STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345109	A. BUILDING _____ B. WING _____	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY PLACE	**24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001**

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to notify the physician for 1 of 5 sampled residents (Resident #92) after	F 157	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	8/29/14

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

Electronically Signed | 08/15/2014

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F 157	Continued From page 1 refusing medications for 9 days. Finding included: Review of the policy titled: Informed Care Decision dated/revised 8/23/13, under procedures. 2. Treatment is defined as care provided for purposes of maintaining/restoring health, improving functional level, or relieving symptoms. Examples include, but are not limited to: refusal of medications or skin/wound treatments. 8. The Attending Physician and the resident's family and/or representative must be notified of refusal of treatment in a time frame determined by the resident's condition and potential serious consequences of the refusal. Notification of the physician and the family should be documented in the medical record. Resident #92 was admitted to the facility with diagnosis which included hypertension, neurogenic bladder, cerebrovascular accident, dementia, hemiplegia, anxiety disorder and depression. The most recent quarterly Minimum Data Set (MDS) assessment dated 6/18/14 revealed Resident #92 had severe cognitive impairment and required extensive assistance with activity of daily living (ADL's). The care plan dated 5/29/14 revealed a problem for Resident #92 indicating a need for assistance with almost everything to get ready for the day. An intervention listed was my nurse will make sure I have my medications daily. During a review of the Medication Administration	F 157	alleged deficiencies. To remain in compliance with all federal and sate regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. For resident affected: On July 29th, 2014 the nurse practitioner was updated on resident 92's behaviors and refusal of medications. On July 30th, 2014, a call was placed to North Carolina Elderly Psychiatric Services regarding resident # 92's behaviors and refusal of medications and new orders were received. On July 31st, 2014 resident 92's ANP-BC visited resident 92 and completed an assessment with new orders received. The licensed nurses who documented resident 92's refusal of medications were in-serviced on the facility's guidelines and procedures for notification of MD when a resident refuses medications by the DON on 07/31/2014. For all residents that have the potential to be affected: An audit was done by medical records on 08/12/2014 and no other residents were affected. However, because all residents have the potential to be affected, all licensed nurses will be in-serviced/re-educated by the Staff Development Coordinator or Director of Nursing on facility's guidelines and procedures for notification of resident	

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F 157	Continued From page 2 Record (MAR) for July 2014 revealed medications listed as followed: amlodipine besylate 5 milligrams (mg) daily for hypertension, calcium-vitamin D 600mg-400 units daily for osteoporosis, labetalol 200 mg 2 times daily for hypertension, multivitamin one daily for chronic illness, polyethylene glycol 17 grams daily for constipation prophylaxis, vitamin D3 1000 units daily for iron D deficiency, divalproex sodium 500 mg 2 times daily for mood disorder, aspirin 81 mg daily for deep vein thrombosis, seroquel xr 400 mg daily for major depressive disorder, ferrous sulfate 325 mg daily for anemia, atorvastatin calcium 10 mg daily for hyperlipidemia, clonazepam 1 mg daily for depression, sertaline hcl 150 mg daily for major depressive disorder. The July 2014 MAR indicated that Resident #92 refused his medications daily from July 21-30, 2014. Review of the nurse's notes dated 7/24/14 at 10:27 AM revealed that Resident #92 refused his medications hollering out, screaming, and giving the middle finger. On 7/26/14 at 11:03 AM the nurses notes indicated that Resident #92 refused his medications, was loud and verbally abusive to staff and nurse, refused to let assigned CNA (certified nurse assistant) change him pulling at his supra pubic catheter wanting it out, screaming when no one was in the room, when staff entered the room to try to help resident cursed. As staff continued to try and help resident, his face became beet red with an angry expression on his face, resident made fists with his left hand or stuck up his middle finger. On 7/26/14 at 11:47 AM the nurse's notes indicated that Resident #92 was verbally	F 157	refusal of, or failure to follow, MD orders by August 29th, 2014 . System Change: The above in-service on facility's guidelines and procedures for notification of resident refusal of, or failure to follow, MD orders will be incorporated into the new employee orientation program for licensed nurses. On August 12, 2014, a task review button was added in our electronic medical records system to review any/all med exceptions in the past seven days to assist the medical records director and nursing supervisors in noting any residents who are refusing medications. Monitoring plan to ensure solutions are sustained: The medical records director will audit up to five residents from the 24 hour report who have refused medications or treatments, and confirm that family/physician contact occurred in the last 24 hours. The audit will occur three times weekly for four weeks then two times weekly thereafter for the remainder of the year to ensure ongoing compliance with notification. Starting on 08/18/2014, the medical records director will pull the med exception report and give to the DON for review twice a week for the remainder of the year. The results of these audits will be presented by the medical records director at the facility's quarterly quality assurance	

