STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation survey on 11/2/17. Event ID # OJXS11. Complaint intake: NC00125328, NC00125361, NC00125869, NC00127266, NC00127992, NC00128235, NC00129392.	F 000		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to implement care plan interventions by not ensuring float boots were in place for 1 of 3 residents reviewed for pressure ulcers (Resident #20) and providing treatments as ordered for 2 of 3 residents reviewed for pressure ulcers (Resident #20, Resident #26). Ex. 1 Resident #20 was admitted to the facility on 2/27/13 with diagnoses including Chronic Kidney Disease, Cerebrovascular Accident and Hemiplegia. Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 10/3/17 identified Resident #20 as cognitively intact.	F 282	Resident #20 was care planned for float boots to bilateral extremities and check placement Q shift, which was not in place nor signed off during survey period. Skin prep ordered prior to putting on boots, which was not signed off on TAR every day as ordered. Also, treatment nurse failed to use prescribed cleanser to wash wound bed. Resident #26 was care planned for a stage 4 pressure ulcer and treatment as prescribed. The treatment nurse observed applying incorrect dressing. Skin prep applied per order and boots applied by hall nursing staff to resident	11/17/17

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

Electronically Signed | 11/16/2017

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F 282	Continued From page 1 Resident #20 required extensive two person assistance with bed mobility and transferring. Walking did not occur. Resident #20 required extensive one person assistance for toileting and hygiene. Resident #20 had range of impairment limitations of the upper and lower extremities bilaterally. Resident #20 was always incontinent of bowel and bladder and had a Stage 4 pressure ulcer. Review of the care plan dated 4/18/17 documented the problem as having an actual pressure ulcer to the coccyx, Stage 4. Approaches, in meeting the goal of areas showing signs of healing through the next review, included, in part, ensuring appropriate pressure relieving devices were in place during repositioning and providing treatments as ordered. Review of the Physician ' s Orders dated 1/20/17 documented an order for Float Boots (similar to bunny boots) to bilateral lower extremities and use pillows under calves to elevate heels and to check placement every shift. Review of the October 2017 Treatment Administration Record showed no documentation on the dates of 10/3/17 through 10/9/17, 10/11/17 through 10/13/17, 10/17/17-10/18/17, 10/21/17 through 10/27/17 and 10/20/17-10/31/17 that the Skin Prep was applied to the left heel on the 6:30AM shift. Further review of the dates 10/1/17, 10/3/17 through 10/8/17, 10/11/17, 10/16/17-10/19/17, 10/21/17-10/23/17, 10/25/17, 10/27/17 and 10/31/17 on the 10:30PM shift showed no documentation the Skin Prep was applied to the left heel.	F 282	#20 and signed TAR signed on 11/2/17. Treatment was re- done by back up treatment nurse and ADON using prescribed cleanser and documented on 11/2/17. The treatment nurse recognized and acknowledged wrong dressing and that she had wrong orders on resident #26. Orders were re-verified, correct treatment applied and TAR signed on 11/1/17. Treatment nurse in- serviced on transcription of treatments to TAR per MD order, using hard copy if computer is unavailable or out of service administering prescribed treatment regimen and signing TAR per nursing protocol after doing treatment on 11/1/17 and 11/2/17 by ADON/DON. 100% audit was done on all residents receiving treatments in the facility by treatment nurse, ADON/ DON and was completed on 11/3/17. Education of all nursing staff on transcription of treatments and meds per MD order, following prescribed regimen and care plans and signing off TAR/ MAR by SDC, ADON, RN Nurse Supervisors, and DON completed on 11/14/17. DON or designee will review MD orders daily to ensure that all components are transcribed to MAR/TAR accurately and reflected in care plan. All nurses educated on signing MAR/TAR off as care completed (by 11/17/17).	

