STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345173	A. BUILDING ______ B. WING ______	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD HEALTH & REHAB CENTER	54 RED MULBERRY WAY LILLINGTON, NC 27546

(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 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to provide recommended dental services for 1 of 1 sampled Medicaid residents deemed cognitively impaired (Resident #33) reviewed for dental needs. Findings included: Resident #33 was admitted to the facility 11/11/10 with cumulative diagnoses of schizophrenia and dementia. His quarterly Minimum Data Set (MDS) dated 1/16/16 indicated severe cognitive impairment and extensive assistance with his activities of daily living (ADLs) to include oral hygiene. He was not coded with any rejection of care. Resident #33 was care planned for ADL assistance and care planned for refusal of nail care and shaving. He was listed as his own responsible party. A quarterly Restorative Functional Data Collection and Decision form dated 10/6/15 indicated Resident #33 was unable to brush own teeth. In an observation on 3/7/16 at 12:08 PM, Resident #33 was observed sitting in the common area. He was verbal but determined unreliable for an interview. His bottom teeth were observed and noted to be broken, missing and decaying.	F 250	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1a. SW contacted APS on 03/16/2016 at 10:15 AM regarding Guardianship for resident #33 due to unable to reach POA. 1b. Psychologist evaluation of cognitive status for resident #33 was completed on 03/18/2016. 2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. 2a. Residents that are residing at the facility will be considered as having potential to have been affected by the deficient practice. 2b. Residents residing in facility will be reviewed for Dental care practices. Any identified will be offered dental care outside facility as warranted. 2c. Dental log will be maintained by Social Worker/designee. 2d. Dental referrals/appointments will be maintained by SW/designee. 3. Address what measures will be put into place or systemic changes made to	4/12/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/31/2016

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.

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EMERALD HEALTH & REHAB CENTER	54 RED MULBERRY WAY LILLINGTON, NC 27546

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F 250	Continued From page 1 A review of the Long Term Care Associates, Inc. Dental History and Record dated 6/25/15 indicated Resident #33 required full mouth extraction due to rampant decay. Hospitalization was recommended. In an interview on 3/9/16 at 10:07 AM, Unit Manager (UM) #1 stated Resident #33 was his own responsible party and he could decide if he wanted to go to the dentist. In an interview on 3/9/16 at 12:43 PM, the transporter stated she took Resident #33 out to the dentist March 24, 2015 but he could not sign his paperwork due to his cognition so the dentist was not able to see him. The transporter returned Resident #33 to the facility and informed the previous social worker (SW) of the outcome of the dentist visit. He was then seen by the in house dentist in June 25, 2015. In an interview on 3/9/16 at 3:43 PM, the social worker (SW) stated she started working at the facility fall of 2015. She stated she was not aware of the dental recommendation made by the in-house dentist on 6/25/16 for complete extraction but acknowledge he was listed as his own responsible party. In another interview on 3/9/16 at 4:40 PM, the SW provided a copy of a General Durable Power of Attorney (POA) dated filed at the courthouse in Johnston County, North Carolina on 7/25/03 listing Resident 33 ' s emergency contact as his responsible party. She stated she was not aware of the existence of the POA form until today. The SW stated left a message with the responsible party to call the facility about setting up a time to	F 250	ensure that the deficient practice will not occur. 3a. Clinical staff will be re-educated on Facility Policies relating to Dental Care by DON/Designee. Education will be provide at time of orientation for new employees. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 4a. New Admits will be reviewed 5x/week for timely completion and accuracy of Dental Assessment by DON/designee for 12 weeks. 4b. New Admits will be reviewed by Regional Director of Clinical Services 1x/week for 12 weeks to ensure timeliness of dental assessments and for potential risk for utilization of the Dental Assessments. 5. Results of the audits will be taken to QA&A meeting monthly for 3 months.	

