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	345215	A. BUILDING _____ B. WING _____	C 06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 No deficiencies were cited as a result of the complaint investigation survey. Event ID #1JBX11.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, interview with staff and the resident's medical record review, facility failed to place the call light within reach for 1 of 25 sampled Residents (Resident #44) Findings included: Resident # 44 was admitted on 3/30/3018 with diagnoses that included Parkinson disease, anxiety disorder and manic depression. Resident # 44 admission Minimum Data Set(MDS) dated 4/6/2018 indicated the resident's cognition was severely impaired ,needed supervision with one person assist with bed mobility and transfer. The resident also needed limited assist with dressing. Observation was made on 5/31/2018 at 9:00 AM. The call light was out of reach for Resident # 44. The call light was observed under the resident's bed. During the interview with the resident he stated he wanted the staff to bring him socks and he could not reach the call light.	F 558	F558 Reasonable Accommodations CFR 483.10 The process that led to this deficiency was the facility failed to place the call light within reach for 1 of 25 sampled residents (resident #44) On 5/31/18 call bell was immediately placed in reach of resident #44 by CNA #1. On 6-20-18 100% audit of all residents was completed by the 100 hall nurse, 200 hall nurse, 300 hall nurse, 400 hall nurse, and 500 hall nurse to ensure that call bell were placed in reach of all resident to promote accommodation of resident needs and maintain health and safety of the residents. All areas of concern were immediately corrected by the 100 hall nurse, 200 hall nurse, 300 hall nurse, 400 hall nurse, and 500 hall nurse using a Call	6/29/18

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

Electronically Signed | 06/24/2018

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F 558	Continued From page 1 Nurse Assistant (NA) #1 was interviewed on 5/31/2018 at 9:20 AM. The NA # 1 confirmed she was assigned to take care of Resident #44. NA # 1 stated she had been in serviced to place the call light within resident's reach at the beginning of the shift. She acknowledged the call light was not placed within the resident's reach and he had no explanation as to why the call light was not within the resident's reach. Nurse #1 was interviewed on 5/31/2018 at 9:50 AM. She stated nurses and NAs were trained to keep the call light within the resident's reach. The nurse added it was the responsibility of the NAs to make sure the call light was placed within the resident's reach at all time. On 5/31/2018 at 1:55 PM, the Director of Nursing stated her expectation was for the call light to be placed within the residents reach at all time.	F 558	Bell Audit Tool. On 5-31-18, a 100% in-service on Call Bells was initiated by the Director of Nursing with all licensed nurses, Assistant Director of Nursing (ADON), nursing assistants (NA) to include NA # 1, Geriatric Care Assistants (GCA), Therapy Director, Therapy staff, Staff Facilitator, Activity Director, Activity Assistants, Treatment nurses, Quality Assurance Nurse (QA), and Minimum Data Set Nurse (MDS) in regards to use of call bells to include: 1. Call lights are to be in the reach of all residents at all times! 2. Put call lights in reach when moving residents from the bed to the chair, etc. 3. Check to ensure call bell in in reach of resident before you leave a resident's room and every time you enter. 4. If the clip/ attachment piece is broken, complete a work order for maintenance to repair/replace. 5. Ensuring call lights are in reach is everyone's responsibility. No licensed nurses, Assistant Director of Nursing (ADON), nursing assistants (NA) to include NA # 1, Geriatric Care Assistants (GCA), Therapy Director, Therapy staff, Staff Facilitator, Activity Director, Activity Assistants, Treatment nurses, Quality Assurance Nurse (QA), and Minimum Data Set Nurses (MDS) will be allowed to work until in-service on Call Bells is completed. In-service will be completed by 6/29/18	

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F 558	Continued From page 2	F 558	All newly hired licensed nurses, Assistant Director of Nursing (ADON), nursing assistants (NA) Geriatric Care Assistants (GCA), Therapy Director, Therapy staff, Staff Facilitator, Activity Director, Activity Assistants, Treatment nurses, Quality Assurance Nurse (QA), and Minimum Data Set Nurses (MDS) will be in-serviced during orientation in regards to Call Bells to include: 1. Call lights are to be in the reach of all residents at all times! 2. Put call lights in reach when moving residents from the bed to the chair, etc. 3. Check to ensure call bell is in reach of resident before you leave a resident's room and every time you enter. 4. If the clip/ attachment piece is broken, complete a work order for maintenance to repair/replace. 5. Ensuring call lights are in reach is everyone's responsibility. 25% audit of call bell use will be completed by the QA nurse and/or ADON utilizing the Call Bell Audit Tool to ensure call bells are placed within reach of the resident to promote accommodation of resident needs and maintain health and safety of the residents, 3 times a week x 4 weeks, weekly x 4 weeks, then monthly x 1 month. All areas of concern will be immediately addressed by the QA nurse and/or ADON to include re-education of staff. The DON will review and initial the Call Bell Audit Tool weekly x 8 weeks, then monthly x 1 month to ensure all areas of concern are addressed appropriately to include re-education of	

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F 558	Continued From page 3	F 558	staff. The Administrator will forward the results of Call Bell Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Call Bell Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		6/29/18

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F 561	Continued From page 4 §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff, physician assistant, family, and resident interviews, the facility failed to honor the preferences of 1 out of 2 (Resident #214) residents who smoked. Findings included: A review of the facility smoking policy last revised 2/1/18 read, in part, "The facility recognizes the rights of its residents with respect to their lifestyle choices and preferences. This facility allows smoking only in designated outdoor areas. Assessment of residents' ability to smoke in a safe manner will occur prior to smoking in designated outside areas." The policy further read, in part and under the heading Determination of smoking residents' supervision needs: Procedure 2) a licensed nurse, upon admission, re-admission, or significant change, will assess each resident who desires to smoke, utilizing the Smoking Evaluation. and 4) The ICP (Interdisciplinary Care Plan) Team will ensure the residents' smoking status, level of supervision, protective smoking equipment needed, if applicable, and resident education, is addressed in the baseline and subsequent comprehensive care plans." Resident #214 was admitted to the facility 5/18/18.	F 561	F561 SELF DETERMINATION The process that led to this deficiency was the facility failed to honor the preferences of 1 out of 2 (Resident #214) residents who smoked. On 6-13-18, the facility bought Resident #214 cigarettes. On 6-13-18, the MDS Nurse conducted a smoking assessment with Resident #214 and Resident #214 was identified as an independent smoker. The MDS Nurse updated Resident #214 care plan to include Smoking Status: Independent Smoker. On 6-18-18 The Social Worker (SW) completed interviews with 55 Interviewable residents, to include resident #214 to identify any resident that smokes or desires to smoke utilizing the following interview tool: 1. Do you smoke? 2. If yes do you wish to stop smoking? 3. If you wish to stop smoking, do you wish to have an intervention to stop smoking? 4. Have you been educated on the facility smoking policy? 5. Do you understand	