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F 282	Continued From page 2 During an observation on 10/3/17 at 2:45PM with Nursing Assistant #1 she stated Resident #20 had foot booties ordered. Resident #20 had her calves elevated on pillows. There were no foot booties on. During an observation on 11/1/17 at 8:30AM with Nursing Assistant #2 she lifted the blankets and the resident had her calves floated on a pillow. The foot booties were sitting on the windowsill. NA #2 stated the boots were supposed to be on her feet. NA #2then left the room to pass breakfast trays. During an interview with the Treatment nurse on 11/2/17 at 10:03AM she stated night shift is responsible for 6:30AM skin prep treatment and the evening nurse is responsible for the 10:30PM treatment and the Treatment Administration Record (eTAR) does not show it being documented as done. The staff should also be putting the bunny boots on after applying skin prep. During an interview with the Director of Nursing on 11/2/17 at 11:00AM she stated it was her expectation for the treatments to be as ordered. She also stated that she expected the eTAR to be documented showing the treatments were given. She stated she expected the skin prep to be done and the float boots to be on as ordered. She stated if the computer is down the nursing staff need to document in the resident's chart. During an interview with the Administrator on 11/2/17 1:18PM she stated she would expect the treatments to be done as ordered and documented as such. She also stated the float boots should be on the resident as ordered and	F 282	On-coming/Off-going nurse to audit MAR/TAR for incomplete documentation daily. DON or designee will monitor daily for four weeks, then weekly for two months, or until substantial compliance is obtained. The DON or designee will report findings monthly in QAPI until substantial compliance is obtained as determined by QA Committee. Appropriate actions will be taken as indicated to secure compliance.	

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F 282	Continued From page 3	F 282		

the care plan followed.
2. Resident #26 was admitted to the facility on 2/2/16 with diagnoses of Alzheimer's Disease, Diabetes Mellitus, Hypertension, a stage 4 pressure ulcer of the left heel and Heart Failure.

A review of Resident #26's annual Minimum Data Set (MDS) 2/8/17 and quarterly MDS dated 7/23/17 revealed he was mildly cognitively impaired with no behaviors. Resident #26 required extensive care for transfers, dressing, toileting and personal hygiene and was totally dependent on staff for bathing. Resident #26 was always incontinent of bowel and bladder and had one stage 4 pressure ulcer to his left heel.

A review of the care plan updated 10/19/17 revealed Resident #26 had a stage 4 pressure ulcer to the left heel. Staff were to provide treatments to the wound as ordered by the physician.

A review of the physician's order dated 10/25/17 documented an order to clean the left heel with Normal Saline, apply cream to the wound and pack lightly with alginate, apply abdominal pad and wrap with Kerlix daily until healed.

On 11/01/17 at 11:02 AM the Treatment Nurse was observed providing a treatment to Resident #26's left heel. She cleansed the left heel with Normal Saline and applied Collagen (Fibercol). The Treatment Nurse then applied an abdominal pad and wrapped the heel with Kerlix.

On 11/1/17 at 3:48 PM the Treatment Nurse stated that she had done the wrong treatment because she had not changed the order on the Treatment Record on October 25, 2017. The

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F 282	Continued From page 4 Treatment Nurse stated that she should have looked at the orders from the computer. On 11/1/17 at 3:50 PM the Director of Nursing stated that the correct treatment should be done and signed off when it was completed. When the wrong treatment was administered the treatment should be corrected immediately. On 11/1/17 at 3:51 PM the Administrator stated that the correct treatment should have been done and signed off when it was completed.	F 282		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to apply Skin Prep as ordered for 1 of 2 residents observed at risk for	F 314	Resident #20 was care planned for float boots to bilateral extremities and check placement Q shift, which was not in place	11/17/17

