

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345492	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2015
NAME OF PROVIDER OR SUPPLIER NC STATE VETERANS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301		
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F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to assure four (Residents #4, # 5, # 6, and #7) of eighteen sampled residents received assistance with activities of daily living to maintain personal hygiene. The facility failed to assure the residents received incontinent care per the residents ' plan of care. The findings included: 1. Record review revealed Resident # 4 was admitted to the facility on 6/9/15 with diagnoses which included: Cerebrovascular Accident, Aphasia, and Muscle Weakness. The resident ' s last MDS (Minimum Data Set) assessment, dated 7/23/15, revealed the facility had assessed the resident to be frequently incontinent of urine and needed assistance with activities of daily living. Review of the resident ' s care plan, which was last reviewed on 7/28/15, revealed the care plan included the intervention " wash and dry after each incontinent episode. " The resident was observed on 9/15/15 at 6:32 AM as NA (Nursing Assistant) # 1 and NA # 2 prepared to check the resident for incontinence needs. The resident ' s adult brief was observed to be saturated with urine. The draw sheet and the bottom sheet were also observed to be wet. The two NAs were observed to change the</p>	F 312	<p>This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.</p> <p>312 ADL Care</p> <p>1. Corrective action for residents affected: Incontinent care was provided for Resident # 4, #5, #6 and #7 when the facility was notified. 2. Residents with potential to be affected All residents have the potential to be affected. The Nurse Managers checked the incontinent residents to ensure they were clean and dry. 3. Systemic Changes to ensure practice is maintained.</p>	10/15/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/05/2015

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 312	<p>Continued From page 1</p> <p>resident ' s soiled brief, soiled draw sheet, and soiled bottom sheet, but were not observed to wash the resident or provide any type of skin cleansing during the care before placing a new brief and clean linens.</p> <p>The NAs were interviewed on 9/15/15 at 7 AM regarding why they had not washed Resident # 4 during his care when they found him soiled. The NAs stated they had felt rushed to complete their assignment. The resident ' s lack of observed incontinent care was shared with the administrator on 9/16/15 at 9 AM. The administrator and Director of Nursing were interviewed again at approximately 3:45 PM on 9/15/15 and stated they had talked with the NAs about lack of incontinent care. The Director of Nursing stated when the NAs were questioned they acknowledged they did not perform incontinent care for the resident and attributed it to the reason that some residents did not like the incontinent wipes because the wipes were cold. The Director of Nursing stated that if residents refused wipes then NAs should utilize warm soap and water and still provide incontinent care.</p> <p>2. Record review revealed Resident # 5 was admitted to the facility on 6/1/2010 with multiple diagnoses which included: Dementia, Depression, and history of Psychosis. The resident ' s last MDS (Minimum Data Set) assessment, dated 7/17/15, revealed the facility had assessed the resident to be always incontinent of urine and in need of assistance for activities of daily living. Review of the resident ' s care plan, which was last reviewed on 7/16/15, revealed the care plan approach " provide incontinent skin care after each incontinent episode. "</p> <p>NA # 1 and NA # 2 were observed on 9/15/15 beginning at 6:32 AM as they checked their</p>	F 312	<p>Education related to ADLs with focus on incontinence care began on 9/16/15 and was provide to 61 Certified Nursing Assistants.</p> <p>On 9/31/15 education with demonstration and return demonstration began on incontinence care, was provided to the Licensed Nursing Staff and Certified Nursing Assistants.</p> <p>Education with return demonstration related to incontinence has been added to the general orientation of new Licensed Nurses and Certified Nursing Assistance. On 10/9/15 the UNC Chapel Hill School of Medicine, Division of Geriatrics, will begin to provide education related to incontinence care with the Licensed Nurses and Certified Nursing Assistants. The Nurse Managers and/or Clinical Competency Coordinator will randomly observe 3 Certified Nursing Assistants providing incontinent care daily for 7 days, weekly for 4 weeks, then monthly thereafter.</p> <p>4. Monitoring of Performance: The Director of Health Services will correlate the data from the Unit Managers / Clinical Competency Coordinator related to provision of incontinent care and present findings to the Quality Assurance / Performance Improvement Committee for review and revision as needed. The UNC Chapel Hill School of Medicine, Division of Geriatrics , Center of Aging will provide review of the facilities Quality Assurance and Performance Improvement Committee to ensure that the QA/PI committee has met and</p>		