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F 157	Continued From page 3 threatening and screaming at others, cursing at others and being heard down the hall yelling FXXX YXX (curse word) repeatedly. The nurse enters the room to observe Resident #92 pointing his finger at room mate and shouting obscenities repeatedly. Resident #92 redirected, curtain between beds pulled. The nurse's notes on 7/27/14 at 11:50AM indicated that Resident #92 was screaming at others, when CNA attempted to lower head of bed to pull resident up for breakfast, resident began swinging, missing CNA's face but hitting her arm twice. On 7/27/14 at 11:53 AM the nurse's notes revealed that the on call physician was called regarding Resident #92's agitation, combativeness and medication refusal. The results of the physician contact revealed no new orders, and to speak with primary care physician tomorrow (7/28/14). The nurse's notes indicated that on 7/30/14 at 4:21 PM, a call was placed to the NCEPS (North Carolina Elderly Psychiatric Services) regarding Resident #92 behaviors and refusal of medications. A return call was noted at 5:13PM and new orders received for Risperdal Consta 12.5mg IM (intramuscular) x 1 then after 14 days increase to 25 mg IM every 2 weeks. During an interview with the director of nurses on 7/31/14 at 10:20AM revealed that her expectations were that the nurses should notify the physician after a resident refuses medications after 3 days to keep the physician updated. During an observation of Resident #92 on 7/31/14 at 10:30AM revealed the resident resting quietly in bed with his eyes closed.	F 157	meetings to ensure ongoing compliance.	

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F 157	Continued From page 4 An interview with Nurse #2 on 7/31/14 at 10:35 AM revealed that her understanding is that if a resident refuses medication after 3 days a physician should be notified.	F 157		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to clean the light fixtures, air vents and fan vents on two (2) of three (3) halls (B and C halls) and in the common area. The findings included: On 7/30/14 at 8:07 AM, an observation of C hall was conducted. At the end of the hall near the exit door, a light fixture was observed and had a large amount of dried brown material noted on the right hand side of the light. Also, at the end of C hall, one ceiling tile was noted to be bowed down and one tile had large dry water stain and bowed down. A ceiling fan at the end of the hall near the exit door had a large amount of dust in the vent screen areas. The air vent just above the exit door on C hall and the grid holding the air vent was totally covered with a large amount of black material. On 7/30/14 at 8:31 AM, an observation of B hall was conducted. One ceiling tile at the end of B hall on front of the exit door was partially pushed	F 253	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies have been or will be corrected by the date(s) indicated. For residents affected: On 07/30/2014 the air vents identified on B and C hall were cleaned with bleach and ceiling fans on B and C hall were cleaned with no evidence of dust or dirt remaining. On 07/30/2014, the ceiling tiles that had been identified on B hall and C hall, as being dirty and showing signs of mold were replaced by the maintenance department. The alcove on B hall was cleaned on 07/31/2014 by the Environmental Services Dept. On	8/29/14