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F 314	Continued From page 5 pressure ulcers (Resident #20) and failed to complete a dressing change as ordered to treat a pressure ulcer for 2 of 2 residents observed receiving wound care (Resident #20, #26). Findings included: 1. Resident #20 was admitted to the facility on 2/27/13 with diagnoses including Chronic Kidney Disease, Cerebrovascular Accident and Hemiplegia. A review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 10/3/17 identified Resident #20 as cognitively intact. Resident #20 required extensive two person assistance with bed mobility and transferring. Walking did not occur. Resident #20 required extensive one person assistance for toileting and hygiene. Resident #20 had range of impairment limitations of the upper and lower extremities bilaterally. Resident #20 was always incontinent of bowel and bladder and had a Stage 4 pressure ulcer. A review of the care plan dated 4/18/17 documented the problem as having an actual pressure ulcer to the coccyx, Stage 4. Approaches, in meeting the goal of areas showing signs of healing through the next review, included, in part, ensuring appropriate pressure relieving devices were in place during repositioning and providing treatments as ordered. A review of the October 2017 Physician ' s Orders documented an order for Skin Prep to be applied to the left heel every shift.	F 314	nor signed off during survey period. Skin prep ordered prior to putting on boots, which was not signed off on TAR every day as ordered. Also, treatment nurse failed to use prescribed cleanser to wash wound bed. Resident #26 was care planned for a stage 4 pressure ulcer and treatment as prescribed. The treatment nurse observed applying incorrect dressing. Skin prep applied per order and boots applied by hall nursing staff to resident #20 and signed TAR signed on 11/2/17. Treatment was re-done by back up treatment nurse and ADON using prescribed cleanser and documented on 11/2/17. The treatment nurse recognized and acknowledged wrong dressing and that she had wrong orders on resident #26. Orders were re-verified, correct treatment applied and TAR signed on 11/1/17. Treatment nurse in- serviced on transcription of treatments to TAR per MD order, using hard copy if computer is unavailable or out of service administering prescribed treatment regimen and signing TAR per nursing protocol after doing treatment on 11/1/17 and 11/2/17 by ADON/DON. 100% audit was done on all residents receiving treatments in the facility by treatment nurse, ADON/ DON and was completed on 11/3/17.	

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F 314	Continued From page 6 Review of the October 2017 Treatment Administration Record showed no documentation on the dates of 10/3/17 through 10/9/17, 10/11/17 through 10/13/17, 10/17/17-10/18/17, 10/21/17 through 10/27/17 and 10/20/17-10/31/17 that the Skin Prep was applied to the left heel on the 6:30AM shift. Further review of the dates 10/1/17, 10/3/17 through 10/8/17, 10/11/17, 10/16/17-10/19/17, 10/21/17-10/23/17, 10/25/17, 10/27/17 and 10/31/17 on the 10:30PM shift showed no documentation the Skin Prep was applied to the left heel. Review of the Physician ' s Orders, dated 9/12/17 documented an order to clean the coccyx with Normal Saline, pack the wound with Alginate and apply a Hydrocolloid dressing every Tuesday, Thursday and Saturday and as needed for a Stage 4 wound. During an observation of the wound dressing change on 11/2/17 at 10:30AM the Treatment Nurse placed her supplies on the top of a covered bedside table. The supplies included gloves, wipes, a bottle of Normal Saline, Alginate and a Hydrocolloid dressing. The Treatment Nurse was observed to wash her hands, don gloves and position Resident #20 on her left side and remove the soiled dressing. The Nurse Consultant was assisting by holding Resident #20 in position. Resident #20 was noted to have stool on her buttocks. The Treatment Nurse proceeded to clean Resident #20 and removed the stool using wipes. The Treatment then removed her gloves and washed her hands. She then re-gloved and took the Alginate packing and inserted the Alginate into the wound. She then covered the wound with the Hydrocolloid dressing. The Treatment Nurse was not observed to clean the	F 314	Education of all nursing staff on transcription of treatments and meds per MD order, following prescribed regimen and care plans and signing off TAR/ MAR by SDC, ADON, RN Nurse Supervisors, and DON completed on 11/14/17. The DON or designee will review MD orders daily to ensure that all components are transcribed to MAR/TAR accurately and reflected in care plan. All nurses educated on signing MAR/TAR off as care completed (by 11/17/17). On-coming/Off-going nurse to audit MAR/TAR for incomplete documentation daily. The DON or designee will monitor daily for four weeks, then weekly for two months, or until substantial compliance is obtained. The DON or designee will report findings monthly in QAPI until substantial compliance is obtained as determined by QA Committee. Appropriate actions will be taken as indicated to secure compliance.	

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F 314	Continued From page 7	F 314		

area with Normal Saline prior to inserting the Alginate packing.