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F 561	Continued From page 5 Review of the 5 day MDS (Minimum Data Set-a tool used to assess residents) dated 5/25/18 revealed Resident #214 was admitted 5/18/18. He was cognitively impaired and had no behaviors, rejection of care, or wandering present. Activities of daily living required extensive to total assistance for completion. There were no limb impairments. Active diagnoses included cognitive communication deficit, and nicotine dependence unspecified, with withdrawal. He had at least 1 fall before admission, and had 2 or more falls since admission. A physician order dated 5/22/18 read: "Nicotine Patch 21 mg (milligram). Apply 1 topically Q AM (every morning), remove QHS (every night at bedtime) x (times) 6 weeks. Then, 14 mg x 2 weeks, then 7 mg x 2 weeks, then stop." A progress note dated 5/19/18 and signed by Nurse #1 read, in part, "Resident states that he needs to go outside and that he needs help. Discussed with pt. (patient) that he cannot smoke here and that he cannot go outside at this time. Pt confused and thinks that he is at his house at times, then he has to be reminded. A progress note dated 5/20/18 at 3:56 PM by Nurse #1 read, "Incident happened at 1030 a.m. Pt slipped from the side of the bed. No injury to resident, lift provided to assist resident back to bed. Resident stated he was trying to go and smoke a cigarette VS (vital signs) BP 128/98 78 16 Temp 100.7 Tylenol given earlier for temp." A progress note dated 5/21/18 by Nurse #1 read, "8:00 BP 154/92 res 16 temp 96.9 SAT 91% (percent). Pt is confuse(d) but will only talk about a cigeratte (cigarette) and that he needs to get uo(p)." An interview was conducted on 5/31/18 at 3:00 PM. She stated admission assessments included	F 561	that smoking with Oxygen is dangerous and could cause and explosion? 6. Do you know where the designated smoking area is located? 7. Do you understand that smoking is not allowed outside of these areas? Seven residents, including Resident #214, were identified as smokers who do not wish for an intervention to stop smoking and zero that identifies as no longer a smoker. There were no other residents identified with the desire to smoke. On 6-20-18 100% audit of progress notes and incident reports x 30 days was completed by the QI Nurse to include resident #214 to identify any other residents who voiced a desire to smoke. There were no other residents identified with the desire to smoke. On 6-18-18 All 7 residents identified as smokers to include resident #214 were educated by the Social Worker in regards to the smoking policy and smoking safety to include: 1. Smoking is only allowed in designated smoke areas 2. Location of smoking area: 3. All smoking materials to include cigarettes and lighters belonging to residents will be housed and locked in the nurse's medication carts and will only be accessible with the aid of a staff member. 4. Smoking aprons, fire extinguishers, smoking blankets and fire proof smoking containers are provided as safety measures and are located in the designated smoking area. 5. Smoking around oxygen is not	

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a smoking assessment if the facility knew the resident smoked. She also stated Resident #214 attempted to get up unassisted numerous times and stated he wanted to go outside to smoke. She stated it was his family member (FM) who had not wanted him to smoke.

A progress note dated 5/22/18 by Nurse #2 read, "(Physician Assistant) PA in facility. Assessed resident, reviewed chart. RR (Responsible party) requests Nicotine patches for resident. New orders (included) Nicotine patch 21mg apply one patch TD (transdermal-on skin) QAM remove QHS x 6 weeks, then Nicotine patch 14mg TD one patch QAM, remove QHS x 2 weeks, then Nicotine patch TD one patch QAM x2 weeks, remove QHS then d/c (discontinue)."

A care plan created on 5/22/18 revealed a focus of "At risk for unmet needs and/or compromised dignity." The stated goals included "Resident will make decision about choice or preference through next review." Interventions included, but were not limited to "allow/encourage resident to make choices."

An interview was conducted on 5/31/18 at 5:40 PM with the Director of Nursing (DON.) She stated her administrative staff completed the admission assessments and included a smoking assessment.

An interview was conducted on 6/1/18 at 9:35 AM with MDS Nurse #1. She stated Resident #214 received medications for nicotine withdrawal while he was hospitalized, and arrived without symptoms of withdrawal any longer. She stated it was not communicated he smoked, desired to continue smoking, and the physician and wife decided he was not to smoke. She stated the resident was not cognitively aware enough at admission to make medical decisions so no

allowed

6. Residents deemed as a supervised smoker can smoke during the facility's designated smoking times as posted throughout the facility.
7. Residents deemed as a safe, unsupervised smoker will be permitted to smoke in the designated smoking area at the time of their choosing. Smoking materials for safe smokers will still be required to be locked in the nurse's medication cart.
8. Residents are not allowed at any time to provide other residents smoking materials to include lighters, matches and/or cigarettes.

On 6-19-18, 100% in service was initiated by the Director of Nursing with Assistant Director of Nursing (ADON), Quality Assurance (QA) nurse, Treatment nurse, Administrator, Account Receivable (AR), Staff Facilitator, Staff Facilitator, MDS nurse, Admissions Coordinator, Payroll, receptionists, maintenance director, maintenance assistant, therapy staff, housekeeping, laundry, licensed nurses to include Nurses #2, nursing assistants, dietary staff, Geri Care aides, Activity Director, and Activity assistant on What to do if a Resident Verbalizes a Desire to Smoke to include:

1. If a resident verbalizes a desire to smoke the staff must notify nursing immediately.
2. Nursing staff should ensure that any resident who desires to smoke has a completed smoke assessment, evaluation on safety with smoking.

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smoking assessment was done. She also stated the resident had no smoking materials, no means to get smoking materials, and made no indication he wanted to continue smoking. She stated he fell shortly after admission and stated he was trying to go smoke. She was not aware of why he subsequently fell. She stated, "His (family member) made his medical decisions when he was admitted and she had not wanted him to smoke. He had nicotine patches on. He had not said whether or not quitting smoking was his choice.

An interview was conducted on 6/1/18 at 9:45 AM with the facility PA. She stated she ordered a nicotine patch for Resident #214 when he was first admitted to help curb his nicotine cravings. She also said she had spoken to him again recently and he indicated he had no intention of quitting tobacco long term. She stated, "He said the patch seemed to help 'a little', but he wanted to continue smoking."

An interview was conducted with the DON and Administrator on 6/1/18 at 10:30 AM. The Administrator stated Resident #214 was not requesting cigarettes from staff and visitors in the first weeks of his admission. He stated the facility took resident rights very seriously, and while not advocating smoking they allowed residents to make lifestyle choices like to smoke or not. He stated if a resident expressed a desire to quit smoking the facility would support that decision too. The DON stated he arrived with a nicotine patch on and it was thought he was attempting to quit. He had no smoking materials, and no means to get smoking material so the nicotine patch was continued from the hospital. The DON also stated the resident's family member called yesterday

3. Nursing staff must ensure any resident with desire to smoke has been educated on facility smoking policy and safety while smoking. Nursing must document resident education in electronic record.
4. MDS must update care plan/care guide to reflect resident smoke preference.

