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	345193	A. BUILDING _____ B. WING _____	06/29/2018

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MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

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F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		7/27/18

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

Electronically Signed | 07/23/2018

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide dignity by standing and looking down at a dependent resident while assisting with a meal for 1 of 3 dependent residents reviewed for dignity (Resident #86). Findings included: Resident #86 was admitted to the facility 03/22/11 with diagnoses including cerebrovascular accident, depression, dysphagia (difficulty with swallowing foods or liquids), and hemiparesis (muscle weakness or partial paralysis). Review of the quarterly Minimum Data Set (MDS) dated 06/08/18 assessed Resident #86's cognition to be severely impaired. The functional needs included total assistance with eating. Review of the care plan effective 01/28/18 identified the problem/risk for alteration in nutrition and hydration due to poor oral intake. The goal included consume 75% of all meals daily for 90 days. The interventions included staff were to feed as needed, encourage to get out of bed, and sit in a bedside chair for meals. During a continuous meal observation which began on 06/25/18 at 11:51 AM, Resident #86 was observed being fed by Nurse Aide (NA) #1. During the entire meal Resident #86 was positioned sitting upright in a bed low to the floor. NA #1 was standing at the bedside facing Resident #86 and looked down while offering bites of food and fluids. Resident #86 would look	F 550	This Plan of Correction is being submitted pursuant to the applicable Federal and State regulation. Nothing contained herein shall be construed as an admission that the facility violated any Federal or State regulation or failed to follow any applicable standard of care. Nursing Staff are using appropriate technique when feeding Resident # 86 and will continue to do so. Nursing staff are using appropriate techniques when feeding other dependent diners and will continue to do so. On 6-29-18 the Director of Nursing (DON) counseled Nursing Assistant (NA) 1 on the proper technique for feeding a resident. NA I demonstrated proper technique when feeding a dependent resident. Based on the past performance of NA 1 and the DON□s discussion with NA 1, NA 1□s action of not sitting down and being eye level when feeding a resident on 6/25/18 was an oversight due to anxiety about the survey and the desire to perform well. On 7-23-18 Certified Nursing Assistants (CNA) will be inserviced by the DON	

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F 550	Continued From page 2 up when NA #1 interacted. Resident # 86's eye level was approximately chest level to NA #1. There were chairs available in the room during the entire time NA #1 assisted Resident #86 with the meal. During an interview on 06/25/18 at 3:06 PM, NA #1 explained Resident #86 has needed feeding assistance with meals for approximately 1 year. She explained she would usually sit in the chair and knew that was the correct way to provide assistance with meals to residents and she should have sat down to feed Resident #86. During an interview on 06/29/18 at 10:56 AM, the Director of Nursing revealed it was her expectation for the staff to be seated when feeding and assisting a dependent resident with meals .	F 550	and/or the Assistant Director of Nursing (ADON) on the proper procedure for assisting a dependent resident with meals. The CNAs knowledge and understanding will be assessed by a post-test. Mandatory make-up inservices will be provided by 7-27-18. Any CNA on leave will be required to make-up the inservice prior to return to duty. Newly hired CNAs will be oriented on assisting a dependent resident with meals including the need to sit when assisting the dependent resident to dine. New hire and annual skill check list will be updated to include demonstration of the appropriate technique for feeding a dependent resident as part of the orientation process. A random audit during meal times (breakfast, lunch and supper) will be conducted by the DON, ADON, or the Nursing Supervisor to observe for the proper technique when feeding a dependent resident weekly for 4 weeks or longer until substantial compliance is achieved and maintained as determined by the QA Committee. Any discrepancies identified during the audit will receive immediate corrective action. The DON will monitor for compliance and report results to the QA Committee. The QA Committee will review audit findings and monitor for any trends or patterns. The QA Committee will direct and institute corrective action with supervision from the DON as necessary when trends and/or	