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F 253	Continued From page 5 up. The alcove area where the facility stored the wheelchairs and lifts was observed and revealed the air vent and surrounding grid was covered with a heavy buildup of black material. On the right side of the wall approximately six (6) inches from the ceiling near the corner of the window, an observation revealed a cob web with a small live spider in the web. One ceiling fan had a moderate amount of dust in the vent screen area. On 7/30/14 at 8:42 AM, an observation of the lobby area was conducted and eight light fixtures were noted with a large amount of insects noted in the globes of the lights. On 7/30/14 at 11:59 AM, the housekeeping supervisor stated the housekeeping staff stated the cleaning of the fans was part of the housekeeper ' s routine and, if dust was noted during their routine cleaning, she expected the fans to be cleaned at that time. She also stated all staff monitored the facility and would write a work order if they saw something that needed to be repaired. The housekeeping supervisor stated maintenance personnel checked daily for work orders. Administrative staff checked the ceiling fans and stated the dust should not have been on the fan vents and should have been cleaned. She also stated the alcove area on B hall should have been cleaned and the spider and spider web removed. On 7/30/14 at 12:13 PM, the maintenance supervisor stated all facility staff have easy access to the repair requisitions and would post them on a board at the nursing stations or place them in his mailbox. He stated he had not received any requisitions for the ceiling tiles, air vents or light fixtures. A walk through observation	F 253	08/01/2014, the light fixtures in the lobby were removed and cleaned of dust and dead bugs. For residents that have the potential to be affected: By end of the day on 07/31/2014, the Environmental Services Dept. had cleaned all of the ceiling fans in the building. All of the common areas, including alcove area on B hall, were cleaned and dusted by 07/31/2014 by the environmental services dept. On 08/01/2014, the environmental services director conferenced with the housekeeper who works the shift that is responsible for cleaning common areas on proper cleaning of the common areas and of the fans. On 07/31/2014, the maintenance dept. had cleaned all of the vents with bleach and replaced all of the ceiling tiles that showed signs of mold or were dirty. In addition, all of the light fixtures were removed and cleaned by maintenance on 08/01/2014. On 07/31/2014, the maintenance director in-serviced the maintenance technician on the importance of rounding on a consistent basis to replace ceiling tiles that were dirty or showed signs of mold and on the importance of cleaning the ceiling vents and light fixtures on a consistent schedule. System changes: By August 29th, 2014, the maintenance director will complete an in-service with the maintenance	

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F 253	Continued From page 6 of C hall, B hall and the lobby area was conducted. The maintenance supervisor stated he would not expect the ceiling tiles, air vents or light fixture lens to be in their current condition. He said maintenance did not have a schedule to inspect and clean the air vents and/or light fixtures. On 7/30/14 at 5:12 PM, an observation of the air vents and ceiling fans on B and C hall revealed the ceiling fans free of dust and both air vents and grid work was clean with no evidence of any black material on the air vent or grid work. On 7/31/14 at 10:00AM, the maintenance supervisor stated the air vents pushed air into the building and hallways. He stated they had cleaned the vents with bleach and the entire mold had been removed.	F 253	technician and the PRN maintenance technician on proper cleaning of the vents, changing/cleaning the ceiling tiles, and cleaning the light fixtures. Effective week of 08/11/2014, the maintenance director, or maintenance tech, will round once a week to check every ceiling tile in the building for mold, dirty and excessive dust and replace of clean the ceiling tile if necessary. The maintenance director or maintenance tech will keep a log of their weekly checks. Effective week of 08/11/2014, the maintenance director, or maintenance technician, will round once a month to clean the vents with bleach. In addition, the vents will be cleaned on an as needed basis when reported by staff. A log will be kept by the maintenance director or maintenance tech. Effective 08/01/2014, the light fixtures will be removed and cleaned once a quarter, and as needed, by the maintenance director or maintenance technician. This will be kept on a log by the maintenance director or maintenance technician. By August 29th, 2014, the environmental services director will complete an in-service with each employee in this department on proper cleaning of the common areas, halls, resident rooms, and ceiling fans. Effective the week of 08/11/2014, there will be a monthly check of each fan in the	

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F 253	Continued From page 7	F 253	building to ensure the fan, including the blades and vent screens, are clean and free of dust. The environmental services director will be responsible for this monthly check and will keep a log of each fan checked and if it needed further cleaning. Effective the week of 08/11/2014, the environmental services director, or designated housekeeper, will complete a weekly check for cleanliness that includes 15 resident rooms; A,B,C,D,E,F HALLS; and every common area (12 total areas, excluding administrative offices) to ensure all areas have been cleaned properly. The environmental services director will keep a log documenting which rooms and areas were surveyed and mark any areas that needed additional cleaning. If areas were found deficient, the environmental services director will follow up with the housekeeper responsible for this area on their next scheduled shift, and will share results of audit at weekly environmental services meeting. Monitoring plan to ensure solutions are sustained: The results of the system changes will be presented by the director of each respective department, or by the administrator, at the facility's quarterly quality assurance meetings. All findings on the logs will be reviewed.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		8/29/14