No Assistant Director of Nursing (ADON), Quality Assurance (QA) nurse, Treatment nurse, Administrator, Account Receivable (AR), Staff Facilitator, Staff Facilitator, MDS nurse, Admissions Coordinator, Payroll, receptionists, maintenance director, maintenance assistant, therapy staff, housekeeping, laundry, licensed nurses to include Nurses #2 and nurse #3, nursing assistants, dietary staff, Geri Care aides, Activity Director, and Activity assistant will be allowed to work until the in-service is completed. In-service will be completed by 6/29/18.

All newly hired Assistant Director of Nursing (ADON), Quality Assurance (QA) nurse, Treatment nurse, Administrator, Account Receivable (AR), Staff Facilitator, Staff Facilitator, MDS nurse, Admissions Coordinator, Payroll, receptionists, maintenance director, maintenance assistant, therapy staff, housekeeping, laundry, licensed nurses, nursing assistants, dietary staff, Geri Care aides, Activity Director, and Activity assistant will be in-serviced during orientation by the Staff Facilitator in regards to What to do if a Resident Verbalizes a Desire to Smoke

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and stated the resident had called her all day and called all his friends and asked them to provide smoking materials to him. No smoking assessment had been completed to this point.

On 5/30/18 at 10:35 AM an interview with the family member was conducted. She stated, "He just wants to smoke, but I don't want him smoking. All he did at home was smoke. So they put a nicotine patch on him when I asked them to."

An interview with the resident was conducted on 5/31/18 at 5:15 PM. He stated, "Hell yes I want to smoke, but my (family member) hates tobacco and won't bring me cigarettes. Why do you think I keep falling out of bed? I'm looking for cigarettes. This patch doesn't work. I don't want to quit smoking."

An interview with Nurse #3 was conducted 5/31/18 at 5:30 PM. She stated the DON or assistant DON completed the admission assessment. She also stated, "(Resident #214) smokes. He said he's looking for cigarettes and he doesn't want to quit. He has oxygen on, but he always takes it off. The (family member) doesn't want him to smoke and she brought the nicotine patches in. I think he's on the highest dose of patch but tells me they don't work and have not curbed his desire to smoke. They thought he was sun downing, but I think he would calm down if they'd just give him a cigarette."

An interview was conducted with the DON and administrator on 5/31/18 at 5:40 PM. The DON stated there was no smoking assessment completed for Resident #214 because, "he came in with a nicotine patch on." The Administrator

to include:
1. If a resident verbalizes a desire to smoke the staff must notify nursing.
2. Nursing staff should ensure that any resident who desires to smoke has a completed smoke assessment, evaluation on safety with smoking.
3. Nursing staff must ensure any resident with desire to smoke has been educated on facility smoking policy and safety while smoking. Nursing must document resident education in electronic record.
4. MDS must update care plan/care guide to reflect resident smoke preference.
On 6/19/18 an in-service in regards to Smoking Assessments was initiated by the Administrator with the Social Worker, all licensed nurses to include nurse #2 and nurse #3, Director of Nursing (DON), ADON, MDS nurse, Treatment Nurse, Staff Facilitator, Admission Coordinator and QA nurse to include:
1. The Social Worker and/or Admission staff will review the smoking policy with all residents and/or resident representatives on admission or re-admission to the facility. Any resident who smokes or verbalizes a desire to smoke regardless of cognition will be referred to the nursing staff for a smoking assessment to be completed.
2. A licensed nurse upon admission, re-admission or with a significant change, will assess each resident who desires to smoke utilizing the Smoking Evaluation in the electronic record.
3. The MDS nurse will ensure the

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F 561	Continued From page 9 stated a smoking assessment should have been done if the staff were aware he was a smoker. He also stated the resident's wishes had to come before the family member, even if she is the responsible party. He also stated a way for Resident #214 had to be provided whether he is safe or unsafe. He stated, "We have the resources to let him smoke whether he needs someone with him or not."	F 561	residents smoking status, level of supervision, protective smoking equipment needed, if applicable and resident education is addressed in the baseline and subsequent comprehensive care plans. 4. Care plan/care guide will be updated by the MDS to reflect resident smoke preference on admission, re-admission or with a significant change. No Social Worker, licensed nurses to include nurse #2 and nurse #3, Director of Nursing (DON), ADON, MDS nurse, Treatment Nurse, Staff Facilitator, Admission Coordinator and QA nurse will be allowed to work until in-service on Smoking Assessments are completed. In-service will be completed by 6/29/18 All newly hired Social Worker, licensed nurses, Director of Nursing (DON), ADON, MDS nurse, Treatment Nurse, Staff Facilitator, Admission Coordinator and QA nurse will be in-serviced on Smoking Assessments during orientation by the Staff Facilitator. The ADON and/or QA will review progress notes and incident reports to include resident #214, 5 times a week x 4 weeks, weekly x 4 weeks then monthly x 1 month utilizing the Smoking Audit Tool to ensure any resident with desire to smoke has a smoking evaluation completed in the electronic record, education on smoking policy and smoking safety has been completed and the care plan/care guide have been updated to reflect resident preference to smoke. All areas of concern will be immediately addressed by the ADON/QA nurse to include resident or	

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(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 561	Continued From page 10	F 561	staff education. The DON will review the Smoking Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern have been addressed. The QA nurse will forward the results of Smoking Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Smoking Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility 1. failed to accurately code the Annual Minimum Data Set (MDS) assessment for rejection of care for 1 of 25 sampled residents reviewed for MDS accuracy. (Resident # 61), and 2. failed to accurately code th Quarterly MDS for dialysis for 1 of 1 dialysis residents (Resident #33). Findings included:	F 641	F641 483.20(G)-ACCURACY OF ASSESSMENTS ACCURACY/COORDINATION/CERTIFIED The process that led to this deficiency was the facility failed accurately code the Annual Minimum Data Set (MDS) assessment for rejection of care for 1 of	6/29/18

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	345215	A. BUILDING _____ B. WING _____	C 06/01/2018