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F 550	Continued From page 3	F 550	patterns are identified. The QA Committee may also deem the new system effective when substantial compliance is maintained. The Administrator will be responsible for implementing this 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 failed to accurately code Minimum Data Sets for 2 of 5 residents reviewed for unnecessary medications (Residents #43 and #6), and 1 of 1 resident reviewed for use of a urinary catheter (Resident #33). The findings included: 1. Resident #43 was admitted to the facility 08/31/16 with diagnoses which included dementia. A review of Resident #43's medical record revealed a physician's order dated 04/18/18 for Seroquel (an antipsychotic medication) 25 milligrams (mg) daily at 6 PM related to a diagnosis of psychosis with aggressive behaviors. An additional physician's order dated 04/18/18 reduced the daily dose of Seroquel to 12.5 mg. A review was conducted of a quarterly Minimum Data Set (MDS) dated 05/07/18. In section	F 641	On 6-28-18 the quarterly MDS of 5-07-18 for resident #43 was modified by the MDS Coordinator to reflect antipsychotic medication use in section N0450 for resident #43. The modified MDS was successfully submitted by the MDS Coordinator to CMS on 6-28-18. On 6-29-18 the quarterly MDS of 3-16-18 for resident #6 was modified by the MDS Coordinator to reflect antipsychotic medication use in section N0450 for resident #6. The modified MDS was successfully submitted by the MDS Coordinator to CMS on 6-29-18. On 6-29-18 the annual MDS of 4-18-18 for resident #33 was modified by the MDS Coordinator to reflect neurogenic bladder diagnoses as the active diagnoses under section Genitourinary I1550. The modified MDS was successfully submitted by the MDS Coordinator to CMS on 6-29-18.	7/2/18

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F 641	Continued From page 4 N0410, the resident was coded as receiving antipsychotic medication 6 days during the 7 days of the assessment period. In the following section, N0450 Antipsychotic Medication Review, the resident was coded No - Antipsychotics were not received. An interview was conducted with the MDS Coordinator on 06/28/18 at 11:22 AM. The MDS Coordinator confirmed coding in section N0410 indicated antipsychotic medication use for 6 days and section N0450 indicated antipsychotic medications were not used for Resident #43. The MDS Coordinator explained section N0450 was not coded correctly and was an error. She immediately began the correction process. An interview with the Director of Nursing (DON) on 06/28/18 at 2:25 PM revealed the DON expected MDS assessments were coded correctly. 2. Resident #6 was admitted to the facility on 10/05/16 with multiple diagnoses including dementia, anxiety, depression and hemiplegia. A review of the physician order dated 03/14/18 indicated that the physician had ordered to start Resident #6 on Geodon 20 milligram (mg) one tablet daily at 6:00 PM. A review of the medication administration record (MAR) indicated that Resident #6 had been receiving Geodon 20 mg, 1 tablet by mouth one time daily at 6:00 PM for delusion from 03/16/18 through 03/29/18. A review of Resident #6's quarterly Minimum Data Set (MDS) assessment dated 03/26/18 indicated that the "Antipsychotic Medication Review" at	F 641	Oversight to fully assess each area by the MDS Assistant was determined by the MDS Coordinator to be the main cause of the coding errors on the MDS. An audit of MDS section N0450 and N0410 for correct MDS coding was completed by the MDS Coordinator on residents with antipsychotic medication orders in the past 6 months. For any deficient practice found the MDS was modified and submitted to CMS by the MDS Coordinator. An audit of MDS section I1550 for correct MDS coding was completed by the MDS Coordinator on residents with indwelling catheters. For any deficient practice found the MDS was modified and submitted to CMS by the MDS Coordinator. On 7-02-18 the part time MDS Assistant was educated regarding the MDS being coded incorrectly by the MDS Coordinator. A check-off list was made for the employee to check when areas are completed. The MDS Coordinator will spot check the assessments completed for correct coding prior to submission. The MDS Coordinator or the ADON will do random audits of the MDS for deficient practices weekly for 4 weeks or longer until substantial compliance is achieved and maintained as determined by the QA Committee. Any discrepancies identified during the audits will receive corrective action. For any deficient practice found,	

