STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING _____ B. WING _____	12/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DRIVE STATESVILLE, NC 28677

(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 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 observations and staff interviews the facility failed to repair metal bumpers along the floor with exposed sharp metal edges on 2 of 2 resident wings (2 West Wing and 1 West Wing), repair resident doors with broken and splintered laminate and wood for 22 of 27 resident rooms (Resident room #134, #136, #137, #140, #141, #145, #146, #147, #148, #158, #159, #160, #164, #165, #237, #238, #239, #241, #257, #258, #259 and #260), failed to repair smoke barrier doors with broken and splintered laminate and wood on the edges of smoke barrier doors on 2 of 2 resident wings (2 West Wing and 1 West Wing) and failed to repair doors with broken and splintered laminate and wood for 2 of 2 tub room doors (2 West Wing and 1 West Wing). Findings included: 1. a. Observations during the initial tour of the facility on 2 West Wing on 12/28/15 at 9:30 AM revealed the floor bumper that ran down each hallway above the level of the floor to prevent walls from being damaged from equipment had missing rubber inserts which revealed sharp metal edges located across from elevators and next to resident rooms #237, #239 and #243. Observations on 2 West Wing on 12/29/15 at 10:50 AM revealed the floor bumper that ran down each hallway above the level of the floor to	F 253	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited on the annual survey dated December 28, 2015. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F253 A. Corrective actions taken for residents found to have been affected by alleged deficient practice: All metal bumpers along 1 West and 2 West have been removed as of January 15, 2016. This will be replaced with Korogard 8" crash rail which has been ordered for 1 & 2 West on January 14, 2016. See Attachment #1. The crash rail is scheduled to be delivered on Monday, February 01, 2016 and will be installed the week of February 01 - 05, 2016 on 1 & 2 West. The crash rail will replace the metal bumpers and is considered a permanent install and will ensure regulatory compliance. The doors to resident rooms #134, #136, #137, #140, #141, #145, #146,#147, #148, #158, #159, #160, #164, #165, #237, #238, #239, #241, #257, #258, #259 and #260, Smoke Barrier Doors and Tub Doors; identified as having broken and splintered laminate and wood on the edges and scratches on the front of doors, were all repaired by the maintenance department by January 15, 2016. B. Corrective actions taken for residents having the potential to be affected by the same alleged deficient practice: The Director of Engineering conducted an audit of all interior doors on 1 West and 2 West to inspect for broken and/or splintered laminate and wood, scratches on outside of doors, or other damages requiring repair on January 14, 2016. Repairs were made to all doors identified in the audit by the maintenance department. See Attachment #2.	01/15/2016 01/14/2016 01/15/2016 01/14/2016

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

Lindsay B. Smith, NHA | Administrator | 01/27/2016

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.