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F 250	Continued From page 2 discuss Resident #33 ' s dental needs. In an interview on 3/10/16 at 12:15 PM, the Administrator stated it was his expectation that any outside or in-house recommendation be followed up on in a timely manner regardless of payer source and the facility be aware of all cognitively impaired resident ' s responsible party information in order to provide services as needed. The Administrator verified Resident #33 dental recommendation made June 25, 2015 was not addressed until today.	F 250		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;	F 272		4/12/16

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F 272	Continued From page 3 Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		
	This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to comprehensive assess a resident identified dental needs for 1 of 19 residents (Resident #33) reviewed for assessment. Findings included: Resident #33 was admitted to the facility 11/11/10 with cumulative diagnoses of schizophrenia and dementia. His annual Minimum Data Set (MDS) dated 7/20/15 was coded as having no oral issues and no Care Area Assessment for his dental needs. He was care planned for refusal of nail care and shaving. A review of the Long Term Care Associates, Inc. Dental History and Record dated 6/25/15 indicated Resident #33 required full mouth extraction due to rampant decay. Hospitalization was recommended. A quarterly Restorative Functional Data Collection		1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1a. Resident #33 Annual Comprehensive Assessment was corrected on 3/10/2016 and submitted. 1b. Current residents with noted dental issues will be corrected and resubmitted for correction per MDS Coordinator. 2. Address how corrective action will be accomplished for those residents having potential to be affected by the deficient practice. 2a. Residents residing at the facility will be considered as having potential to have been affected by the same deficient practice. 2b. Residents residing in facility will have their Comprehensive Assessment reviewed for accuracy of dental care.	

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F 272	Continued From page 4 and Decision form dated 10/6/15 indicated Resident #33 was unable to brush own teeth. In an observation on 3/7/16 at 12:08 PM, Resident #33 was observed sitting in the common area. He was verbal but determined unreliable for an interview. His bottom teeth were observed and noted to be broken, missing and decaying. In an interview on 3/9/16 at 2:15 PM, the MDS nurse stated she completed section L (dental assessment) on Resident #33 ' s annual MDS assessment dated 7/20/15 and noted she did not code the MDS correctly. The MDS nurse stated had she coded the annual MDS dated 7/20/15 correctly, a Care Area Assessment would have been triggered for dental referrals and Resident #33 ' s dental needs would have been followed up on at the time of the assessment in July. In an interview on 3/10/16 at 12:15 PM, the Administrator stated it was his expectation that any outside or in-house recommendation be followed up on in a timely manner and social services be aware of who each resident ' s responsible party is for cognitive impaired residents. The Administrator verified Resident #33 dental recommendation made June 25, 2015 was not addressed until today.	F 272	3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. 3a. MDS Coordinator was re-educated regarding Section L of the RAI (Resident Assessment Instrument) conducted by Resident Director of Clinical Services on 03/14/2016. New MDS Coordinators will be educated upon orientation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 4a. New Comprehensive Assessments will be reviewed weekly for 12 weeks for accuracy of Section L. 4b. New Comprehensive Assessments will be reviewed by Regional Director of Clinical Services 1x/week for 12 weeks to ensure accuracy of Section L and for any potential residents at risk. 5. Results of the audits will be taken to QA&AQ meeting monthly x 3 months.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279		4/12/16

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F 279	Continued From page 5 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to care plan for dental needs for 1 of 19 residents (Resident #33) reviewed for care planning. Findings included: Resident #33 was admitted to the facility 11/11/10 with cumulative diagnoses of schizophrenia and dementia. His annual Minimum Data Set (MDS) dated 7/20/15 was coded as having no oral issues and no Care Area Assessment for his dental needs. He was care planned for refusal of nail care and shaving. A review of the Long Term Care Associates, Inc. Dental History and Record dated 6/25/15 indicated Resident #33 required full mouth extraction due to rampant decay. Hospitalization was recommended. A quarterly Restorative Functional Data Collection and Decision form dated 10/6/15 indicated	F 279	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1a. Resident #33 Comprehensive Care Plan was corrected and updated on 03/10/2016 related to dental care. 2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. 2a. Residents that are residing at the facility will be considered as having potential to have been affected by the deficient practice. 2b. Residents residing in facility will have their Care Plans reviewed for Dental Service accuracy. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