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F 312	Continued From page 2 assigned residents for incontinent needs. As NA # 1 And NA # 2 checked Resident # 5 during this time period, the resident ' s disposable brief was observed to be heavily saturated with urine. The NAs stated that the resident was a " heavy wetter " when asked when they had last checked the resident. The NAs were observed to remove the soiled brief and replace it with a clean one without performing any incontinent care or skin cleansing. The NAs were interviewed on 9/15/15 at 7 AM regarding why they had not washed Resident # 5 during his care when they found him soiled. The NAs stated they had felt rushed to complete their assignment. The resident ' s lack of observed incontinent care was shared with the administrator on 9/16/15 at 9 AM. The administrator and Director of Nursing were interviewed again at approximately 3:45 PM on 9/15/15 and stated they had talked with the NAs about lack of incontinent care. The Director of Nursing stated when the NAs were questioned they acknowledged they did not perform incontinent care for the resident and attributed it to the reason that some residents did not like the incontinent wipes because the wipes were cold. The Director of Nursing stated that if residents refused wipes then NAs should utilize warm soap and water and still provide incontinent care. 3. Record review revealed Resident # 6 was admitted to the facility on 2/26/14. The resident had multiple diagnoses which included Dementia and a History of a Cerebrovascular Accident. Review of the resident ' s last MDS (Minimum Data Set) assessment, dated 7/24/15, revealed the facility had assessed the resident to be always incontinent of urine and in need of assistance with activities of daily living. Review of the resident ' s most recent care plan, dated 7/15/15, revealed the intervention, " cleanse	F 312	implemented appropriate plans of actions and maintained the implemented procedure to monitor interventions the Committee has put into place.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312	Continued From page 3 perineal area after each incontinent episode. " NA # 1 and NA # 2 were observed on 9/15/15 beginning at 6:32 AM as they checked their assigned residents for incontinent needs. As NA # 1 And NA # 2 checked Resident # 6 during this time period, the resident ' s disposable brief was observed to be saturated with urine. The NAs were observed to remove the soiled brief and replace it with a clean one without performing any incontinent care or skin cleansing. The NAs were interviewed on 9/15/15 at 7 AM regarding why they had not washed Resident # 6 during the care when they found the resident soiled. The NAs stated they had felt rushed to complete their assignment. The resident ' s lack of observed incontinent care was shared with the administrator on 9/16/15 at 9 AM. The administrator and Director of Nursing were interviewed again at approximately 3:45 PM on 9/15/15 and stated they had talked with the NAs about lack of incontinent care. The Director of Nursing stated when the NAs were questioned they acknowledged they did not perform incontinent care for the resident and attributed it to the reason that some residents did not like the incontinent wipes because the wipes were cold. The Director of Nursing stated that if residents refused wipes then NAs should utilize warm soap and water and still provide incontinent care. 4. Record review revealed Resident # 7 was admitted to the facility on 6/21/05. The resident had diagnoses which included but were not limited to Osteoarthritis, Joint Pain and History of Femur/Hip fracture. Review of the resident ' s last MDS (Minimum Data Set) assessment, dated 8/28/15, revealed the resident was always incontinent of urine and needed assistance with activities of daily living. Review of the resident ' s care plan, dated 8/28/15, revealed the	F 312			

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F 312	Continued From page 4 intervention " provide incontinent care after each incontinent episode." NA # 1 and NA # 2 were observed on 9/15/15 beginning at 6:32 AM as they checked their assigned residents for incontinent needs. As NA # 1 And NA # 2 checked Resident # 7 during this time period, the resident ' s disposable brief was observed to be wet with urine. The NAs were observed to remove the soiled brief and replace it with a clean one without performing any incontinent care or skin cleansing. The NAs were interviewed on 9/15/15 at 7 AM regarding why they had not washed Resident # 7 during the care when they found the resident soiled. The NAs stated they had felt rushed to complete their assignment. The resident ' s lack of observed incontinent care was shared with the administrator on 9/16/15 at 9 AM. The administrator and Director of Nursing were interviewed again at approximately 3:45 PM on 9/15/15 and stated they had talked with the NAs about lack of incontinent care. The Director of Nursing stated when the NAs were questioned they acknowledged they did not perform incontinent care for the resident and attributed it to the reason that some residents did not like the incontinent wipes because the wipes were cold. The Director of Nursing stated that if residents refused wipes then NAs should utilize warm soap and water and still provide incontinent care.	F 312			
F 441 SS=E	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.	F 441		10/15/15	

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F 441	<p>Continued From page 5</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to assure staff members were washing their hands and handling soiled briefs in a manner to assure standards of infection control were followed while care was</p>	F 441	<p>This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of</p>		