DHSR Mecklenburg Received JAN 28 2016 by: SKH

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F 253	Continued From page 1 prevent walls from being damaged from equipment had missing rubber inserts which revealed sharp metal edges located across from elevators and next to resident rooms #237, #239 and #243. Observations on 2 West Wing on 12/30/15 at 8:30 AM revealed the floor bumper that ran down each hallway above the level of the floor to prevent walls from being damaged from equipment had missing rubber inserts which revealed sharp metal edges located across from elevators and next to resident rooms #237, #239 and #243. b. Observations during the initial tour of the facility on 1 West Wing on 12/28/15 at 12:18 PM revealed the floor bumper that ran down each hallway above the level of the floor to prevent walls from being damaged from equipment had missing rubber inserts which revealed sharp metal edges located across from elevators and next to resident rooms #135, #140, #143, #146, #147, #159 and #160. Observations on 1 West Wing on 12/29/15 at 11:10 AM revealed the floor bumper that ran down each hallway above the level of the floor to prevent walls from being damaged from equipment had missing rubber inserts which revealed sharp metal edges located across from elevators and next to resident rooms #135, #140, #143, #146, #147, #159 and #160. Observations on 1 West Wing on 12/30/15 at 11:10 AM revealed the floor bumper that ran down each hallway above the level of the floor to prevent walls from being damaged from equipment had missing rubber inserts which revealed sharp metal edges located across from elevators and next to resident rooms #135, #140, #143, #146, #147, #159 and #160.	F 253	C. Measures taken and systematic changes implemented to prevent alleged deficient practice: The Administrator met with the Director of Engineering on January 11, 2016 to review the findings of the survey. A new "Door & Rail Maintenance Audit" tool was initiated. See Attachment #3A & 3B. This audit is to ensure doors within the facility in need or repair are identified and repaired timely as well as crash rail. The Director of Engineering or Maintenance designee will conduct a monthly inspection of all doors and rail within the facility. All doors and rail requiring repair will be listed on the Door & Rail Maintenance Audit tool which will include location of the door/rail and the type of repair needed. The maintenance staff will make necessary repairs to each door and any rail and indicate the date the repair was completed and who completed the repair. A copy of the monthly audit will be given to the Administrator when repairs are completed. The Administrator and the Director of Engineering will then visually inspect all doors and rail listed on that months audit to ensure all necessary repairs have been made.	01/11/2016 1/18-19/2016
			The Environmental Services/Housekeeping Staff was provided in-service training on January 18 & 19, 2016. This in-service emphasized the need to look for doors that are damaged or scratched, including all wood or veneer damages while cleaning resident rooms. They were encouraged to look for other wood areas that could be damaged within the resident rooms. Finally, the staff were educated on the proper protocol they should follow when a Maintenance Request needs to be filled out for any areas of concerns they should identify while cleaning such as a damaged or scratched wood or veneer service or door. See Attachment #4.	

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F 253	Continued From page 2 2. a. Observations of Room #134 on 12/28/15 at 9:38 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 10:50 AM revealed the door of resident room #134 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:16 AM revealed the door of resident room #134 had broken and splintered laminate on the edges of the bottom half of the door. b. Observations of Room #136 on 12/28/15 at 9:39 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 10:52 AM revealed the door of resident room #136 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:17 AM revealed the door of resident room #136 had broken and splintered laminate on the edges of the bottom half of the door. c. Observations of Room #137 on 12/28/15 at 9:40 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 10:53 AM revealed the door of resident room #137 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:18 AM revealed	F 253	D. How the facility plans to monitor its performance to make sure that solutions are sustained: The Administrator and Director of Engineering will review the results of the monthly Door and Rail Maintenance Audits on a monthly basis for 3 months to ensure compliance. Once compliance is obtained after 3 months, Door & Rail Audits will be conducted with the semi- annual Environmental Care Rounding by the Director of Engineering and Administrator. The results of these door and rail audits will be reviewed and discussed at the quarterly QA Committee meeting for a period of 6 months to ensure compliance is sustained. The next QA Meeting is scheduled for March 03, 2016.	

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F 253	Continued From page 3 the door of resident room #137 had broken and splintered laminate on the edges of the bottom half of the door. d. Observations of Room #140 on 12/28/15 at 9:41 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 10:55 AM revealed the door of resident room #140 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:19 AM revealed the door of resident room #140 had broken and splintered laminate on the edges of the bottom half of the door. e. Observations of Room #141 on 12/28/15 at 9:42 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 10:56 AM revealed the door of resident room #141 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:20 AM revealed the door of resident room #141 had broken and splintered laminate on the edges of the bottom half of the door. f. Observations of Room #145 on 12/28/15 at 9:43 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 10:57 AM revealed the door of resident room #145 had broken and	F 253		