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F 282	Continued From page 8 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and resident interview, the facility failed to follow the care plan for one of one sampled resident (Resident #56) by not assessing the vascular access site. The findings included: Resident #56 was readmitted to the facility 3/12/13. Cumulative diagnoses included end stage renal (kidney) disease (11/16/12), renal hypertension and renal dialysis (3/13/13). Resident #56 had a vascular access site for dialysis in her left upper arm. A Quarterly Minimum Data Set (MDS) dated 5/21/14 indicated Resident #56 was cognitively intact. Dialysis was checked as having been administered during the assessment period. A care plan dated 9/25/13 and last reviewed 5/29/14 stated the following: Problem: I am at risk of dehydration or edema. Goal was met as noted by no complications noted from dialysis or diuretic use. Approaches included: Nurses--monitor labs. Monitor vitals. Monitor weight. Report signs/ symptoms of complications. Assess vascular site for complications. The Medication Administration Record (MAR) for July 2014 was reviewed and revealed no documentation that the nursing staff had monitored and/or recorded any assessments of	F 282	The statements made on this plan of correction are not an admission to and do not constitute an agreement with alleged deficiencies. To remain in compliance with all federal and sate regulations, the facility has taken or will take the actions set forth in this plan of correction. the plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies have been or will be corrected by the date(s) indicated. For resident affected: A doctor's order was received on 08/06/2014 to assess the shunt for resident 56. The order was put onto the MAR and nurses have to sign off each time they complete their assessment of the shunt. The residents care plan was updated on 08/07/2014 to reflect the doctor's order and to accurately reflect what is being assessed by the nurses. The MDS coordinator was in-serviced by the administrator on 08/07/2014 on the importance of adding interventions according to protocol and physician orders. For residents that have potential to be affected: There are no other residents in the facility receiving dialysis so there are no other	

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F 282	Continued From page 9 the vascular access site (shunt) for thrill and bruit. Nursing notes from 7/1/14 through 7/29/14 were reviewed. A nursing note dated 7/8/14 at 12:05 AM stated there was some discoloration to upper left arm at dialysis site. No further documentation was noted during the month of July regarding assessing the dialysis shunt for thrill and bruit. On 7/30/14 at 9:32 AM, Nurse #1 stated Resident #56 had a shunt in her left upper arm that was used for dialysis. She said Resident #56 had a history of a lot of problems with the shunt. Nurse #1 stated nursing staff did not check the shunt anymore and that it had been on the MAR (Medication Administration Record) previously but was no longer on the MAR. She stated she had checked the shunt about three weeks ago. On 7/30/14 at 5:08 PM, Resident #56 stated had had many problems with her shunt (fistula) in the past with the last shunt placed in February 2014. She said the nursing staff used to check her shunt daily for thrill and bruit but stopped and she did not know why they had stopped assessing her fistula site. Resident #56 stated she never told anyone she did not want it checked and was uncomfortable that they had stopped checking it because "that was her lifeline" and she just could not understand why it was no longer checked. She said she did not check it every day herself for thrill and bruit but wished the facility nurses would check it daily.	F 282	care plans for care of fistula or shunt. System Changes: Care plans with interventions for assessment of shunt/fistula will be added to the MAR. Nurses will be in-serviced by DON or Staff Development Coordinator by 08/29/2014 on the importance of following the resident care plan, including care and assessment of shunt/fistula and follow-up documentation required. Monitoring plan to ensure solutions are sustained: Once a week for one month the Staff Development Coordinator or Director of Nursing will check care plans and MARS for all residents with a shunt or fistula and ensure the care plans are being followed correctly. Once a month for the rest of the year, the Director of Nursing or the Staff Development Coordinator will check the care plans and MARS for all residents with a shunt or fistula and ensure the are plans are being followed correctly. The results of the system changes will be presented by the Director of Nursing or Staff Development Coordinator at facility's quarterly assurance meetings and all findings will be reviewed.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		8/29/14

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F 332	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review and staff interviews, the facility failed to ensure that the medication error rate was 5% or below as evidenced by two (2) errors (Resident #79) of twenty-five (25) opportunities for error resulting in an eight (8)% error rate. The findings included: A review of the facility policy titled "Oral Dosage Forms That Should Not Be Crushed" last updated March 2012 stated, in part, the following medications should not be crushed: KCL (potassium chloride) extended release and Metoprolol (medication for hypertension) extended release. Resident #79 was readmitted to the facility 6/21/14. Cumulative diagnoses included hypertension. On 7/30/14 at 8:46AM, Resident #79 was observed during the medication pass. Medication aide (MA) #1 was observed to prepare, crush and administer the medications including KCL ER (extended release) 20 meq. (milliequivalents) one (1) tab and metoprolol succinate ER (extended release) 100 mg. (milligrams) one (1) tab po. (by mouth). The two medications, KCL ER and metoprolol succinate ER had both been crushed prior to administration to Resident #79. On 7/30/14 at 10:00AM, MA #1 stated, to her knowledge, all the medications ordered and sent from the pharmacy were able to be crushed. She stated she would get a "prompt" from the	F 332	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. the plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. For resident affected: On July 30th, 2014 resident 79 was monitored with no adverse effects noted or observed. On July 30th, 2014 medication aide #1 was in-serviced by the DON on the policy, "Oral Dosage Forms That Should Not Be Crushed". On 08/15/2014, an order was received for an alternate to metoprolol that can be crushed and an order was received for resident to get liquid potassium. Resident 79 is able to take medications whole, but wishes to receive medications crushed or in liquid form at this time if possible. For all resident that have the potential to be affected: All residents that receive crushed medications have the potential to be affected. There are 21 residents who receive their medications crushed. An audit was completed on 08/15/2014 on all	