During an interview with the Treatment Nurse on 11/2/17 at 10:50AM, she stated she forgot to clean the area with Normal Saline but she had cleaned the area well with the wipes when removing the stool. The Treatment Nurse also stated that the hall nurses were responsible for applying the skin prep to the resident's left heel.

During an interview with the Director of Nursing on 11/0/17 11:00AM, she stated it was her expectation for treatments to be done as ordered. She stated the floor nurses were responsible for documenting in the computer and if the computer were down they should document in the chart that the treatments were done on their respective shifts.

During an interview with the Administrator on 11/02/17 at 1:18PM, she stated she would expect the treatment to be done as ordered and documented as such. She stated the nurse went back in and re-did the dressing change correctly.

2. Resident #26 was admitted to the facility on 2/2/16 with diagnoses including Alzheimer's Disease, Diabetes Mellitus, Hypertension, a Stage 4 pressure ulcer of the left heel and Heart Failure.

A review of Resident #26 ' s annual Minimum Data Set (MDS) 2/8/17 and quarterly MDS dated 7/23/17 revealed he was mildly cognitively impaired with no behaviors. Resident #26 required extensive care for transfers, dressing,

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F 314	Continued From page 8	F 314		

toileting and personal hygiene and was totally dependent on staff for bathing. Resident #26 was always incontinent of bowel and bladder and had one stage 4 pressure ulcer to his left heel.

A review of the October 2017 treatment record, revealed Resident #26 was ordered apply collagen (Fibercol) every day and discontinued on 10/25/17. A review of the treatment record documentation revealed Resident #26 did not receive his treatment on 10/17/17, 10/20/17 and 10/23/17.

A review of the care plan updated 10/19/17 revealed the resident had a stage 4 pressure ulcer to the left heel. Staff were to provide treatments to the wound as ordered by the physician.

A review of the physician's order dated 10/25/17 documented an order to clean the left heel with Normal Saline, apply cream to the wound and pack lightly with alginate, apply abdominal pad and wrap with Kerlix daily until healed.

On 11/01/17 at 11:02 AM the Treatment Nurse was observed providing a treatment to Resident #26's left heel. She cleansed the left heel with Normal Saline and applied Collagen (Fibercol). The Treatment Nurse then applied an abdominal pad and wrapped the heel with Kerlix.

On 11/1/17 at 3:48 PM the Treatment Nurse stated that she had done the wrong treatment because she had not changed the order on the Treatment Record on October 25, 2017. The Treatment Nurse stated that she should have looked at the orders from the computer.

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F 314	Continued From page 9 On 11/1/17 at 3:50 PM the Director of Nursing stated that the correct treatment should be done and signed off when it was completed. When the wrong treatment was administered the treatment should be corrected immediately. On 11/1/17 at 3:51 PM the Administrator stated that the correct treatment should have been done and signed off when it was completed.	F 314		
F 356 SS=C	POSTED NURSE STAFFING INFORMATION CFR(s): 483.35(g)(1)-(4) 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data	F 356		11/17/17

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F 356	Continued From page 10 specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to post the daily nursing staffing sheet at the beginning of each shift for one of five days during the recertification and complaint survey. Findings included: During the initial tour of the facility on 10/29/17 at 2:30 PM the census was posted for 10/27/17. There was no posting for beginning of first shift for 10/29/17. On 11/02/17 at 9:11 AM the Administrator stated that there was a process for the staff posting to be posted at the beginning of the shift everyday including weekends. The Administrator stated that	F 356	10/28/17 and 10/29/17 census and staffing hours were not posted. All shifts daily have the potential to be out of compliance. Education provided by SDC or designee for all nurses on the requirement to post nurse staffing and census data to be completed by 11/17/2017. At the start of each shift, the 100 Hall nurse will post the nurse staffing and census data. The DON or designee will confirm accurate nurse staffing and census data is posted daily. Actions to be taken as indicated to secure compliance.	