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F 253	Continued From page 4 splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:23 AM revealed the door of resident room #145 had broken and splintered laminate on the edges of the bottom half of the door. g. Observations of Room #146 on 12/28/15 at 9:44 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 10:58 AM revealed the door of resident room #146 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:24 AM revealed the door of resident room #146 had broken and splintered laminate on the edges of the bottom half of the door. h. Observations of Room #147 on 12/28/15 at 9:45 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 10:59 AM revealed the door of resident room #147 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:25 AM revealed the door of resident room #147 had broken and splintered laminate on the edges of the bottom half of the door. i. Observations of Room #148 on 12/28/15 at 9:46 AM during the initial tour of the facility revealed the door of the resident's room had splintered laminate broken off on the edges of the	F 253		

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F 253	Continued From page 5 bottom half of the door. Observations on 12/29/15 at 11:00 AM revealed the door of resident room #148 had splintered laminate broken off on the edges of the bottom half of the door. Observations on 12/30/15 at 11:26 AM revealed the door of resident room #148 had splintered laminate broken off on the edges of the bottom half of the door. j. Observations of Room #158 on 12/28/15 at 9:52 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 11:03 AM revealed the door of resident room #158 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:27 AM revealed the door of resident room #158 had broken and splintered laminate broken off on the edges of the bottom half of the door. k. Observations of Room #159 on 12/28/15 at 9:53 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 11:04 AM revealed the door of resident room #159 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:28 AM revealed the door of resident room #159 had broken and splintered laminate broken off on the edges of the bottom half of the door. l. Observations of Room #160 on 12/28/15 at	F 253		

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F 253	Continued From page 6 9:55 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 11:05 AM revealed the door of resident room #160 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:29 AM revealed the door of resident room #160 had broken and splintered laminate on the edges of the bottom half of the door. m. Observations of Room #164 on 12/28/15 at 9:56 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door and the door was scraped across the front. Observations on 12/29/15 at 11:06 AM revealed the door of resident room #164 had broken and splintered laminate on the edges of the bottom half of the door and the door was scraped across the front. Observations on 12/30/15 at 11:41 AM revealed the door of resident room #164 had broken and splintered laminate on the edges of the bottom half of the door and the door was scraped across the front. n. Observations of Room #165 on 12/28/15 at 9:58 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door and the door was scraped across the front. Observations on 12/29/15 at 11:07 AM revealed the door of resident room #165 had broken and splintered laminate on the edges of the bottom	F 253		

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F 253	Continued From page 7 half of the door and the door was scraped across the front. Observations on 12/30/15 at 11:42 AM revealed the door of resident room #165 had broken and splintered laminate on the edges of the bottom half of the door and the door was scraped across the front. o. Observations of Room #237 on 12/28/15 at 9:30 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 11:09 AM revealed the door of resident room #237 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:12 AM revealed the door of resident room #237 had broken and splintered laminate on the edges of the bottom half of the door. p. Observations of Room #238 on 12/28/15 at 9:32 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 11:15 AM revealed the door of resident room #238 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:11 AM revealed the door of resident room #238 had broken and splintered laminate on the edges of the bottom half of the door. q. Observations of Room #239 on 12/28/15 at 9:33 AM during the initial tour of the facility revealed the door of the resident's room had	F 253		

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F 253	Continued From page 8 broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 11:17 AM revealed the door of resident room #239 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:10 AM revealed the door of resident room #239 had broken and splintered laminate on the edges of the bottom half of the door. r. Observations of Room #241 on 12/28/15 at 9:33 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 11:19 AM revealed the door of resident room # 241 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:09 AM revealed the door of resident room #241 had broken and splintered laminate on the edges of the bottom half of the door. s. Observations of Room #257 on 12/28/15 at 9:35 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 11:20 AM revealed the door of resident room #257 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:08 AM revealed the door of resident room #257 had broken and splintered laminate on the edges of the bottom half of the door.	F 253		