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F 441	Continued From page 6 observed provided for seven residents (Residents #3, # 4, # 5, # 6, # 7, # 8, and # 18) of seven sampled residents observed during incontinent checks. The findings included: Review of the facility ' s policy for " incontinence briefs and pad handling " revealed instructions that staff were to " keep soiled briefs and pads away from other surfaces " while providing care. Review of the policy revealed multiple steps the staff were to take and included hand hygiene as one of the steps to take before providing incontinent care, after providing the care and discarding of the soiled brief into a bag and disposing of gloves, and after disposing of soiled items in a soiled utility room. 1. NA # 1 and NA # 2 were observed on 9/15/15 beginning at 6:32 AM as they worked together to check their assigned residents for incontinent needs. At the beginning of this time period, the two NAs were observed to enter Resident # 4 ' s room and don gloves to check Resident # 4 for incontinence needs. The resident was observed heavily saturated with urine. The resident ' s brief, draw sheet, and bottom sheet were all wet. After providing the resident with a clean brief and linens the NAs were observed to bag and dispose of their soiled items and gloves. The NAs were not observed to wash or sanitize their hands before they exited or next entered into another room where Resident # 18 and Resident # 5 resided. NA # 1 and NA # 2 were observed to don gloves in Resident #18 ' s and #5 ' s room. After doing so NA # 1 emptied and returned Resident # 18 ' s urinal. Without changing gloves or washing hands, NA # 1 joined NA # 2 to check Resident # 5 for incontinent needs. Resident # 5 ' s disposable brief was observed heavily saturated with urine. After the two NAs worked together to	F 441	the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. 441 Infection Control 1. Corrective action for residents affected. The two certified nursing assistant identified were educated prior to their next scheduled shift. 2. Residents with potential to be affected. All residents have the potential to be affected. Education began on 9/16/15 related to infection control with focus on hand washing. 3. Systemic change to ensure practice is maintained Education began on 9/16/15 related to infection control with focus on hand washing for 87 certified nursing assistance, housekeeping and dietary employees. On 9/31/15 education with demonstration and return demonstration of proper hand washing techniques began with Licensed Nurses, Certified Nursing Assistance and Housekeeping personnel. Hand washing technique with return demonstration has been added to the general orientation of all staff. On and 10/9/15 the UNC Chapel Hill School of Medicine, Division of Geriatrics will begin to provide an education on Infection control to all staff. The Director of Health Services, Clinical Competency coordinator and/or Nurse Managers will observe 3 certified nursing		

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F 441	Continued From page 7 remove Resident # 5 ' s soiled brief and provide a clean one, they were observed to bag and dispose of the soiled brief and gloves. The NAs were not observed to wash their hands before they exited the room or entered the next room where Resident # 6 and # 7 resided. Upon entry to the room, the NAs were observed to don gloves and check Resident # 6 for incontinence needs. Resident # 6 ' s disposable brief was observed wet with urine. After the soiled brief was removed, NA # 1 placed the soiled brief on the floor where it remained while the two NAs worked together to place a clean brief on the resident. After providing the resident with a new brief the NA was observed to remove the soiled brief from the floor and bag it. After disposing of their soiled item and gloves in a bag within the room the NAs were observed to don new gloves without washing their hands and proceeding to the other side of the room to care for Resident # 7. They then checked Resident # 7 for incontinence needs. Resident #7 ' s brief was also observed to be wet with urine. The NAs worked together to remove the soiled brief and provide a clean one. Once they completed this care the NAs were observed to dispose of their gloves and soiled item. The NAs had still not been observed to wash or sanitize hands. Without washing hands, NA # 2 entered the room adjacent to Residents # 6 ' s and # 7 ' s room and was not followed for observation at that time. NA # 2 was observed to be briefly in this adjacent room. Upon NA # 2 ' s exit from this last room, NA # 1 and NA # 2 were questioned regarding why they had not washed their hands during the incontinent round check. The NAs stated they washed or sanitized their hands at the completion of their rounds. NA # 1 was questioned why she had placed Resident # 7 ' s soiled brief on the floor. NA # 1 stated there	F 441	assistants daily for proper hand washing techniques for 7 days, then weekly for 4 weeks then monthly thereafter. 4. Monitoring of Performance The Director of Health Services will correlate the data from the Unit Managers / Clinical Competency Coordinator related to hand washing techniques and present findings to the Quality Assurance / Performance Improvement Committee for review and revision as needed. The UNC Chapel Hill School of Medicine, Division of Geriatrics , Center of Aging will provide review of the facilities Quality Assurance and Performance Improvement Committee to ensure that the QA/PI committee has met and implemented appropriate plans of actions and maintained the implemented procedure to monitor interventions the Committee has put into place.		

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F 441	Continued From page 8 was not a trash can on the bedside where she stood to provide care. NA # 1 stated she didn ' t want to hand the wet brief over the resident and therefore had placed it on the floor. 2. Na # 3 was observed to assist NA # 4 as they checked Resident # 3 for incontinent needs on 9/15/15 at 1:10 AM. Resident # 3 ' s brief was observed wet with urine. The two NAs worked together to provide the resident with incontinent care. After completing the care, bagging the soiled items, and removing gloves NA # 3 was not observed to wash hands before directly walking to the soiled utility room. The NA then disposed of the bagged items, obtained the soiled linen barrel, and rolled it near Resident # 8 ' s room. The NA still had not been observed to wash hands before she then entered to check Resident # 8 for incontinent needs. The NA donned gloves to check Resident # 8 and found the resident ' s brief to be wet with urine. While providing care for the resident, NA # 3 was observed to place the soiled brief on the floor. Following the observation of Resident # 8 ' s care, NA # 3 was questioned about why she had not washed her hands after completing Resident # 3 ' s care and stated that it was her practice to do so and she forgotten.	F 441			