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F 641	Continued From page 11 1. Resident # 61 was admitted to the facility on 11/23/2018 with multiple diagnoses that included anxiety, dementia and hallucination. The annual Minimum Data Set (MDS) assessment dated 4/17/2018 indicated that Resident # 61 cognition was moderately impaired. Further review of the MDS revealed Resident # 61 was not coded for the rejection of care. Review of Resident # 61 nurse's notes revealed the resident had history of resisting care. On 4/14/2018 the nurse's note documented "Resident refused to be changed into her nightgown and refused to have her disposable brief changed. Attempt was made several times without success by her Nurse Assistant and another Nurse Assistant." Further review of the Nurse's note revealed Resident # 61 resisted care on the following dates: 4/18/2018, 5/12/2018, and 5/31/2018. On 5/31/ 2018 at 11:10 PM, the MDS Nurse was interviewed. She verified that Resident # 61 had history of resisting care and the MDS assessment should have been coded with the resisting of care. MDS Nurse also stated that moving forward she will review all the MDS carefully for the accuracy in the coding. On 6/1/ 2018 at 12:35 PM, the Administrator was interviewed. He stated that he expected the MDS assessments to be accurate. The Administrator further stated moving forward the MDS nurse will be checking closely for the accuracy of the MDS. 2. Resident #33 was admitted 9/20/17. Review of a quarterly MDS (Minimum Data Set-a tool used for resident assessment) dated 3/19/18 revealed	F 641	25 sampled residents (resident #61 and failed to accurately code the Quarterly MDS for dialysis for 1 of 1 dialysis residents (resident #33) The MDS coordinator completed a significant correction to prior comprehensive assessment for Resident # 61 to reflect accurate coding of resisting care by the MDS nurses. The MDS coordinator completed a modification for Resident # 33 to reflect accurate coding of receiving special treatment dialysis. 100% audit of sections E and O for all current resident most current MDS assessment will be reviewed, to include resident # 61 and resident # 33 by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Quality Improvement Nurse (QI Nurse) to ensure all MDS's completed are coded accurately to include all residents that are resistive to care and receiving special treatment dialysis, 100% audits of sections E and O will be completed by 6/25/18 using a MDS Accuracy QI tool. Modifications will be completed by the MDS nurses during the audit for any identified area of concern with the oversite from the DON. 100% in-service of the MDS nurses, to include MDS #1 and #2, regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately to include all residents that are resistive to care and receiving special treatment	

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F 641	Continued From page 12 Resident #33 had no cognitive impairments. Active diagnoses included end stage renal disease. The section of the MDS used to indicate any special care needs, and included a selection of dialysis was marked "No". Reviewed care plans included a focus for "End Stage renal disease-at risk for complications due to hemodialysis. Resident has fistula to right arm (old) and new fistula to left arm. Stated goals included: Will not experience complications from dialysis treatment without appropriate intervention through next review. Interventions included, but were not limited to Dialysis (T-Tuesday, Th-Thursday, Sat-Saturday). Communicate with Dialysis Treatment Center as indicated for adjustments in resident's care and/or treatment plan. Assess resident upon return from dialysis treatment and notify physician of any significant changes. Do not draw blood or take blood pressure in arm with access site (Left Arm Fistula). Maintain dressing as ordered. Monitor access site for bleeding and/or signs of infection (Left AV-arterial-venous Fistula). An interview was conducted on 6/1/18 at 2:30 PM with the MDS nurse. She stated Resident #33 received dialysis every Tuesday, Thursday and Saturday, but the quarterly MDS dated 3/19/18 had not reflected dialysis. She stated, "That was definitely a typo (typographical error). He's marked as dialysis on all the other ones." On 6/1/ 2018 at 12:35 PM, the Administrator was interviewed. He stated that he expected the MDS assessments to be accurate. The Administrator further stated moving forward the MDS nurse will be checking closely for the accuracy of the MDS. Based on record review and staff interviews, the facility 1. Failed to accurately code the Annual Minimum Data Set (MDS) assessment for rejection of care for 1 of 25 sampled residents	F 641	dialysis, are coded correctly on the MDS. These in-services will be completed by 6-29-18 10% of completed MDS's, to include resident # 61 and resident # 33, will be reviewed to ensure accurate coding of the MDS to include resident that are resistive to care and receiving special treatment dialysis by the ADON, and QI Nurse 3 X's a week X's 4 weeks, then weekly X's 4 weeks and then monthly X's 1 utilizing a MDS Accuracy QI tool. All identified areas of concern will be addressed immediately by the DON by retraining the MDS nurse and completing necessary modification to the MDS. The DON will review and initial the MDS Accuracy QI tool weekly X's 8 weeks and then monthly X's 1 to ensure any areas of concerns have been addressed. The QA nurse will forward the results of MDS Accuracy Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the MDS Accuracy Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

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F 641	Continued From page 13	F 641		

reviewed for MDS accuracy. (Resident # 61), and
2. Failed to accurately code the Quarterly MDS for dialysis for 1 of 1 dialysis residents (Resident #33).

Findings included:
1. Resident # 61 was admitted to the facility on 11/23/2018 with multiple diagnoses that included anxiety, dementia and hallucination. The annual Minimum Data Set (MDS) assessment dated 4/17/2018 indicated that Resident # 61 cognition was moderately impaired. Further review of the MDS revealed Resident # 61 was not coded for the rejection of care.
Review of Resident # 61 nurse's notes revealed the resident had history of resisting care. On 4/14/2018 the nurse's note documented "Resident refused to be changed into her nightgown and refused to have her disposable brief changed. Attempt was made several times without success by her Nurse Assistant and another Nurse Assistant." Further review of the Nurse's note revealed Resident # 61 resisted care on the following dates: 4/18/2018, 5/12/2018, and 5/31/2018.
On 5/31/ 2018 at 11:10 PM, the MDS Nurse was interviewed. She verified that Resident # 61 had history of resisting care and the MDS assessment should have been coded with the resisting of care. MDS Nurse also stated that moving forward she will review all the MDS carefully for the accuracy in the coding.
On 6/1/ 2018 at 12:35 PM, the Administrator was interviewed. He stated that he expected the MDS assessments to be accurate. The Administrator further stated moving forward the MDS nurse will be checking closely for the accuracy of the MDS.

2. Resident #33 was admitted 9/20/17. Review of

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F 641	Continued From page 14 a quarterly MDS (Minimum Data Set-a tool used for resident assessment) dated 3/19/18 revealed Resident #33 had no cognitive impairments. Active diagnoses included end stage renal disease. The section of the MDS used to indicate any special care needs, and included a selection of dialysis was marked "No". Reviewed care plans included a focus for "End Stage renal disease-at risk for complications due to hemodialysis. Resident has fistula to right arm (old) and new fistula to left arm. Stated goals included: Will not experience complications from dialysis treatment without appropriate intervention through next review. Interventions included, but were not limited to Dialysis (T-Tuesday, Th-Thursday, Sat-Saturday). Communicate with Dialysis Treatment Center as indicated for adjustments in resident's care and/or treatment plan. Assess resident upon return from dialysis treatment and notify physician of any significant changes. Do not draw blood or take blood pressure in arm with access site (Left Arm Fistula). Maintain dressing as ordered. Monitor access site for bleeding and/or signs of infection (Left AV-arterial-venous Fistula). An interview was conducted on 6/1/18 at 2:30 PM with the MDS nurse. She stated Resident #33 received dialysis every Tuesday, Thursday and Saturday, but the quarterly MDS dated 3/19/18 had not reflected dialysis. She stated, "That was definitely a typo (typographical error). He's marked as dialysis on all the other ones." On 6/1/ 2018 at 12:35 PM, the Administrator was interviewed. He stated that he expected the MDS assessments to be accurate. The Administrator further stated moving forward the MDS nurse will be checking closely for the accuracy of the MDS.	F 641		
F 655	Baseline Care Plan	F 655		6/29/18

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F 655 SS=D	Continued From page 15 CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and	F 655		