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F 279	Continued From page 6 Resident #33 was unable to brush own teeth. In an observation on 3/7/16 at 12:08 PM, Resident #33 was observed sitting in the common area. He was verbal but determined unreliable for an interview. His bottom teeth were observed and noted to be broken, missing and decaying. In an interview on 3/9/16 at 9:45 AM, nursing assistant (NA) #1 stated Resident #33 often refused oral care and he could become combative at times. In an interview on 3/9/16 at 2:15 PM, the MDS nurse stated she completed section L (dental assessment) on Resident #33 ' s annual MDS assessment dated 7/20/15 and noted she did not code the MDS correctly. The MDS nurse stated had she coded the annual MDS dated 7/20/15 correctly, a Care Area Assessment would have been triggered for dental referrals and care planning. In an interview on 3/10/16 at 10:55 AM, NA #4 stated Resident #33 refused oral care most days and he could be combative at times. In an interview on 3/10/16 at 12:15 PM, the Administrator stated it was his expectation the MDS assessment and care planning be accurate in order to identify and meet resident needs.	F 279	occur. 3a. MDS Coordinator was re-educated on #15 of CAAS (Care Area Assessment) and process of proceeding to care plan per the RAI (Resident Assessment Instrument) on 03/14/2016. 3b. Training will be conducted to any new MDS Coordinator during orientation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 4a. IDT will audit CAAS and Care Plans for appropriate dental care of new Comprehensive Assessments weekly x 12 weeks. Any omissions of noted dental care will be revised and care planned. 4b. Regional Director of Clinical Services will audit new CAAS and Care Plans 1x/week for 12 weeks to ensure compliance. 4c. Omissions will be reported to the Administrator with disciplinary action as indicated. 5. Audits will be taken to QA&A for 3 months for review.	
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	F 309		4/12/16

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F 309	Continued From page 7 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to monitor the condition of a resident after dialysis treatment for 1 of 1 sampled resident (Resident #50) reviewed for dialysis. Findings included: Resident #50 was admitted on 5/4/15 with a diagnosis of end stage renal disease (ERSD). His significant change Minimum Data Set dated 2/26/16 indicated severe cognitive impairment and extensive assistance with his activities of daily living. He was care planned for dialysis which included the following interventions: no blood pressure checks to his left arm, no lab draws to his left arm and monitor Resident #50 ' s dialysis access site for signs of bleeding. A review of the facility policy titled " Protocol for Dialysis " dated 7/07 indicated that after dialysis, the staff were to monitor the access site dressing for bleeding and presence of thrill/bruit and to notify the physician for significant changes in blood pressure after dialysis treatment. In an observation on 3/8/16 at 9:00 AM, Resident #50 was lying in bed. He had no dressing to his left arm. In an interview on 3/9/16 at 9:45 AM, nursing assistant (NA) #1 stated she got Resident #50 up and ready to go to dialysis this morning. She stated he was cooperative and took a bag lunch	F 309	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1a. Resident #50 discharged to hospital from dialysis and expired at the hospital. No further action can be rendered for resident #50. 2. Address how corrective action will be accomplished for those resident having potential to be affected by the same deficient practice. 2a. Dialysis residents residing at the facility will be considered as having potential to be affected by the same deficient practice. 2b. Dialysis residents will be assessed prior to departing to dialysis and upon re-entering from dialysis to monitor condition of resident. 2c. Dialysis residents charts will be reviewed for omission of documentation 3x/week for 12 weeks. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. 3a. Licensed Nurses and Certified Nursing Assistance will be educated on facility policy and procedure of dialysis residents for which will be conducted by DON/designee. Education will be provided	

