baumannii complex in her wound which is a multi-drug resistant organism which was why she was on contact precaution. She further stated Nurse #1 should have donned a gown and gloves prior to administering the medications. She stated the new CDC guidelines dated 7/26/19 were the guidelines in use at the facility.

During an interview on 10/17/19 at 2:01 PM the Director of Nursing stated Nurse #1 should had donned a gown and gloves prior to providing medications and care to Resident #9.

2. The policy and procedure for contact precautions for the facility dated 5/18/19 revealed staff were to don a gown and gloves before entering the resident's room to comply with contact precautions.
The recommendation in use at the facility was if a resident was on contact precautions, staff were required to use gown and gloves on every entry to the resident's room.

Resident #3 was admitted to the facility on

these audits to the monthly Quality Assurance and Performance Improvement committee meetings for 3 months until compliance s achieved and sustained, then quarterly thereafter to ensure the alleged deficient practice does not recur.

Date of Compliance: 11/15/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING ______ B. WING ______	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(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 880	Continued From page 36 6/15/18. Her diagnoses included a wound infection infected with a multi drug resistant organism. During an observation on 10/16/19 at 8:50 AM a sign was observed at Resident #3's door. The sign indicated Resident #3 was on contact precautions. The sign read hand hygiene was to be performed prior to entering or leaving the room. Gloves were to be worn when entering the room and when touching the patient's intact skin, surfaces or articles in close proximity. Gowns were to be worn when entering the resident's room and whenever anticipating that clothing would touch patient items or potentially contaminated environmental surfaces. During an observation on 10/16/19 at 8:51 AM Direct Care Aide #1 was observed in Resident #3's room to assist with breakfast. The aide did not have on a gown or gloves. She was observed to move the bedside table with her hand and open Resident #3's milk carton. The aide's clothing was observed to come in contact with the bed and side rail. The aide was then observed to move the bedside table back, washed her hands and left the room. During an interview on 10/16/19 at 10:55 AM Direct Care Aide #1 stated she did not need to don a gown and gloves because she was not providing direct care. She reported she just opened Resident #3's milk and prepared her coffee. The aide indicated only nurse aides were required to don gown and gloves. During an interview on 10/16/19 at 3:45 PM the Infection Control Nurse stated if a resident is on contact precautions staff must don gown and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING ______ B. WING ______	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 37 gloves in order to deliver food trays or open food items for residents. She reported Resident #3 was a contact precautions due to the multidrug resistant organism in a wound not expected to heal. During an interview 0n 10/18/19 at 10:50 AM the Director of Nursing indicated Direct Care Aide #1 should have donned a gown and gloves prior to delivering a food tray or opening food items for Resident #3.	F 880		