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F 332	Continued From page 11 computer if a resident's medication should not be crushed. MA#1 stated there was not a list of medications that were not to be crushed on the medication cart. She said she did check on the medication cards for any alerts posted on the card by the pharmacy. MA #1 reviewed Resident #79's medication cards and stated there were labels on the KCL ER and on the metoprolol succinate ER that stated "Do not chew or crush before swallowing". On 7/30/14 at 11:46AM, Administrative staff #1 stated the list provided by the pharmacy was kept on each medication cart as well as a copy was in the medication drug room. She said she expected nursing staff to follow the instructions and not to crush any medications listed on the "Do Not Crush" list.	F 332	21 residents who receive their medications crushed to ensure that no medications are being crushed that cannot be crushed. System Change: A copy of a list of medications that should not be crushed was placed on each medication cart and in each drug room for quick referencing by the DON on July 30th, 2014. All current licensed nurses will be in-serviced by the Staff Development Coordinator or DON by August 29th, 2014 on the policy for oral dosage forms that should not be crushed. All newly hired nurses and medication aides will be in-serviced on the 'Medications That Should Not Be Crushed" policy as well as be informed of where the list can be found for quick referencing, by the SDC during orientation. The DON, SDC or MDS nurse will complete a medication administration observation of each licensed nurse and each medication aide, for all shifts and the weekend nurses and medication aides by August 29th, 2014 to ensure compliance with medication administration policies. Nurses and medication aide who do not have a scheduled shift before August 29th will be observed completing a medication administration upon their first scheduled shift. Monitoring plan to ensure solutions are sustained: Beginning the week of September 1, 2014, the DON, SDC, or MDS nurse will complete a medication	

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F 332	Continued From page 12	F 332	observation on two randomly selected nurses/medication aides weekly for one month, then monthly for one quarter, then quarterly for the remainder of the year to ensure that licensed nurses and medication aides are adhering to the policy on medications that should not be crushed. Any issues will be addressed immediately by the DON, SDC or MDS nurse. The results of the audits will be presented by the DON, SDC or MDS nurse at at the facility's nursing meetings and will be reviewed and discussed at the facility's quarterly quality assurance (QA) meetings to ensure ongoing compliance.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356		8/29/14

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F 356	Continued From page 13 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to accurately post the resident census and staffing information consistently. The findings included: On 7/28/14 at 6:30PM, an initial tour of the facility was conducted. An observation of the staff posting information revealed the census was documented as 70. It was also noted that there were four (4) RNs' (registered nurses) noted to be working on the evening shift. During the initial tour, it was noted that there were three (3) RNs' on the evening shift, one LPN (licensed practical nurse) and one medication aide. At the time of the initial tour, the census of the facility was 72. A review of the skilled daily assignment sheet for the 3--11 shift on 7/28/14 indicated that four RNs' and one LPN were scheduled for that shift. On 7/29/14 at 5:30PM, Administrative staff #1 reviewed the staff posting for 7/28/14. An observation of that posting also revealed that the census information was blank for the 11-7 shift. She stated there was a change in the staffing for 3--11 on 7/28/14 and, in fact, there were only three RNs' that worked on that shift. She stated	F 356	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. For all residents and families affected: On July 29th, 2014 corrections were made to the staff posting requirement sheet. For all residents and families with the potential to be affected: On July 29th, 2014 the scheduling coordinator, nursing shift supervisors, third shift nurses, and weekend charge nurse were all in-serviced by the DON on each of their roles and responsibilities for staff posting requirements as set forth by the regulation in regards to proper posting	