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F 253	Continued From page 9 t. Observations of Room #258 on 12/28/15 at 9:36 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 11:21 AM revealed the door of resident room #258 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:07 AM revealed the door of resident room #258 had broken and splintered laminate on the edges of the bottom half of the door. u. Observations of Room #259 on 12/28/15 at 9:34 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 11:22 AM revealed the door of resident room #259 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:06 AM revealed the door of resident room #259 had broken and splintered laminate on the edges of the bottom half of the door. v. Observations of Room #260 on 12/28/15 at 9:35 AM during the initial tour of the facility revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/29/15 at 11:24 AM revealed the door of resident room #260 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:05 AM revealed the door of resident room #260 had broken and	F 253		

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F 253	Continued From page 10 splintered laminate on the edges of the bottom half of the door. 3. a. Observations on 2 West Wing on 12/28/15 at 8:34 AM during the initial tour of the facility revealed the smoke barrier doors located on 2 West Wing at resident rooms #240 and #241 had rough and splintered edges with chipped laminate on the lower half of both doors. Observations on 12/29/15 at 11:16 AM revealed the smoke barrier doors located on 2 West Wing at resident rooms #240 and #241 had rough and splintered edges with chipped laminate on the lower half of both doors. Observations on 12/30/15 at 8:34 AM revealed the smoke barrier doors located on 2 West Wing at resident rooms #240 and #241 had rough and splintered edges with chipped laminate on the lower half of both doors. b. Observations on 1 West Wing on 12/28/15 at 9:35 AM during the initial tour of the facility revealed the smoke barrier doors located at room #133 revealed a large piece of splintered laminate which protruded outward on the edge of the lower half of the door. Observations on 12/29/15 at 10:45 AM revealed the smoke barrier doors located on 1 West Wing at room #133 had a large piece of splintered laminate which protruded outward on the edge of the lower half of the door. Observations on 12/30/15 at 8:34 AM revealed the smoke barrier doors located on 1 West Wing at room #133 had a large piece of splintered laminate which protruded outward on the edge of the lower half of the door. 4. a. Observations on 2 West Wing on 12/28/15 at 9:30 AM during the initial tour of the facility	F 253		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DRIVE STATESVILLE, NC 28677

(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 253	Continued From page 11 revealed the tub room door had splintered laminate on the edges of the bottom half of the door. Observations on 2 West Wing on 12/29/15 at 11:18 AM revealed the tub room door had splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 11:00 AM on 2 West Wing revealed the tub room door had splintered laminate on the edges of the bottom half of the door. b. Observations on 1 West Wing on 12/28/15 at 10:00 AM during the initial tour of the facility revealed the tub room door had splintered laminate on the edges of the bottom half of the door. Observations on 1 West Wing on 12/29/15 at 11:22 AM revealed the tub room door had splintered laminate on the edges of the bottom half of the door. Observations on 12/30/15 at 8:19 AM on 1 West Wing revealed the tub room door had splintered laminate on the edges of the bottom half of the door with a string caught in the splintered laminate. During an environmental tour and interview on 12/30/15 at 4:33 PM with the Director of Engineering and Operations and the Vice President, the Director of Engineering explained he made environmental care rounds in the facility on a routine basis. He stated they had a maintenance request system and staff could generate a request for repairs in the computer system and it was sent to himself and a maintenance supervisor. He explained the request also printed out in the maintenance shop and they prioritized when the repair would be	F 253		

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F 253	Continued From page 12	F 253		

completed. He stated if something needed immediate attention staff paged maintenance staff or called them when they were on call. He stated any staff could access the maintenance request system at any time but if something needed to be repaired on an emergency basis he expected staff to contact their supervisor and notify maintenance staff immediately. He further stated he expected for staff to notify him when they saw damage to doors or splinters on doors. He explained splinters should be removed and the edges of doors sealed when damaged. He confirmed the bumpers along the floors had missing rubber inserts which exposed sharp metal edges and they could not be repaired but would need to be replaced. He further stated he had not noticed or received any requests to repair the bumpers along the floors and had not received requests to repair the splintered laminate on resident doors, smoke prevention doors or tub room doors.