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F 655	Continued From page 16 dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed to formulate a baseline care plan within 48 hours of a resident's admission to the facility for 1 of 1 residents (Resident #214). The findings included: Resident #214 was admitted 5/18/18. Review of the 5 day MDS (Minimum Data Set-a tool used for resident assessment) dated 5/25/18 revealed Resident #214 was cognitively impaired, displayed no behaviors, rejection of care, or wandering, and all activities of daily living required extensive to total assistance. Active diagnoses included malnutrition, anxiety, chronic obstructive pulmonary disease, cognitive communication deficit, and delirium. Resident #214 had 1 fall prior to admission, and 2 or more additional falls since admission. Review of the Nursing Admission & Re-entry Evaluation dated 5/18/18 (the day of admission) revealed Resident #214 had fall within 30 days prior to admission. A falls risk assessment was completed 5/18/18 (the day of admission) and Resident #214 scored 10 on the assessment. A score of 10 or more is a falls risk. A review of the falls investigations for Resident #214 and dated 5/20/18, 5/23/18, 5/27/18, and 5/31/18 revealed interventions were put in place after each fall, but no baseline care plan was initiated within the required 48 hour time frame of the resident's admission to the facility.	F 655	F655 Baseline Care Plan The process that led to this deficiency was the facility failed to formulate a baseline care plan within 48 hours of a resident's admission to the facility for 1 of 1 residents. (Resident #214). A 100% audit of all admissions and/or readmissions x 60 days to include resident #214 will be completed by 6/27/18 by the Assistant Director of Nursing and Quality Improvement Nurse (QI) utilizing the Baseline Care Plan Audit Tool to ensure all admissions or readmissions had a baseline care plan developed and implemented within 48 hours of admission to the facility that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care to include risks of falls. All areas of concerns were immediately addressed by the ADON and the Minimum Data Set Nurse (MDS). On 6/22/18 100% in-service was initiated by the Administrator with all licensed nurses, Director of Nursing (DON), Assistant Director of Nursing (ADON,)	

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F 655	Continued From page 17 A care plan initiated 5/23/18 focused on "Risk for falls characterized by history of falls/actual falls, injury, and multiple risk factors related to disease process, impaired balance, impaired cognition, impaired cognition, impaired mobility, other (generalized weakness), poor safety awareness/unaware of safety needs, unsteady gait, and psychotropic drug use. The stated goal was for Resident #214 to not sustain serious injury through next review. Interventions included, but were not limited to bed in lowest position, rehab (rehabilitation) referral, fall mat, assist as necessary, frequent reminders to call for assistance before getting up, and non-slip footwear. An interview was conducted on 6/1/18 at 1:15 PM with the Quality Improvement Nurse. She stated her responsibilities included initiating baseline care plans within 48 hours of admission, unless she was not in the facility, and then the baseline care plans were carried over to the comprehensive care plans if indicated. She stated she had not completed a baseline care plan related to falls for Resident #214. An interview with the Director of Nursing was conducted on 6/1/18 at 1:20 PM. She stated a baseline care plan was due within 48 hours of admission, and if a falls risk assessment indicated a resident was a falls risk a baseline care plan for falls should be completed. She stated Resident #214 was a falls risk when he was assessed on 5/18/18, but his falls care plan was not initiated until 5/23/18. She stated her expectation was for a baseline care plan to be completed within 48 hours of a resident's admission to the facility.	F 655	Quality Improvement Nurse (QI), Staff Facilitator, Treatment nurse, Nurse Supervisor, MDS Coordinator, and MDS nurse in regards to Baseline Care Plans to include: 1. The facility must develop and implement a baseline care plan for each new admission and/or readmission that includes the instructions needed to provide effective and person-centered care of the resident. 2. Baseline Care Plans must be developed within 48 hours of a resident's admission 3. Baseline Care Plans should include the minimum healthcare information necessary to properly care for a resident including but not limited to a. Initial goals based on admission orders b. Physician orders c. Dietary orders d. Therapy services e. Social services f. Risks for Falls-safety g. Risk for wandering 4. The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan is completed within 48 hours and meet guidelines for the comprehensive care plan 5. The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: a. The initial goals of the resident b. A summary of the resident's medications and dietary instructions	

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F 655	Continued From page 18	F 655	c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. No licensed nurses, DON, ADON, Quality Improvement Nurse (QI), Staff Facilitator, Treatment nurse, Nurse Supervisor, MDS Coordinator, and MDS nurse will work until in-service is complete. In-service will be completed by 6/29/18 All newly hired licensed nurses, DON, ADON, Quality Improvement Nurse (QI), Staff Facilitator, Treatment nurse, Nurse Supervisor, MDS Coordinator, and MDS nurse will be in-serviced in regards to Baseline Care Plans during orientation to include: 1. The facility must develop and implement a baseline care plan for each new admission and/or readmission that includes the instructions needed to provide effective and person-centered care of the resident. 2. Baseline Care Plans must be developed within 48 hours o f a resident's admission 3. Baseline Care Plans should include the minimum healthcare information necessary to properly care for a resident including but not limited to a. Initial goals based on admission orders b. Physician orders c. Dietary orders d. Therapy services e. Social services f. Risks for Falls-safety	

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F 655	Continued From page 19	F 655	g. Risk for wandering 4. The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan is completed within 48 hours and meet guidelines for the comprehensive care plan 5. The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: a. The initial goals of the resident b. A summary of the resident's medications and dietary instructions c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. 10% audit of all admissions and/or readmissions to include resident #214 will be completed by the ADON and QI nurse utilizing the Baseline Care Plan Audit Tool three times a week x 4 weeks, weekly x 4 weeks and then monthly x 1 month to ensure all admissions or readmissions had a baseline care plan developed and implemented within 48 hours of admission to the facility that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care to include risks of falls. All areas of concerns will be immediately addressed by the ADON, QI nurse and the Minimum Data Set Nurse (MDS) to include retraining of staff as indicated. The DON will review and initial the Baseline Care Plan Audit Tool weekly X's 8 weeks and then monthly X's 1 to ensure any areas of	

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F 655	Continued From page 20	F 655	concerns have been addressed. The QA nurse will forward the results of Baseline Care Plan Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Baseline Care Plan Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview, and record review of the Facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 6/8/2017 annual recertification survey. This was for one recited deficiency in the areas of accuracy of assessments (F 641). This deficiency was cited again on the annual recertification and complaint survey on 6/1/2018. This continued failure of the	F 867	F 867 The process that led to this deficiency was that the facility failed adequately monitor and implement changes to prevent the reoccurrence of deficient practice. Specifically, the facility failed to maintain implemented procedures designed to monitor interventions for accurate coding of MDS assessments.	6/29/18