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F 641	Continued From page 5 N0450 under Section N had been coded as "Antipsychotic were not received". On the other hand, the "Medication Received" at N0410 under Section N coded Resident #6 had received antipsychotic for 7 days during the last 7 days look back period. On 06/29/18 at 09:48 AM an interview was conducted with MDS Coordinator who acknowledged that the coding for "Antipsychotic Medication Review" for N0450 under Section N was incorrect. It should be coded as "Yes - Antipsychotic were received on a routine basis only" instead of "No - Antipsychotic were not received" to be consistent with the coding for N0410 part A. The MDS Coordinator stated that Resident #6's quarterly MDS dated 03/26/18 was completed by a new MDS staff who had worked only 1 day per week since January, 2018. The MDS Coordinator stated she had been reviewing the new MDS staff's works before submission for about 1 month when she started. She stopped reviewing her works after she felt that the new MDS staff was capable of handling her MDS assignments alone. The new MDS staff was not available for an interview. She was on vacation during this survey. On 06/29/18 at 10:47 AM an interview was conducted with the Director of Nursing (DON) who stated that the new MDS nurse had received adequate MDS training before she started her job in the facility. The DON added it was a human error for the new MDS nurse to enter a inconsistent coding in Section N0450. She expected the MDS Coordinator to review the new MDS nurse's works before submission and to modify and resubmit the incorrect quarterly MDS	F 641	the MDS will be modified and sent to CMS by the MDS Coordinator. The DON and the Administrator will monitor the audits for compliance. Any deficient practice will be documented and reported to the QA Committee and corrective action will be taken. The Administrator will be responsible for implementing this plan of correction.	

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F 641	Continued From page 6	F 641		

dated 03/26/18 in order to accurately reflect the actual medications received by Resident #6's. It was her expectation for all the MDS to be coded accurately, consistently and submitted in a timely manner.

On 06/29/18 at 11:27 AM an interview was conducted with the Administrator who stated that the incorrect MDS coding in Section N for Resident #6's was a human error. It was his expectation for all the MDS to be coded accurately with consistency to avoid confusion of users.

3. Resident #33 was admitted to the facility 04/17/17 with diagnoses including neurogenic bladder and history of falling.

Review of the annual Minimum Data Set (MDS) dated 04/11/18 assessed Resident #33's cognition to be moderately impaired. The MDS included extensive assistance needs for toilet use, transfers, and bed mobility. The bowel and bladder needs revealed an indwelling catheter. The Care Area Assessment for urinary incontinence read as initiated due to extensive assistant needs for toileting and the presence of an indwelling catheter. The diagnoses for the indwelling catheter was a neurogenic bladder and urinary retention. Under the MDS section for active diagnoses the area Genitourinary I1550, neurogenic bladder was not coded.

During an interview on 06/29/18 at 10:43 AM, the Director of Nursing revealed it was her expectation for the MDS to be correctly coded to reflect Resident #33's active diagnoses included a neurogenic bladder.

During an interview on 06/29/18 at 11:02 AM, the

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F 641	Continued From page 7 MDS Coordinator explained it was an oversight the active diagnoses under the section Genitourinary I1550 missed coding the neurogenic bladder. A modification to the MDS has been done to correctly identify and code the diagnoses.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		7/2/18

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F 656	Continued From page 8 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to develop care plans for activities of daily living and for eye care/monitoring for 2 of 24 residents with care plan review (Residents #10 and #43). The findings included: 1. Resident #10 was admitted to the facility 03/15/18 with diagnoses which included stroke and vascular disease. An admission Minimum Data Set (MDS) dated 03/22/18 indicated the resident's cognition was severely impaired. The MDS coded the resident was totally dependent on staff assistance for all activities of daily living. The MDS further coded the resident had no skin related issues. Review of Resident #10's medical record revealed an ophthalmology consult dated 05/10/18. The Ophthalmologist diagnosed the resident with a bacterial conjunctivitis blepharitis (an inflammation of the eye lid most commonly caused by a bacterial infection) and ectropion (an eye condition where the lower eyelid rolls away from the eye leaving the cornea dry and prone to	F 656	On 6-28-18, a Care Plan for resident #10 was developed by the MDS Coordinator to include monitoring for signs and symptoms of infection and for observing for eye debris or discomfort. An appointment was made with an eye surgeon for eyelid repair. On 6-28-18, an ADL Care Plan for resident #43 was developed by the MDS Coordinator that included staff supervision for personal hygiene, dressing, ambulation in room and hallway, and staff assistance with bathing. The MDS Coordinator failed to do the Care Plan as outlined in the CAA Summary. The omission of monitoring eyes for signs and symptoms of infection from the Care Plan by a licensed nurse was an oversight due to human error. On 6-28-18, the ADON and the RN Supervisor audited all residents in the facility. A Care Plan was developed by the MDS Coordinator for any resident found	