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F 356	Continued From page 14 the charge nurse would have been responsible for making the changes on the staffing sheet for the RN coverage as well as changing the census numbers. She stated there had been two residents (one a new admission and one a return to the facility following a leave of absence) and those residents were in the facility around 4:30 PM. Administrative staff #1 stated the charge nurse on the evening and the night shifts were responsible for making any changes to the staffing numbers and/or the census numbers and should have changed the staff posting and the census numbers when those changes occurred.	F 356	and data required for compliance. System Changes: Monday through Friday, it will be the responsibility of the scheduling coordinator to complete the staff posting requirement sheets for the entire 1st, 2nd, 3rd shift staffing. The scheduling coordinator will also make changes when needed from 7a-3p. If the scheduling coordinator is not here, the first shift supervisor will complete. After scheduling coordinator leaves for the day, it will be the responsibility of the charge nurse on the skilled side to make corrections to the census number or staffing as needed. On third shift, the nurse on the skilled side will be responsible for inputting the census number and making corrections as needed. On the weekends, it will be the responsibility of the charge nurse to complete the staff posting requirement sheets for the entire day for Saturday and Sunday and make changes to staffing numbers and to input census. After the charge nurse completes her 12 hour shift it will be the responsibility of the oncoming 12 hour nurse on the skilled side to make changes as required. Monitoring to ensure solutions are sustained: The DON will audit the staff posting requirement sheet for compliance three times weekly for three months. The weekend RN supervisor will audit the staff posting requirements weekly on Saturday/Sunday for three months. The	

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F 356	Continued From page 15	F 356	DON will report results of audit to the QA committee quarterly.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		8/29/14

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F 441	Continued From page 16 infection. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to post a contact isolation sign for 1 (Resident # 138) of 1 sampled resident with clostridium difficile (c-diff), a bacterial infection that can cause symptoms ranging from diarrhea to life threatening inflammation of the colon. The findings included: The facility's policy on " Transmission-Based Precaution " dated 8/18/13 was reviewed. The policy read in part " In addition to standard precaution, implement contact precaution for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Examples of infections which may require contact precaution include, but are not limited to diarrhea associated with clostridium difficile. " The policy further indicated " posts the appropriate notice on the room entrance door so that all personnel will be aware of precautions or be aware that they must first see a nurse to obtain additional information about the situation before entering the room. " Resident #138 was admitted to the facility on 6/25/14 with multiple diagnoses including septicemia. The admission Minimum Data Set (MDS) assessment dated 7/3/14 indicated that Resident	F 441	The statements on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with al federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. For all residents and families affected: On July 29th, 2014 the Infection Preventionist Nurse posted a Contact Precautions sign on resident 138's door. The infection Preventionist nurse in-serviced/re-educated the nurse who initiated the transmission based precautions on 07/29/2014. For all residents that have the potential to be affected: All licensed nurses will be in-serviced/re-educated by the Staff Development Coordinator on the "Transmission Based Precautions" policy by August 29th, 2014. System Changes: On July 29th, 2014 the Infection Preventionist Nurse placed a folder at each nurses desk containing copies of all three transmission based precautions signs as determined by the	

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F 441	Continued From page 17 #138 was cognitively intact. The assessment also indicated that Resident #138 had received an antibiotic medication. Review of the physician's orders revealed that on 7/21/14, Resident #138 had an order to send a stool sample for c-diff. The report revealed that c-diff toxin was positive. On 7/22/14, the physician had ordered flagyl and vancomycin, both were antibiotic medications, for c-diff. On 7/28/14 at 6:30 PM and 7/29/14 at 9:10 AM and 2:30 PM, the room of Resident #138 was observed. There was no contact isolation sign posted on the room entrance door. On 7/31/14 at 9:30 AM, Nurse Supervisor #1 was interviewed. Nurse Supervisor #1 stated that he was responsible for posting the isolation sign and he acknowledged that the contact isolation sign was not posted when Resident #138 was known to have a positive c-diff toxin on 7/21/14.	F 441	CDC. The Infection Preventionist Nurse will check the folders every week to ensure copies are available. The Infection Preventionist Nurse will audit each time a resident is placed on precautions to ensure policy is adhered to. Monitoring to ensure solutions are sustained: A log of each person on precautions and documentation that their room was checked will be kept by the Infection Preventionist Nurse. The Infection Preventionist Nurse will report the results of audits to the QA committee.	