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F 356	Continued From page 11 she was not sure what happened.	F 356	Results will be reported to QAPI by SDC or designee monthly and actions will be taken as indicated to secure compliance. Audit will be discontinued after two months if substantial compliance has been obtained as determined by the QA Committee.	
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 441		11/17/17

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	345291	A. BUILDING _____ B. WING _____	C 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 441	Continued From page 12 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, the facility failed to	F 441	The isolation sign for resident #171 was posted on the door at eye level	

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F 441	Continued From page 13 post a visible isolation sign outside a resident ' s door for 1 of 1 resident who was placed on isolation precautions (Resident #171) for 4 of 5 days during the recertification survey. Findings included: A review of the admission diagnoses on 10/23/17 revealed Resident #171 was admitted with clostridium difficile and was placed on contact isolation. On 10/29/17 at 2:30 PM during the initial tour revealed there was a PPE (personal protection equipment) cart outside of Resident #171 ' s room. There was no contact isolation sign observed on the resident ' s door. On 10/30/17 at 8:38 AM there was no contact isolation sign observed on the resident ' s door. The contact isolation sign was observed on top of the PPE cart with a box of gloves partially covering the sign. On 10/30/17 at 9:15 AM Resident #171 identified as alert and oriented stated he was on contact isolation due to having clostridium difficile. On 10/31/17 at 9:04 AM there was no contact isolation sign observed on the resident ' s door. The contact isolation sign was observed on top of the PPE cart with a box of gloves partially covering the sign. On 11/1/17 at 2:10 PM there was no contact isolation sign observed on the resident ' s door. The contact isolation sign was observed on top of the PPE cart with a box of gloves partially covering the sign.	F 441	immediately. All residents have the potential to be affected. 100% Audit of all (2) residents on isolation was completed immediately. Education provided by SDC or designee to all nursing staff on proper posting of isolation signs completed by 11/17/2017. The SDC or designee will make daily rounds on all residents on isolation to ensure compliance. Corrective actions will be taken as indicated to secure compliance. Audit may be discontinued after two months if substantial compliance has been obtained. The SDC or designee will report findings monthly in QAPI until substantial compliance is obtained as determined by QA Committee. Appropriate actions will be taken as indicated to secure compliance.	

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F 441	Continued From page 14 On 11/1/17 at 2:19 PM the Infection Control Coordinator stated that the contact isolation sign should be placed at eye level on the door of a resident that was on contact isolation. On 11/2/17 at 2:21PM the Administrator stated that the contact isolation sign was posted and fell off the door and was placed on the PPE cart with a box of gloves on top of the sign. The Administrator stated that the door had been painted and the sign did not stay on the door. She stated that she kept taking the gloves off of the sign and thought that the family kept putting the gloves on the sign.	F 441		
F 520 SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to	F 520		11/17/17

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F 520	Continued From page 15 coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. 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 observations, staff interview and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and to monitor the interventions the committee put into place following the recertification survey 11/10/16. This was for one deficiency which was recited during the recertification survey of 11/2/17 in the area of Infection Control (F-441). The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to:	F 520	Correction for resident affected is accomplished by response to F-Tag# 441. All residents have the potential to be affected. Prior citation pertaining to F441 was for failure to wear gloves when entering a resident's room on contact isolation and failing to wash hands before leaving the room and prior to handling meal trays. Current citation for F441 is for failure to post a visible isolation sign. Infection Control QAPI plan now includes a component to address posting of isolation signs monitored by SDC or designee, and QA Committee.	

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F 520	Continued From page 16 The facility was recited for F-441 for failing to post a visible isolation sign outside a resident's door for 4 of 5 days during a recertification survey. F-441 Infection Control was originally cited during the November 10, 2016 recertification survey for failing to wear gloves when entering a resident's room on contact isolation and failing to wash hands before leaving the room and prior to serving meals to another resident during 1 of 2 meal observations. On 11/2/17 at 2:21 PM the Administrator stated that the contact isolation sign was posted and fell off the door and was placed on the PPE (personal protection equipment) cart with a box of gloves on top of the sign. The Administrator stated that the door had been painted and the sign did not stay on the door. She stated that she kept taking the box of gloves off of the sign and thought that the family kept putting the gloves on the sign.	F 520	The QA Committee will review monthly all audit tools triggered by issued deficiencies. Actions will be taken as indicated to obtain substantial compliance. Duration of audits will continue as listed in F441 monitored by SDC or designee, and QA Committee.	