During an interview on 12/30/15 at 5:15 PM with the Vice President he stated it was his expectation that the area in need of repair should be reported promptly by staff to the maintenance department. He explained the Director of Engineering and Operations had the authority to fix damaged items unless it involved a large capital expense and then it would be budgeted and prioritized. He stated he had instructed department managers to take ownership of their departments and they were expected to report things that needed repair and to ensure they were fixed. He explained all staff received instruction to report repairs that needed to be made in orientation and at their routine staff meetings. He stated he routinely asked for departments to submit lists of items that needed renovation or

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F 253	Continued From page 13 repairs and he and the Director of Engineering and Operations and the Environmental Services Director walked through the areas and prioritized lists of repairs. He further stated he was not aware of the sharp metal edges on the floor bumpers or the splintered laminate on resident doors, smoke prevention doors or tub room doors but expected for them to be fixed.	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to assess and implement interventions when a resident went greater than 3 days without a bowel movement and had to have hard stool digitally removed for 1 of 6 sampled residents (Resident #150). The findings included: A document titled "Medication PRN (as needed) Order Set" dated 06/06/14 read in part: Laxatives: - Dulcolax Laxative 5 mg by mouth PRN for constipation - Milk of Magnesia 30 mL by mouth PRN for constipation - Colace 100 mg by mouth PRN for	F 309	A. Corrective actions taken for residents found to have been affected by alleged deficient practice: It is the policy of this facility to provide adequate supervision for the well being of all residents to ensure a routine bowel program. Resident #150 did have a spontaneous bowel movement on 12/09/15 and the resident was discharged back to an Assisted Living facility on 12/18/2015 therefore, no further interventions were necessary to correct this issue. B. Corrective actions taken for residents having the potential to be affected by the same alleged deficient practice: On January 04, 2016, the Director of Nursing reviewed every residents' chart to ensure that each resident's bowels had moved within 3 days from their last documented bowel movement. See Attachment #5. C. Measures taken and systematic changes implemented to prevent alleged deficient practices: On 01/13/2016 all nursing staff were in-serviced by the Director of Nursing on the facility's bowel program, that included an emphasis on daily monitoring of bowel movement activity, C.N.A. reporting the absence of bowel movements to the licensed nurse, and licensed nurse assessment /monitoring of bowel movement activity and intervening when needed according to Physician orders. See Attachment #6.	01/04/2016 01/13/2016

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F 309	Continued From page 14 constipation May select one additional laxative from the following for use if above is not effective after 24 hours. - Dulcolax laxative 10 mg suppository per rectum for constipation - Fleet enema 133 mL per rectum for constipation Resident #150 was admitted to the facility on 11/24/15 and discharged on 12/18/15. Resident #150 was admitted with diagnoses that included constipation. The admission Minimum Data Set (MDS) dated 12/01/15 specified the resident had moderately impaired cognition, was totally dependent on staff for toileting but had not had a bowel movement in the last 7 days. Review of Resident #150's bowel elimination record revealed that from 11/25/15 through 12/02/15 (6 days) no bowel movement was documented. A nurse's note dated 12/02/15 revealed that the resident complained of hemorrhoid pain and was given medication to relieve the pain from hemorrhoids. On 12/02/15 Resident #150 had a spontaneous bowel movement. Review of Resident #150's medication administration record (MAR) revealed that no PRN medications were administered for constipation. Further review of Resident #150's bowel elimination record revealed that from 12/04/15 through 12/08/15 no bowel movement was documented. A nurse's note dated 12/08/15 made by Nurse #2 specified Resident #150 complained of pain and requested assistance with his bowels. Nurse #2 documented that she checked Resident #150 for a fecal impaction and noted a "very large hard formed stool" that she removed digitally. On 12/30/15 at 3:20 PM MDS Coordinator #1 was	F 309	D. How the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing and / or Patient Care Coordinator or MDS RN will monitor all resident's bowel movement records to ensure interventions are implemented if the resident does not have a bowel movement for a 3 day period. The monitoring will occur daily for 3 months, then taper to twice a week for 6 months. The results will be reviewed and discussed in the quarterly Quality Assurance Committee meetings for a period of 6 months to ensure compliance is sustained. The next QA meeting is scheduled for March 03, 3016.	

