STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345375	A. BUILDING _____ B. WING _____	R-C 10/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTLAND MANOR HEALTH CARE CENTER	920 JR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874

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{F 315} SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to change the bath water and failed to change gloves prior to providing catheter care for 1 of 1 residents who received catheter care (Resident #56). Findings included: Resident # 56 was admitted on 5/16/14 with diagnoses that included spinal cord injury. The most recent Minimum Data Set (MDS), a quarterly dated 8/11/14, indicated Resident # 56 was cognitively intact. The MDS also noted the presence of an indwelling urinary catheter. Documentation on the MDS revealed the resident had not had an urinary tract infection in the prior 30 days. The care plan, last reviewed on 8/21/14, included providing catheter care per policy. On 10/29/14 at 2:20 PM, an observation was made of the resident receiving a bath from Nursing Assistant (NA) # 1 with Nurse # 1 and the Treatment Nurse present at the bedside. The NA washed the upper body to the waistline, arms, axillary area and upper legs. Without changing	{F 315}	1. Education was immediately provided to NA #1, Nurse #1, and the Treatment nurse by the SDC. 2. Pericare audits and monitoring have been completed by licensed nurses daily with CNA□s on varying shifts/wings to ensure pericare procedures were followed and that no other residents were affected by the stated deficient practice. Any concerns were addressed and corrected by the nurse immediately. 3. Nursing assistants have been educated by the SDC or DON through demonstration and education prior to scheduled shift. This education was completed by 11/03/14. This training will be provided to all nurse assistants upon hire during orientation and at least annually through skills review. 4. Ongoing audits by Licensed nurses for observation and review of documentation of pericare to ensure proper technique is being followed by nursing assistants. This	11/5/14

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

Electronically Signed

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{F 315}	Continued From page 1 the water, washcloth or changing her gloves, the NA proceeded to provide perineal care and catheter care. The nurses, standing at the bedside did not intervene and request the NA change her gloves and the bath water before proceeding with catheter/perineal care. At 2:45 PM on 10/29/14, the Director of Nursing was interviewed. She stated staff had been trained to change gloves and to change the bath water prior to providing catheter care or perineal care. NA # 1 was interviewed on 10/29/14 at 3:05 PM. She stated she had been trained to change the water prior to providing catheter care or perineal care. The NA stated not changing the water and not changing gloves prior to providing perineal/catheter care could cause infection. NA # 1 stated she was concentrating on getting the resident's care completed and changing the bath water and her gloves slipped her mind. She added she was nervous. Nurse # 1 and the Treatment Nurse were interviewed on 10/29/14 at 3:08 PM. They both stated they had been taught to change the water before providing catheter care. The nurses stated they were focused on completing care and they were nervous as the reason they did not stop the NA from proceeding with catheter/perineal care. Nurse # 1 stated not changing the bath water or the gloves prior to providing catheter/perineal care could potentially cause an infection.	{F 315}	educations include pericare with resident with catheters. These audits will five days per weeks for two weeks, then weekly for two weeks, then monthly for three months. All data will be summarized and presented to the facility QAPI meeting monthly by the DON or SDC. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services.	
{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	{F 441}		11/5/14

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{F 441}	Continued From page 2 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 infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to change gloves and wash hands when going from dirty to clean tasks for 1 for 2	{F 441}	1. Education was immediately provided to NA #1, Nurse #1, and the Treatment nurse by the SDC to reduce the potential	

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{F 441}	Continued From page 3 residents (Resident # 56) who was observed receiving care. Findings included: On 10/29/14 at 2:20 PM, an observation was made of the resident receiving her daily bath from Nursing Assistant (NA) # 1. Nurse # 1 and the Treatment Nurse were at the bedside. The NA washed Resident # 56's upper body and then her perineal area, providing catheter care at that time. She did not change the bath water or her gloves. The NA then completed washing the resident's legs and feet. NA # 1 changed the bath water before proceeding to the resident's feet and legs, but did not change her gloves or wash her hands. With the assistance of Nurse # 1, Resident # 56 was turned to her right side. It was revealed at this time the resident had a bowel movement. NA # 1 removed the bulk of the stool using the disposable pad on which the resident was lying. The disposable pad was removed and placed in the trash. The NA did not remove the gloves or wash her hands after removing the bowel movement from Resident # 56. NA # 1, using the same gloves, placed a clean sheet and a clean disposable pad under the resident. Without removing the gloves used when cleaning the bowel movement or washing her hands, the NA removed the top from a jar of ointment and stuck a finger from the gloved hand used to clean the bowel movement into the jar of ointment and applied the ointment to the resident's buttocks. The DON was interviewed on 10/29/14 at 2:45 PM. She stated staff had been trained to change gloves between dirty and clean tasks. NA # 1 was interviewed on 10/29/14 at 3:05 PM.	{F 441}	risk of infection control and to reinforce the facility policy and procedure related to incontinent care. 2. CNA□s and Licensed nurses were educated by 11/3/14 regarding the facility□s incontinence care policy and procedure, as well as, glove changing, and the handling of clean and dirty linens to insure the infection control process/procedure is adhered to for the facility. 3. Nursing assistants have been educated by the SDC or DON by 11/03/14 through return demonstration and education. This training will be provided to all nurse assistants upon hire during orientation and at least annually through skills review. 4. Licensed nurses will observe and document observation of incontinence care, glove changing, and linen handling to ensure proper technique is being followed by nursing assistants. These audits will five days per weeks for two weeks, then weekly for two weeks, then monthly for three months. All data will be summarized and presented to the facility QAPI meeting monthly by the DON or SDC. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services.	

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{F 441}	Continued From page 4 She stated she had been trained to change gloves between dirty and clean tasks. The NA stated not continuing care without changing gloves or washing her hands after cleaning the bowel movement could cause infection. She stated she was concentrating on getting the resident's care completed and changing her gloves slipped her mind. She added she was nervous. Nurse # 1 and the Treatment Nurse were interviewed on 10/29/14 at 3:08 PM. They both stated they had been taught to change gloves between dirty and clean tasks. The nurses stated they were focused on completing care and was nervous as the reason they did not stop the NA. The treatment nurse stated when the NA stuck her fingers into the jar of ointment, with the same gloves used to clean the bowel movement, the dirty gloves contaminated the entire jar of ointment. The charge nurse stated not changing gloves could increase the potential for infection.	{F 441}		