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F 867	Continued From page 21 facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA programs. Findings included: This tag is cross referenced to: F- 641 Based on record review and staff interviews, the facility 1. Failed to accurately code the Annual Minimum Data Set (MDS) assessment for rejection of care for 1 of 25 sampled residents reviewed for MDS accuracy. (Resident # 61), and 2. Failed to accurately code the Quarterly MDS for dialysis for 1 of 1 dialysis residents (Resident #33). Findings included: 1. Resident # 61 was admitted to the facility on 11/23/2018 with multiple diagnoses that included anxiety, dementia and hallucination. The annual Minimum Data Set (MDS) assessment dated 4/17/2018 indicated that Resident # 61 cognition was moderately impaired. Further review of the MDS revealed Resident # 61 was not coded for the rejection of care. 2. Resident #33 was admitted 9/20/17. Review of a quarterly MDS (Minimum Data Set-a tool used for resident assessment) dated 3/19/18 revealed Resident #33 had no cognitive impairments. Active diagnoses included end stage renal disease. The section of the MDS used to indicate any special care needs, and included a selection of dialysis was marked "No". An interview was conducted with the facility Administrator on 6/01/18 at 4:23 PM. He stated the QAA committee consisted of himself, the QI nurse, Director of Nursing, medical director, Pharmacist, Dietary, and the treatment nurse. He	F 867	On 6/25/18 The Administrator, Director of Nursing (DON) and Quality Assurance (QA) Nurse were educated by the Facility Nurse Consultant on the QI process, to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include professional standards. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. A 100% audit of previous citations and action plans within the past year to include coding accuracy of Minimum Data Set Assessments to ensure that the QA committee has maintained and monitored interventions that were put into place will be completed by the Director of Nursing by 6/29/18. Action plans will be revised as needed and updated and presented to the QA Committee by the Administrator for any concerns identified. All data collected for identified areas of concerns to include coding accuracy of MDS Assessments will be taken to the Quality Assurance committee for review monthly x 6 months by the Quality Improvement Nurse. The Quality Assurance committee will review the data and determine if plan of corrections are being followed, if changes in plans of	

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F 867	Continued From page 22 also stated, "We meet monthly, but at least quarterly with the physician and Pharmacist. We look at trends and look for a root cause. If we have any issues we talk about it openly and put audit tools in place. If things are improving we continue, if not we start the process all over again. For MDS assessments we reserve the right to bring other people in to the committee so the MDS going forward will be part of the QI committee and part of the process to help correct the repeat deficiency.	F 867	action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QA Nurse. The Facility Nurse Consultant will ensure the facility is maintaining an effective QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include coding accuracy of Minimum Data Set Assessments and all current citations and QA plans are followed and maintained Quarterly x2. The minimum Data Set Nurse will be a part of the QA Executive Committee. The Facility Consultant will immediately retrain the Administrator, DON and QA nurse for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		6/29/18

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F 880	Continued From page 23	F 880		

designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(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:

§483.80(a)(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;

§483.80(a)(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 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

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F 880	Continued From page 24 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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 record review, staff interviews, and observations, the facility: 1. failed to perform hand hygiene before and after wearing gloves, in between handling dirty and clean linens, and after handling trash and soiled linens without wearing gloves and then entering a 3 out of 25 resident rooms (Rooms 406, 410 and 412) and 2. Failed to use established isolation precautions and cleaning methods for 1 of 1 contact isolation rooms. Findings included: The hand washing procedure in the facility's infection control manual reads, in part, "You should wash your hands: after handling contaminated items (soiled incontinent briefs,	F 880	F880 The process that led to this deficiency was facility failed to perform hand hygiene before and after wearing gloves, in between handling dirty and clean linens, and after handling trash and soiled linens without wearing gloves and then entering 3 out of 25 resident rooms (rooms 406, 410, and 412) and facility failed to use established isolation precautions and cleaning methods for 1 of 1 contact isolation rooms for resident #43. On 5-29-18, rooms 406, 410, and 412	

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F 880	Continued From page 25 linens, trash, etc.)." A continuous observation was made on 5/29/18 from 12:15 PM through 12:20 PM while a Nursing Assistant (NA#1) assisted a resident with activities of daily living care. While gloved, NA #1 removed the dirty linens from the room, placed them in the soiled utility room, exited the soiled utility room without gloves, and entered the clean utility/linen room. NA #1 removed clean linens, re-entered the resident room, donned a clean pair of gloves, placed the clean linens on the bed, took off her gloves, exited the room, entered the clean linen/utility room again, removed a clean blanket, re-entered the resident room, placed the clean blanket on the bed and left the room. No hand hygiene was performed until NA #1 was observed as she sanitized her hands from a sanitizing dispenser in the hallway. An interview was conducted with NA #1 on 5/31/18 at 3:00 PM. She stated, "You should perform hand hygiene every time you leave a room. You should wash or sanitize your hands before and after gloving, before and after touching a patient, after touching dirty linen or trash. You should use the hand sanitizer on the wall outside the dirty utility room every time you exit the dirty utility room and before you enter the clean utility room. We are in-serviced on hand washing about 1-2 times per month. I didn't perform hand hygiene when you were observing me. I think I didn't wash my hands because you were watching me and I got nervous." An observation was made on 5/30/18 at 10:05 AM as NA #2 completed morning care of Resident #98 in her room. After care was completed, NA #2 removed her gloves, gathered the dirty linens and soiled briefs, pushed them into a plastic bag, gathered the trash from the can, exited the room, placed the dirty linens in the	F 880	were cleaned by the 400 hall housekeeper. On 5-30-18, the housekeeping cart to include mop head, broom and dust pan was removed from service by the housekeeping supervisor until all items were cleaned and sanitized per facility protocol On 5-30-18 rooms 100, 102, 103, and 105 were deep cleaned by housekeeping staff. On 6-15-18, 100% in-service in regards to Hand Washing Procedure/Technique was initiated by the Director of Nursing with all licensed nurses, nursing assistants (NA) to include NA #1 and NA #2, Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Facilitator, Quality Improvement (QI) nurse, Treatment nurse, Minimum Data Set Nurse (MDS), Activity Director, Activity Assistant, Accounts Payable, Accounts Receivable, Housekeeping staff, Dietary Manager, Dietary staff, Social Worker, Admissions, Scheduler, and Nurse Supervisor to ensure all staff follow infection control guidelines for handwashing to include: 1. Technique for washing hands with return demonstration 2. When to wash hands a. When reporting to work and before going home b. Before and after contact with residents c. After coming in contact with any body fluids d. After handling contaminated items	