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F 309	Continued From page 15 interviewed and reported that she had documented on the MDS that Resident #150 went 7 days with not bowel movement. She added that she should have notified the Director of Nursing but could not recall if she did. On 12/30/15 at 4:04 PM Nurse #2 was interviewed and explained that nurse's were expected to review the electronic medical record for verification that a resident had a bowel movement within the last 3 days. She added that if a resident had not experienced a bowel movement in 3 days then PRN (as needed) medication would be administered for constipation. Nurse #2 stated she recalled Resident #150 complaining of constipation and was having difficulty eliminating stool. The Nurse stated that she administered a suppository that was not successful and due to the resident's complaint she performed a rectal exam and noted the hard stool in the resident's rectal vault and removed the large hard stool. Nurse #2 added that prior to giving the suppository she reviewed Resident #150's bowel records and noted that he had gone more than 3 days with no bowel movement. Nurse #2 was not aware why Resident #150 had not received medication for constipation prior to 12/08/15 when he went 4 days without a bowel movement. On 12/30/15 at 4:15 PM the Director of Nursing (DON) was interviewed and reported that she expected nurses to check daily that residents had bowel movements and implement interventions when a resident went 3 days without a bowel movement. The DON was unaware that Resident #150 and two episodes of constipation and had to have stool digitally removed the second time he went greater than 3 days with no bowel movement.	F 309		

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F 441 F 441 SS=E	Continued From page 16 483.65 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 infection.	F 441 F 441	A. Corrective actions taken for residents found to have been affected by alleged deficient practice: It is the policy of this facility to provide adequate supervision for the well being of all residents to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection. In regards to Resident #160, who was admitted to HBSNF on 12/23/2015 with the diagnosis of chronic urinary tract infections and C-diff upon admission. Resident was placed on proper Isolation Precautions on December 28, 2015, by the Charge Nurse, in conjunction with the Infection Preventionist Nurse. B. Corrective actions taken for residents having the potential to be affected by the same alleged deficient practice: An audit was completed on December 30, 2015 by the Director of Nursing of all residents residing on HBSNF who were placed on Isolation Precautions. See Attachment #8. C. Measures taken and systemic changes implemented to prevent alleged deficient practice: On December 30, 2015, the Admission Report form was updated to include Isolation Precautions to ensure appropriate measures are taken for compliance with the Infection Control Policy. See Attachment #9. Effective January 04, 2016, a Quality Assurance tool was developed by the Director of Nursing to monitor all new admissions for adherence to Isolation Precautions orders. See Attachment #10.	12/28/2015 12/30/2015 12/30/2015 01/04/2016

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F 441	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to implement isolation precautions for a resident diagnosed with Clostridium Difficile (C-Diff) for 1 of 3 residents who required isolation precautions (Resident #160) and failed to adhere to contact precaution guidelines for disposing of visibly soiled linens for 1 of 3 residents with contact precautions. (Resident #160). Findings included: 1. Resident #160 was admitted to the facility on 12/23/15 with diagnoses which included chronic urinary tract infections and C-Diff (a bacterial infection in the intestines which causes diarrhea). There was no Minimum Data Set (MDS) available for the new admission. A review of a hospital discharge summary dated 12/22/15 indicated septic shock and C-Diff sepsis. The summary revealed Resident #160 had a series of complications after surgery and developed C-Diff and developed shock from that which was treated with Vancomycin (antibiotic) and Flagyl (antibiotic) but was now just treated with Flagyl. A review of physician's orders dated 12/23/15 at 6:58 PM indicated "precautions" for Resident #160. A review of a facility document titled Adult Admission Assessment dated 12/23/15 revealed Resident #160 was alert and cooperative. The	F 441	D. How the facility plans to monitor its performance to make sure the solutions are sustained: The Quality Assurance Audit for monitoring Isolation Precautions will be conducted by the Director of Nursing or the Patient Care Coordinator or MDS RN. These audits will be conducted daily for the next 4 weeks; then taper down to twice a week for the next 3 months and monthly thereafter for 3 months to ensure all residents are placed on proper Isolation Precautions on admission. Any deficiencies will be corrected on the spot. The results will be reviewed and discussed in the quarterly QA Committee meetings for a period of 6 months to ensure compliance is sustained. The next QA Meeting is scheduled for March 03, 2016.	