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F 309	Continued From page 8 with him to dialysis. NA #1 stated she was aware she should not take his blood pressure in his left arm but he never returned from dialysis on her shift. In an interview on 3/9/16 at 10:00 AM, Unit Manager (UM) #1 stated there were orders for the staff to remove the fistula dressing at 8:00 PM and Resident #50 arrived back from dialysis usually between 5:30 PM and 6:00 PM. The UM verified a dialysis communication sheet was completed prior to leaving dialysis, during dialysis but there was no documentation of post dialysis assessment. In an interview on 3/9/16 at 10:25 AM, nursing assistant (NA) #2 stated she had worked consistently with Resident #50 and she was aware that he should not have his blood pressure taken in his left arm. She stated that was the only training or special interventions she was aware of regarding Resident #50. In an interview on 3/9/16 at 11:20 AM, Nurse #1 stated she did not assess his vital signs or his access site after dialysis because he usually returned toward the end of her shift and she was usually busy assisting with feeding residents. Nurse #1 stated he was assessed after his dialysis treatment by the nurse who came in at 7:00 PM. Nurse #1 confirmed Resident #50 arrived back from dialysis on her 7:00 AM to 7:00 PM shift and she had not been assessing Resident #50 ' s fistula or vital signs after his dialysis treatments. In an interview on 3/9/16 at 4:15 PM, NA #3 stated when Resident #50 returned from dialysis she placed him in the bed and fed him dinner.	F 309	at time of orientation for new Licensed Nurses and Certified Nursing Assistance. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 4a. Dialysis residents will be reviewed 3x/week for 12 weeks by DON/designee for timely documentation of departing and returning dialysis residents. 4b. Dialysis residents assessments prior to departure and returning from dialysis will be reviewed 1x/week x 12 weeks by the Regional Director of Clinical Services to review for potential risk and utilization of the dialysis process. 5. Results of the audit will be taken to QA&A meeting monthly x 3 months.	

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F 309	Continued From page 9 She stated she was unsure if Nurse #1 assessed Resident #50 ' s left arm or vital signs when he returned from dialysis. In a telephone interview on 3/9/16 at 6:15 AM, Nurse #2 stated Resident #50 was always back from dialysis when she arrived for her shift at 7pm. She stated she removed the dressing around 8:00 PM as ordered and assumed Nurse #1 or the nurse on duty at the time of his return got his vital signs and assessed his fistula for bleeding after he returned from his dialysis treatment. In an interview on 3/10/16 at 10:05 AM, the transporter stated she picked up Resident #50 at dialysis and he was usually back at the facility between 5:00 and 6:00 PM on Monday, Wednesdays and Fridays. In an interview on 3/10/16 at 11:30 AM, the Director of Nursing stated it was her expectation the nurse working at the time of Resident #50 returned from dialysis, assess and document his blood pressure and his fistula for signs of bleeding.	F 309		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or	F 412		4/12/16

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F 412	Continued From page 10 damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to provide recommended dental services for 1 of 1 sampled Medicaid residents (Resident #33) reviewed for dental needs. Findings included: Resident #33 was admitted to the facility 11/11/10 with cumulative diagnoses of schizophrenia and dementia. His quarterly Minimum Data Set (MDS) dated 1/16/16 indicated severe cognitive impairment and extensive assistance with his activities of daily living (ADLs) to include oral hygiene. He was not coded with any rejection of care. Resident #33 was care planned for ADL assistance and care planned for refusal of nail care and shaving. A quarterly Restorative Functional Data Collection and Decision form dated 10/6/15 indicated Resident #33 was unable to brush own teeth. In an observation on 3/7/16 at 12:08 PM, Resident #33 was observed sitting in the common area. He was verbal but determined unreliable for an interview. His bottom teeth were observed and noted to be broken, missing and decaying. Resident #33 denied discomfort related his teeth. A review of the Long Term Care Associates, Inc. Dental History and Record dated 6/25/15 indicated Resident #33 required full mouth extraction due to rampant decay. Hospitalization was recommended.	F 412	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1a. SW contacted APS on 03/16/2016 at 10:15 AM regarding Guardianship for resident #33 due to unable to reach POA. 1b. Psychologist evaluation of cognitive status for resident #33 was completed on 03/18/2016. 2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. 2a. Residents that are residing at the facility will be considered as having potential to have been affected by the deficient practice. 2b. Residents residing in facility will be reviewed for Dental care practices. Any identified will be offered dental care outside facility as warranted. 2c. Dental log will be maintained by Social Worker/designee. 2d. Dental referrals/appointments will be maintained by SW/designee. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. 3a. Clinical staff will be re-educated on Facility Policies relating to Dental Care by DON/Designee. Education will be provide at time of orientation for new employees.	