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F 656	Continued From page 9 irritation and ulcers which could affect vision) of the right eye. Antibiotic eye drops were ordered for 10 days. In addition, an antibiotic ointment was ordered for 30 days or until a consult could be obtained from an eye surgeon as recommended for long term management. A physician's order dated 05/10/18 instructed the facility to follow the Ophthalmologist's recommendations. Continued medical record review revealed no care plan related to ectropion and possible complications that could occur. An observation conducted 06/26/18 at 3:12 PM revealed the resident was in bed apparently sleeping. The right eye was closed. Redness which appeared like a red line was noted across the entire lower lid. An interview was conducted with the facility's Physician Assistant (PA) on 06/28/18 at 7:31 AM. The PA described Resident #10's lower right lid was "rolled out." He explained eye lashes or debris could get stuck in that area and cause discomfort and infection. The PA stated a surgical repair of the lower lid would take care of the lid rolling outward and should be done by a plastic surgeon. The PA further explained without the surgery and until the surgery, this resident would require nurse monitoring to prevent complications. An interview was conducted 06/28/18 at 10:58 AM with the Admissions Nurse (AN), Assistant Director of Nursing (ADON), and MDS Coordinator. The AN stated a care plan was needed to direct the care of the resident. The care plan should include monitoring for signs and	F 656	with ectropion of the eye to include monitoring for signs and symptoms of infection and observing for eye debris or discomfort. Residents will be assessed quarterly by a licensed nurse for eye problems. If any eye problems are observed, the MDS Coordinator will be notified to add to the care plan. New residents will be assessed by a licensed nurse for ectropion eye on admission. If any eye problems are observed, the MDS Coordinator will be notified to add to the care plan. The MDS Coordinator audited the past 3 months Care Area Assessments (CAA) summaries to see that if decision was made to proceed to Care Plan, a care plan was developed Any deficient practices were corrected immediately. On completion of every full assessment, the MDS Coordinator will print off a Care Area Assessment (CAA) summary sheet. Beside every care plan decision to proceed to Care Plan, a corresponding care plan number will be written on CAA sheet to reflect that the area has been addressed in the resident□s Care Plan. DON or ADON will review random CAA summaries weekly for 4 weeks or longer until substantial compliance is maintained as determined by the QA Committee. Any discrepancies identified during review will receive corrective action. Any deficient	

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F 656	Continued From page 10 symptoms of infection and observing for eye debris/discomfort. During an interview on 06/28/18 at 2:25 PM, the Director of Nursing stated the facility should have a care plan. She added nurses needed to monitor the resident's eye for complications. 2. Resident #43 was admitted to the facility 08/31/16 with diagnoses which included dementia. An annual Minimum Data Set (MDS) dated 08/16/17 indicated the resident's cognition was severely impaired. The MDS coded the resident required staff supervision for personal hygiene, dressing, and ambulation in room and hallway and required staff assistance with bathing. A care area assessment (CAA) associated with the annual MDS and related to activities of daily living (ADL) specified Resident #43 required set-up and supervision with dressing, toileting, and personal hygiene and total assistance with showers. The resident fed herself after tray set-up and required assistance with showers. The CAA further specified proceeding to care plan with interventions to maintain the resident's highest level of functioning. A review of Resident #43's medical record revealed no care plan that was related to ADLs. During an interview on 06/28/18 at 12:11 PM the MDS Coordinator was unable to locate an ADL care plan and acknowledged the ADL care plan had been overlooked. The MDS Coordinator stated Resident #43 should have had a care plan as specified in the CAA.	F 656	practices will be documented and corrected immediately. The Administrator will be monitor for compliance. Any deficient practices will be documented and reported to the QA Committee and corrective action will be taken. The Administrator will be responsible for implementing this plan of correction.	