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F 441	Continued From page 18 assessment also indicated Resident #160 had diarrhea and was incontinent of urine. A review of a nurse's progress note dated 12/23/15 at 10:02 PM indicated Resident #160 was alert and oriented. A review of a nurse's note dated 12/25/15 indicated Resident #160 continued on Flagyl due to sepsis (infection throughout the body) from C-Diff. During an initial tour of the facility on 12/28/15 at 10:00 AM of Resident #160's room revealed there was no isolation precaution sign on the resident's door and there were no isolation supplies visible. A review of a physician's order dated 12/28/15 at 3:04 PM indicated isolation precautions and reason was due to C-Diff in stool. A review of an interim plan of care with a handwritten note at the bottom of the page dated 12/28/15 indicated C-Diff contact precautions. During an observation on 12/28/15 at 3:05 PM a contact isolation precaution sign was taped to Resident #160's door and isolation supplies were organized in a rack that hung on the outside of the resident's door. During an interview on 12/30/15 at 2:37 PM with the infection control nurse she explained when residents were admitted from the hospital with isolation precautions in place, the isolation precautions were supposed to be continued when the resident was admitted to the facility. She confirmed C-Diff had been identified for Resident #160 on 12/07/15 while she was in the hospital	F 441		

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F 441	Continued From page 19 and the physician had ordered contact isolation precautions. She stated Resident #160 was discharged from the hospital and admitted to the facility on 12/23/15 and staff should have put her on contact isolation immediately upon admission. She explained she was unaware the contact isolation precautions had not been implemented because she was off from work for several days and when she returned to work on 12/28/15 she looked into it. She stated when she learned Resident #160 was not on contact isolation precautions she told staff to get her back on contact isolation precautions because Resident #160 was still having loose stools. She explained the hospital nurse who gave report to the nurse in the facility stated Resident #160 had a history of C-Diff but did not report Resident #160 had an active case of C-Diff. During an interview on 12/30/15 at 3:47 PM with Nurse #3 who admitted Resident #160 on 12/23/15 she explained a nurse from the hospital called and gave her report on 12/23/15 before Resident #160 arrived. She stated the nurse told her Resident #160 had a history of C-Diff and had diarrhea in the past but did not report Resident #160 was currently having diarrhea so she was not aware Resident #160 had active C-Diff upon admission to the facility. She explained she looked at Resident #160's admission packet when she arrived around 4:00 PM but didn't see anything in the papers about contact isolation precautions. She stated the nurse aide did not report to her Resident #160 had any diarrhea or loose stools during the shift and she did not question the antibiotics that had been ordered for Resident #160 related to infection. She further stated if the hospital nurse had reported to her Resident #160 was on isolation in the hospital	F 441	A. Corrective actions taken for residents found to have been affected by alleged deficient practice: It is the expectation and the policy of Iredell that each healthcare provider properly don PPE prior to and remove PPE after caring for the resident on contact precautions to ensure protection for other residents, visitors and staff members. In regards to Nurse #1 who was observed exiting Resident #160's room wearing personal protection gown and gloves in hallway, an immediate discussion between employee and Director of Nursing took place so employee was aware that all soiled linens from contact precaution rooms require the soiled linen hamper be pulled to the door and soiled linens should be placed directly into the hamper. Director of Nursing emphasized that PPE should not be worn in hallways. Conversation took place with Nurse #1 on December 29, 2015. B. Corrective actions taken for residents having the potential to be affected by the same alleged deficient practice: On January 04 – January 08, 2016, the Director of Nursing conducted surveillance observations of residents on Isolation Precautions of healthcare staff who provided direct care for these individuals. The audit found staff to be in compliance with infection control policy in regards to Isolation Precautions. See Attachment #11 C. Measures taken and systematic changes implemented to prevent alleged deficient practice: To enhance currently compliant operations, on January 13, 2016, in-service education regarding Iredell's Infection Control Policy and Proper Isolation Precautions was provided to all nursing staff under the direction of the Director of Nursing and the Infection Preventionist Nurse. The training emphasized the importance of placing residents on proper isolation precautions and maintaining proper PPE while in the room of a contact resident and removing it prior to departing resident's room. See Attachment #6.	12/29/2015 01/4-8/2016 01/13/2016