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F 880	Continued From page 26 dirty linen cart in the hall, placed the trash in the trash bin in the hall and immediately entered another resident room on the hall without hand hygiene being performed. A continuous observation was made on 5/31/18 from 9:48 AM through 9:50 AM. NA #2 was observed without gloves on as she placed soiled incontinent briefs in a clear, plastic bag and then removed the trash bag from the trash can and exited the room. NA #2 was observed as she dropped the trash bag in a canister in the hall, entered the soiled utility/linen room and dropped the bag of dirty linens. She then entered a resident room without performing hand hygiene. During an interview on 5/31/18 at 9:50 AM NA #2 stated she must have overlooked the hand sanitizers. She stated hand hygiene was supposed to be performed before and after all resident care, when dirty linens or trash was handled, and when hands were visibly soiled. She also stated, "I'm supposed to wear gloves to put dirty linens in bags, and when I handle trash. I should wash my hands or use sanitizer after handling dirty linen and before touching clean linen. I guess I overlooked my hand washing. I'm not sure why." An interview was conducted on 5/31/18 at 10:00 AM with the Director of Nursing (DON). She stated staff were in-serviced on hand hygiene at the time of hire and as needed. She also stated the staff were supposed to perform hand hygiene before and after their shift, before a resident room was entered, before and after resident care, and before and after wearing gloves. She also stated dirty linens and trash were not to be handled without gloves. She stated her expectation was for staff to wash their hands before and after patient care, before and after gloves were worn, and after dirty linens or trash were handled.	F 880	(soiled incontinent briefs, linens, trash, etc.) e. Before and after eating or drinking f. After using the bathroom g. After smoking h. After coughing, sneezing, or blowing your nose i. Whenever your hands are obviously soiled. j. In between handling soiled linen and clean linen k. After leaving one resident room and before entering the next resident room. 3. Use of alcohol hand sanitizer- an alcohol based hand sanitizer may be used unless the hands are visibly soiled. The hands should be free of dirt and organic material when using an alcohol hand sanitizer. The hands should be washed with soap and water after exposure to blood or body fluids 4. Procedure for use of alcohol hand sanitizer No licensed nurses, nursing assistants (NA) to include NA #1 and NA #2, Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Facilitator, Quality Improvement (QI) nurse, Treatment nurse, Minimum Data Set Nurse (MDS), Activity Director, Activity Assistant, Accounts Payable, Accounts Receivable, Housekeeping staff, Dietary Manager, Dietary staff, Social Worker, Admissions, Scheduler, and Nurse Supervisor will be allowed to work until in-service with return demonstration is completed. In-service will be completed by 6-29-18	

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F 880	Continued From page 27 2. Resident #43 was admitted to the facility on 9/30/16. His active diagnoses included scabies. Resident #43 was in an isolation room with contact precautions. Review of the policy and procedure for contaminated isolation room cleaning for scabies from the contract housekeeping services utilized by the facility dated 6/2016 revealed the entire floor must be mopped with a dust mop. Once completed the dust mop head should be double bagged and then washed in 140 degree hot water prior to reuse. A damp mop as well would be utilized to clean the floor and then double bagged and washed in 140 degree hot water prior to reuse. Isolation personal protective equipment would then be removed and double bagged prior to exiting the room. The policy concluded that personal protective equipment should be removed by grasping the front of the gown with gloved hands, pull the gown away from the torso, fold the gown inside out, and while removing the gown, peel off the gloves so as to only touch the inside of the gown and gloves while removing them. Review of Resident #43's most recent quarterly minimum data set assessment dated 4/6/18 revealed he was assessed as cognitively intact. He did not have any skin issues at that time. Review of a dermatology consult dated 5/22/18 revealed Resident #43 was documented to have signs and symptoms which favored scabies. During observation on 5/30/18 at 10:15 AM 112 the Housekeeper was observed cleaning Resident #43's room. She donned gloves, a gown, and a mask prior to entering the room. The	F 880	All newly hired licensed nurses, nursing assistants (NA) to include, Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Facilitator, Quality Improvement (QI) nurse, Treatment nurse, Minimum Data Set Nurse (MDS), Activity Director, Activity Assistant, Accounts Payable, Accounts Receivable, Housekeeping staff, Dietary Manager, Dietary staff, Social Worker, Admissions, Scheduler, and Nurse Supervisor will be in-serviced during orientation by the Staff Facilitator in regards to Hand Washing Procedure/Technique to include: 1. Technique for washing hands with return demonstration 2. When to wash hands a. When reporting to work and before going home b. Before and after contact with residents c. After coming in contact with any body fluids d. After handling contaminated items (soiled incontinent briefs, linens, trash, etc.) e. Before and after eating or drinking f. After using the bathroom g. After smoking h. After coughing, sneezing, or blowing your nose i. Whenever your hands are obviously soiled. j. In between handling soiled linen and clean linen k. After leaving one resident room and before entering the next resident room.	

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F 880	Continued From page 28 Housekeeper took a broom from her housekeeping cart in the room and swept the floor. She moved his fan and shoes with her gloved hands. She then moved his bed, using her torso to adjust the bed which caused her gown to come in contact with his bed. She then swept around and underneath his bed. She returned to her housekeeping cart and pulled it halfway into Resident #43's room. The side of the cart with the trash bin was on the outside of the room. She entered the bathroom and returned with a trash bag from the bathroom. She walked to her housekeeping cart and leaned over the cart to place the trash in the housekeeping cart trash bin. By doing this, her gown touched the handles on the front and sides of her cart. She then picked up her dust bin and swept the debris into the dust bin and then returned both the broom and dust bin to her cart. She then pulled her gown forward and reached into her pocket with her gloved hand to remove her housekeeping cart key. She then pulled the cart approximately 80% of the way into the room and unlocked and opened the side of her housekeeping cart which was the side of the cart inside the isolation room. She removed a cleaning solution and took a rag from a pile of rags on top of the housekeeping cart and then went to the bathroom. She returned and placed the solution in the cart and placed the rag back on top of the cart. She then removed her gloves at this time and adjusted the cart again, placing her hands where her gown had touched the side of the cart. She then donned new gloves and took her duster from the housekeeping cart and dusted Resident #43's bed frame, bedside table, and night stand. She then returned the duster to her housekeeping cart. The Housekeeper then mopped the floor with her damp mop. Once finished she replaced	F 880	3. Use of alcohol hand sanitizer- an alcohol based hand sanitizer may be used unless the hands are visibly soiled. The hands should be free of dirt and organic material when using an alcohol hand sanitizer. The hands should be washed with soap and water after exposure to blood or body fluids 4. Procedure for use of alcohol hand sanitizer On 5-30-18, 100% in-service was initiated by the housekeeping supervisor with all housekeeping staff in regards to Contaminated Isolation Room Cleaning (scabies) to include: 1. Identifying sign posted regarding an isolation room and checking with the nursing staff to be informed of any precautions that need to be taken prior to entering room 2. When entering the isolation room, every effort is made to keep the parasite in the room and isolated in the double bag procedure along with using EPA approved Solution 3. Steps for cleaning room a. Emptying trash using double bag system b. Cleaning Horizontal Surfaces c. Cleaning Walls d. Cleaning Cubical Curtains, drapes and linen e. Cleaning and disinfecting bathrooms f. Dust Mop to include removing dust mop head and double bag before removing from room. Mop head must be washed in 140 degree hot water. g. Damp Mop to include removing dust	