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F 412	Continued From page 11 A review of the physician progress notes from June 2015 to present did not indicate any concerns related to Resident #33 ' s oral condition. In an interview on 3/9/16 at 9:45 AM, nursing assistant (NA) #1 stated Resident #33 often refused oral care and he could become combative at times. NA #1 recalled something about Resident #33 having all his teeth removed due to the decay but she did not know why it had not been done. She stated he did not complain of oral pain and he had no issues eating except he ate too fast. In an interview on 3/9/16 at 10:07 AM, Unit Manager (UM) #1 stated Resident #33 was his own responsible party and he could decide if he wanted to go to the dentist. In another interview on 3/9/16 at 10:50 AM, the UM #1 stated Resident #33 was taken to the dentist last year sometime but the family refused any dental follow up. In an observation on 3/9/16 at 12:37 PM, Resident #33 was observed eating his lunch in the dining room. He required set up assistance only and occasional cueing to slow down. He did not seem to have issues eating and he did not voice discomfort with his teeth while eating. He was prescribed a reduced concentrated sweets, regular, ground meat diet. In an interview on 3/9/16 at 12:43 PM, the transporter stated she took Resident #33 out to the dentist March 24, 2015 but he could not sign his paperwork due to his cognition so the dentist was not able to see him. The transporter returned	F 412	4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 4a. New Admits will be reviewed 5x/week for timely completion and accuracy of Dental Assessment by DON/designee for 12 weeks. 4b. New Admits will be reviewed by Regional Director of Clinical Services 1x/week for 12 weeks to ensure timeliness of dental assessments and for potential risk for utilization of the Dental Assessments. 5. Results of the audits will be taken to QA&A meeting monthly for 3 months.	

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	345173	A. BUILDING ____ B. WING ____	03/10/2016

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F 412	Continued From page 12	F 412		

Resident #33 to the facility and informed the previous social worker (SW) of the outcome of the dentist visit. He was then seen by the in house dentist in June 25, 2015.

In an interview on 3/9/16 at 3:00 PM, the speech therapist stated Resident #33 diet was downgraded in January to ground meats not related to his oral condition but rather due to his impulsive eating and choking. She stated she was under the impression Resident #33 was having his teeth extracted but did not know when it was planned. The verified he had not had any weight loss and the referral was due to his choking with eating too fast.

In an interview on 3/9/16 at 3:43 PM, the social worker (SW) stated she started working at the facility in June 2015. She stated she was not aware of the dental recommendation made by the in-house dentist on 6/25/16 for complete extraction.

In an interview on 3/10/16 at 10:30 AM, restorative aide (RA) #1 stated Resident #33 had complained of oral pain in the past and she reported it to the nurse. She stated she thought he was going out to have his teeth pulled a long time ago but it never happened. She stated Resident #33 had no issues eating but he did have to be cued to slow down due to poor impulse control. RA #1 stated she was aware the Resident #33 refused his ADLs at time but unsure about his oral care.

In an interview on 3/10/16 at 10:55 AM, NA #4 stated Resident #33 had never complained of mouth pain to her but he refused oral care most days and he could be combative at times.

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F 412	Continued From page 13 A review of the medical administration records from January 1, 2016 to present did not indicate any pain medications were administered for any reported pain. In an interview on 3/10/16 at 12:15 PM, the Administrator stated it was his expectation that any outside or in-house recommendation be followed up on in a timely manner and Resident #33 dental recommendation made June 25, 2015 was not addressed until today.	F 412		
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	F 441		4/12/16