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F 441	Continued From page 20 she would have put Resident #160 on contact isolation precautions when she was admitted on 12/23/15. During an interview on 12/30/15 at 4:39 PM with the Director of Nursing (DON) she stated it was her expectation for nursing staff to question when a resident was admitted to the facility with a history of C-Diff to find out if the resident currently had active C-Diff. She further stated she expected for nursing staff to find out if the resident was on contact precautions in the hospital and if so to put isolation precautions into place upon admission to the facility. During a follow up interview on 12/30/15 with the DON she explained she had identified when Resident #160 was discharged from the hospital the computer system resolved the physician's orders for contact isolation precautions. She stated if the contact isolation had been identified as active in the computer system instead of resolved, the admitting nurse could have seen the orders for contact isolation precautions when she completed Resident #160's admission orders. 2. Resident #160 was admitted to the facility on 12/23/15 with diagnoses that included clostridium difficile (c-diff) and others. There was no Minimum Data Set (MDS) information available for the new admission. On 12/29/15 at 2:33 PM nurse #1 was observed exiting Resident #160's room wearing a personal protection gown and gloves; and in her hands she was carrying a towel wadded in a ball covered with light brown smears. Nurse #1 walked from Resident #160's room down the 1 West hall, passing the nurse's station and with her gloved hand punched the combination to the key-pad and enter the "soiled linen" room.	F 441	D. How the facility plans to monitor its performance to make sure that solutions are sustained: Effective January 04, 2016, a Quality Assurance tool was implemented by the Director of Nursing and the support of the Infection Preventionist Nurse to monitor staff entering and exiting Isolation Precaution rooms and following proper precautions. The Director of Nursing or Patient Care Coordinator or MDS RN will monitor adherence to proper Isolation Precautions of staff weekly for 3 months, then taper down to monthly for the next 3 months. Any deficiencies will be corrected on the spot. The results will be reviewed and discussed in the quarterly QA Committee meeting for a period of 6 months to ensure compliance is sustained. The next QA meeting is scheduled for March 03, 2016. See Attachment #12.	01/04/2016

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F 441	Continued From page 21 On 12/29/15 at 2:35 PM nurse #1 was interviewed and explained that she had provided care for Resident #160 who was on contact precautions for c-diff and had removed the soiled linens by carrying them down the hall to the soiled linen room wearing gloves and gown. The nurse stated the towels were soiled with feces. Nurse #1 added that she was trained to take a soiled linen barrel to a resident's room for disposing of soiled linens but failed to do so because she was in a hurry. Nurse #1 also stated that she should have removed her gloves when in the hallway and pushing the buttons on the key-pad of the soiled linen room. On 12/30/15 at 7:47 AM the Director of Nursing (DON) was interviewed and reported that she expected nurse's to adhere to infection control procedures for disposing contaminated linens by placing a soiled linen barrel outside a resident's room and disposing of the linens by placing them in the barrel. The DON explained that soiled linens should not be transported in the hallway by carrying them and that soiled gloves should not be worn in the hallway.	F 441		