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F 880	Continued From page 29 the damp mop on the housekeeping cart and then pushed the cart back into the hallway and stepped into the hall with her personal protective equipment on. She removed her left glove, removed her mask, and then used both her gloved and ungloved hand to remove her gown. She then pushed her housekeeping cart down the hall. The head of the mop, broom, and duster had not been removed and bagged. At 11:11 AM the housekeeper pushed the cart down the 100 hall to room 100, donned gloves, and entered with the same broom and began sweeping the floor in the room. During an interview on 5/30/18 at 11:17 AM the Housekeeper stated she did not need to change any equipment between isolation precaution rooms and other resident rooms. She further stated she did not feel she had broken any infection control techniques while she cleaned the isolation precaution room. During an interview on 5/30/18 at 11:18 AM the Housekeeping Manager stated equipment such as brooms and dusters were not changed between rooms after cleaning an isolation precaution room to her knowledge. She stated she did not believe she had any policies about dedicated equipment for isolation rooms. The housekeeping manager further stated the Housekeeper should not have reached behind her gown and removed her keys with her gloved hand, should not have put her housekeeping cart in the room, and should have removed her personal protective equipment prior to leaving the room. She further stated she should not have touched items on her cart while still in the room with personal protective equipment that had been in contact with items in the room. She stated it	F 880	mop head and double bag before removing from room. h. Procedure for exiting room to include removing isolation clothes, double bagging linen, trash and mop heads, disinfecting all tools utilized to clean isolation room and proper handwashing. i. Housekeeping cart should not be taken into resident rooms No housekeeping staff will be allowed to return to work until in-service is completed. In-service will be completed by 6-29-18. All newly hired housekeeping staff will be in-serviced by the housekeeping supervisor and copy of training provided to the facility prior to working in regards to Contaminated Isolation Room Cleaning (scabies) to include: 1. Identifying sign posted regarding an isolation room and checking with the nursing staff to be informed of any precautions that need to be taken prior to entering room 2. When entering the isolation room, every effort is made to keep the parasite in the room and isolated in the double bag procedure along with using EPA approved Solution 3. Steps for cleaning room a. Emptying trash using double bag system b. Cleaning Horizontal Surfaces c. Cleaning Walls d. Cleaning Cubical Curtains, drapes and linen e. Cleaning and disinfecting bathrooms	

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F 880	Continued From page 30 was her expectation that infection control policies and procedures be followed for isolation rooms. During an interview on 5/30/18 at 12:16 PM the Infection Control Nurse stated she was not aware of any policy and procedure the facility had about dedicated housekeeping equipment for isolation rooms. She further stated this was because they contracted the house keeping services and did not know if they had any policies and procedures about dedicated equipment. She further stated it was her expectation that staff follow infection control policies and procedures regarding isolation rooms. She stated Resident #43 was considered to be contagious as his scabies was diagnosed by the dermatologist based on symptoms. She further stated that contact precautions should be followed for his room. She stated because the facility's policy was to use dedicated medical equipment she felt it was appropriate for the housekeeping supplies to be dedicated as well. She further stated the housekeeper should not have moved her cart into the resident's room, she should not have placed her gloved hands under her gown and removed her keys, and she should not have waited to remove her personal protective equipment until she was outside of the room. During an interview on 5/30/18 at 12:17 PM the Director of Nursing stated Resident #43 must be treated as if he had scabies and follow contact precaution. She further stated it was her expectation that any equipment used in isolation precaution rooms be dedicated to that room. The Director of Nursing stated the housekeeper should not have placed the cart partway in the room, should not have reached behind her gown to remove her keys, should not have touched her	F 880	f. Dust Mop to include removing dust mop head and double bag before removing from room. Mop head must be washed in 140 degree hot water. g. Damp Mop to include removing dust mop head and double bag before removing from room. h. Procedure for exiting room to include removing isolation clothes, double bagging linen, trash and mop heads, disinfecting all tools utilized to clean isolation room and proper handwashing. 4. Housekeeping cart should not be taken into resident rooms On 6-15-18, 100% in-service was initiated by the Director of Nursing in regards to Infection Control and use of standard precautions, droplet precautions and contract precautions with all licensed nurses, nursing assistants (NA), Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Facilitator, Quality Improvement (QI) nurse, Treatment nurse, Minimum Data Set Nurse (MDS), Activity Director, Activity Assistant, Accounts Payable, Accounts Receivable, Housekeeping staff, Dietary Manager, Dietary staff, Social Worker, Admissions, Scheduler, and Nurse Supervisor to include: 1. Handwashing 2. Use of PPE 3. Linen 4. Sharps No all licensed nurses, nursing assistants (NA), Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Facilitator, Quality	

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RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 880	Continued From page 31 cart while in the resident's room, and not removed her personal protective equipment in the hallway outside of her room.	F 880	Improvement (QI) nurse, Treatment nurse, Minimum Data Set Nurse (MDS), Activity Director, Activity Assistant, Accounts Payable, Accounts Receivable, Housekeeping staff, Dietary Manager, Dietary staff, Social Worker, Admissions, Scheduler, and Nurse Supervisor will be allowed to work to work until in-service is completed. In-service will be completed by 6-29-18 All newly hired all licensed nurses, nursing assistants (NA), Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Facilitator, Quality Improvement (QI) nurse, Treatment nurse, Minimum Data Set Nurse (MDS), Activity Director, Activity Assistant, Accounts Payable, Accounts Receivable, Housekeeping staff, Dietary Manager, Dietary staff, Social Worker, Admissions, Scheduler, and Nurse Supervisor will be in-serviced on Infection Control and use of standard precautions, droplet precautions and contact precautions to include: 1. Handwashing 2. Use of PPE 3. Linen 4. Sharps 10% audit of all housekeeping staff will be completed by the Housekeeping Supervisor utilizing the Housekeeping Audit Tool weekly x 8 weeks, then monthly x 1 month to ensure appropriate cleaning technique is completed to include cleaning of contaminated isolation rooms, proper bagging of soiled linen and trash, and cleaning of mop head/broom and dust	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/01/2018

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F 880	Continued From page 32	F 880	pans to include rooms 100, 112, 406, 410, 412 and 100 hall. All areas of concern will be immediately addressed by the Housekeeping Supervisor to include re-training of staff on infection control and re-cleaning of rooms. The Administrator will review the Housekeeping Audit Tool weekly x 8 weeks, then monthly x 1 month to ensure all areas of concern were addressed. 10% audit of all licensed nurses, nursing assistants (NA) to include NA #1 and NA #2, Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Facilitator, Quality Improvement (QI) nurse, Treatment nurse, Minimum Data Set Nurse (MDS), Activity Director, Activity Assistant, Accounts Payable, Accounts Receivable, Housekeeping staff, Dietary Manager, Dietary staff, Social Worker, Admissions, Scheduler, and Nurse Supervisor will be completed by the ADON and QI nurse utilizing the Handwashing Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all staff follow infection control guidelines for handwashing. All areas of concern will be immediately addressed by the ADON or QI Nurse to include re-training of staff. The DON will review and initial the Handwashing Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will forward the results of the Housekeeping Audit Tool and the	

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F 880	Continued From page 33	F 880	Hand washing Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI committee will meet monthly x 3months and review the Infection Control Monitoring Audit Tools to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	