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F 657	Continued From page 11	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews the facility failed to update a care plan to reflect resident refusals of wearing arm and ankle splints as ordered for 1 of 24 residents' care plans reviewed (Resident #74). The findings revealed:	F 657	On 6-29-18, the MDS Coordinator developed a Care Plan for resident #74 that reflects that resident takes the splint off the left arm. Interventions were added to direct restorative aides and nurses what procedure to follow when the resident refuses to wear splints or when to	7/27/18

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F 657	Continued From page 12 Resident #74 was admitted to the facility 05/08/14 and readmitted 03/07/17 with diagnoses which included bilateral contracture of lower extremities, depression, and hemiplegia (paralysis of one side of the body) related to a previous stroke. A care plan initiated 04/28/15 described the restorative splint program for Resident #74. The resident was described with very limited movement in his left arm related to left hemiplegia and decreased movement of lower extremities and was at risk for contractures. Therapy recommended he wear an elbow splint to left arm (applied in the morning and removed at bedtime), bilateral knee braces (applied in the morning and worn for 2 hours) and bilateral ankle foot braces {AFO} (applied in the afternoon and worn for 2 hours). A note dated 08/26/17 and inserted in the care plan problem specified the resident refused to wear the knee braces so they had been discontinued. The resident could remove the elbow splint, but was unable to apply it and unable to apply or remove the AFO due to physical impairment. The care plan goal was for the resident to wear the splints/braces/AFO as ordered, would not form any new contractures, and experience no skin breakdown from splints for the next 90 days. Interventions included apply splint to resident's left hand in the morning and remove in the afternoon, should wear splint for at least 4 hours, report any skin breakdown, document the resident's tolerance and response to wearing splint/brace/AFO monthly, contact therapy as needed, and apply ankle foot brace to ankles in the afternoon to be worn for 2 hours. This care plan was reviewed 06/07/18 with no changes designated. The only documentation of refusals was related to the knee braces.	F 657	notify the physician of these issues. Lack of documentation and physician notification of Resident #74□s refusal to wear splints and taking the splint off by himself was due to the lack of a clear policy and procedure for staff on how to handle resident refusals to wear braces and/or splints and when to notify the physician. On 6-30-18, the Restorative Nurse was educated by the DON on the importance of a comprehensive care plan for residents and interventions to direct restorative aides and nurses what procedure to follow when the resident refuses splints or takes them off or when to notify the physician of these issues. An audit was done by the restorative nurse on residents that have braces/splints and care plans were updated to reflect the resident□s acceptance or refusal of braces or splints. Policy and procedure was updated and interventions were put in place for CNA□s, restorative aides and nurses to follow if resident refuses or removes splints or when to notify the physician of these issues. The restorative aides were educated by the Restorative Nurse on 7-03-18 on notifying the charge nurses of resident refusals at the time of occurrence so the nurse can evaluate and if the refusal was due to improper fit, pain, the time the splint/brace is set to be on interferes with	

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F 657	Continued From page 13 A quarterly Minimum Data Set (MDS) dated 05/30/18 indicated the resident's cognition was intact. The MDS coded Resident #74 with clear speech, could be understood and could understand others, had no behaviors, was totally dependent on staff assistance for all activities of daily living with exception to eating. He was independent with eating. The MDS further coded the resident with bilateral impairment of upper and lower extremities. An observation on 06/26/18 at 9:17 AM revealed Resident #74 was in his room and had no splint on his left elbow. During an interview on 06/27/18 at 8:56 AM the Restorative Nurse Aide (RNA) stated she provided range of motion for Resident #74 daily. She added she applied the left arm splint that fit from the resident's elbow to forearm. The RNA described that the splint pulled the resident's arm down at the elbow to help reduce a contracted elbow. She added the resident would remove the left arm splint whenever he wanted. The RNA stated she encouraged the resident to keep the splint on for at least 2 hours, but an hour was his usual time for wearing the splint. The RNA stated the resident refused the leg braces and had been for months. She stated she reported the resident's refusal to the Restorative Nurse (RN) who supervised the restorative program. An interview and observation was conducted with Resident #74 on 06/28/18 at 9:55 AM. The resident was lying in his bed in his room and was observed with no splint on his left arm or AFO on his ankles. The resident stated he did not like the arm splint. He demonstrated how much he	F 657	other interests or activities, etc. Random audits of braces and splints will be done weekly for 4 weeks by the DON or ADON to monitor that the Care Plan reflects the resident□s acceptance or refusal of braces and splints and that the interventions in place address procedures for restorative aides and nurses to follow if resident refuses or take splints off or when to notify the physician of these issues. On 7-23-18, nursing staff will be inserviced on the proper documentation of splint and brace refusal or acceptance and the procedure to notify the restorative nurse when resident refuses splints or braces. Make-up inservices will be provided by 7-27-18. Any nursing staff on leave will be required to make-up the inservice prior to return to duty. Newly hired nursing staff will be oriented on the procedures for refusal or acceptance of splints and braces by a licensed nurse. The DON will monitor for compliance and report the results to the QA Committee. The QA Committee will review audit findings and monitor for any trends or patterns. The QA Committee will direct and institute corrective action with supervision from the DON as necessary when trends and/or patterns are identified. The Administrator will be responsible for implementing this plan of correction.	