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F 441	Continued From page 14 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, staff interviews and record review the facility failed to maintain accepted infection control practices during a pressure ulcer treatment by using contaminated scissors to cut a medicated dressing to be applied to a pressure ulcer for 1 of 2 sampled residents (Resident #1) reviewed for pressure ulcers. Findings included: A review of the facility policy titled " Skin and Wound Care Guideline " dated July 2012 and last revised October 2015 indicated the following: Clean technique strategies should be used to reduce the transmission of microorganisms from one person to another or from one place to another. Clean technique involved meticulous hand-washing, maintaining a clean environment by preparing a clean field, using clean gloves, sterile instruments and prevent the direct contamination of materials or supplies. During a wound care observation on 3/9/16 at 12:05 PM, Unit Manager (UM) #1 completed a	F 441	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1a. UM #1 is no longer employed by the facility. 2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. 2a. Residents with wounds that are residing at the facility will be considered as having potential to have been affected by the deficient practice. 2b. Residents residing at the facility with a wound will be observed during wound care practices DON/designee. Any deficient practice will be corrected immediately. Residents will be monitored for any signs/symptoms of infection. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

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F 441	Continued From page 15 wound care treatment on Resident #1. The wound bed had already been cleaned and prepared for the new dressing by the wound care physician. UM #1 had his supplies lying out on a sanitized bedside table. UM #1 then reached into the waistband of his scrub pants, retrieved a pair of scissors and cut a portion of a medication dressing measuring 2 inches by 3 inches to be applied to Resident # ' 1 ' s pressure ulcer. He neglected to clean the scissors prior to using them to cut the dressing and once he finished cutting the dressing, he then returned the scissors to the inside waistband of his scrub pants. UM #1 next applied the dressing to Resident #1 ' s pressure ulcer and completed the dressing change by securing the dressing in place. In an interview on 3/9/16 at 12:35 PM, UM #1 stated he should have wiped the scissors with an sanitizing wipe and allow them to air dry on a clean surface prior to using them to cut the medicated dressing. In an interview on 3/9/16 at 1:00 PM, the Director of Nursing stated her expectation was for the scissors be properly cleaned and sanitized prior to using them to prepare a dressing to be placed on any wound or pressure ulcer.	F 441	occur. 3a. Licensed Nurses will be educated on "Skin and Wound Care Guidelines" which will be conducted by DON/designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 4a. Wound care on 3 residents will be observed weekly for 12 weeks by Unit Manager for appropriate wound care and infection control techniques. 4b. Wound care will be observed 1x/week x 12 weeks by DON. 5. Results of observation will be taken to QA&A meeting monthly x 3 months.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the	F 520		4/12/16

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F 520	Continued From page 16 facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility Quality Assessment and Assurance Committee failed to maintain implement, monitor and revise as need the action plan developed to correct a deficiency at well-being (F309) cited during a compliant survey of 8/7/15. As a result, a deficiency in the area of well-being was again cited on the current recertification/complaint survey of 3/10/16. This tags is cross referenced to: F 309: Based on observations, staff interviews and record review, the facility failed to monitor the condition of a resident after dialysis treatment for 1 of 1 sampled resident (Resident #50) reviewed for dialysis.	F 520	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1a. Resident #50 discharged to hospital from dialysis and expired at the hospital. No further action can be rendered for resident #50. 2. Address how corrective action will be accomplished for those resident having potential to be affected by the same deficient practice. 2a. Dialysis residents residing at the facility will be considered as having potential to be affected by the same deficient practice. 2b. Dialysis residents will be assessed	

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F 520	Continued From page 17 An interview on 3/10/16 at 12:15 PM, the Administrator acknowledged the facility recently regained compliance in the area of well-being on 9/23/15. The administrator acknowledged understanding of reciting of F309 during recertification/complaint survey of 3/10/16.	F 520	prior to departing to dialysis and upon re-entering from dialysis to monitor condition of resident. 2c. Dialysis residents charts will be reviewed for omission of documentation 3x/week for 12 weeks. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. 3a. Licensed Nurses and Certified Nursing Assistance will be educated on facility policy and procedure of dialysis residents for which will be conducted by DON/designee. Education will be provided at time of orientation for new Licensed Nurses and Certified Nursing Assistance. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 4a. Dialysis residents will be reviewed 3x/week for 12 weeks by DON/designee for timely documentation of departing and returning dialysis residents. 4b. Dialysis residents assessments prior to departure and retuning from dialysis will be reviewed 1x/week x 12 weeks by the Regional Director of Clinical Services to review for potential risk and utilization of the dialysis process. 5. Results of the audit will be taken to QA&A meeting monthly x 3 months.	