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F 657	Continued From page 14	F 657		

could bend his left elbow which formed a right angle with his upper arm when the elbow was extended. He explained at present, he had a rash on his elbow which itched. The splint was very uncomfortable on his elbow and he could not even stand to wear it an hour. He stated the leg braces were terribly painful and he would not wear them at all.

An interview was conducted via phone with the RN on 06/28/18 at 12:27 PM. The RN stated she supervised the facility's restorative program. She explained Resident #74 refusing his splints/AFO/braces was an ongoing problem. The RN stated she would go and talk with him and he would wear the splint for a while. She added he will do better for a while and then starts refusing them again. The RN stated she does the restorative care plans and reviews them quarterly when MDS assessments were due. The RN explained refusals were such an ongoing issue with Resident #74 she did not think to document that anywhere. The RN added she could see the importance of why she should document this issue and update the care plan.

An interview was conducted with the Director of Nursing (DON) and MDS Coordinator on 06/29/18 at 8:48 AM. The DON stated Resident #74 would not accept leg splints anymore. The care plan was reviewed at this time by the DON and MDS Coordinator. They were unable to find interventions that directed restorative aides/nurses what procedure to follow when the resident refused to wear splints or when to notify the physician of these issues.

An additional interview was conducted with Resident #74 on 06/29/18 at 9:26 AM. The

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F 657	Continued From page 15 resident stated he did have his arm splint on this morning, but took it off. He added he was trying to get up the nerve to try the leg splints again. The resident stated the left side of his body was affected by the stroke and he was unable to straighten out his left leg.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide incontinence care before a meal to 1 of 5 residents reviewed for activities of daily living (Resident #43). The findings included: Resident #43 was admitted to the facility 08/31/16 with diagnoses which included dementia. A quarterly Minimum Data Set (MDS) dated 05/07/18 indicated Resident #43's cognition was severely impaired. The MDS coded the resident required limited staff assistance with personal hygiene and toilet use and was occasionally incontinent of bladder. An observation on 06/25/18 at 11:57 AM revealed Resident #43 was lying in bed in her room. An odor of urine was noted upon entering the room. A dark circle was observed in the crotch of the resident's light gray pants.	F 677	On 6-25-18, resident #43 was provided incontinence care by a CNA and afterwards resident #43 finished her lunch. On 6-28-18, NA #1 was counseled by the DON on incontinence care before a meal when the incontinence care product in use indicates the resident is due for a change. Nursing staff are using appropriate techniques to provide incontinence care for Resident # 43 if needed based on the indicator line on the brief, clothing and/or linen condition, etc. before a meal and will continue to do so. Nursing staff are using appropriate techniques to provide incontinence care for incontinent residents, if needed, based on the indicator line on the brief, clothing and/or linen condition, etc. before a meal and will continue to do so.	7/27/18

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F 677	Continued From page 16 An additional observation was conducted on 06/25/18 at 12:17 PM. Resident #43 was eating lunch from an overbed tray that was positioned by the side of the bed. The resident was leaning to her left side. A large dark area was observed over the seat of the resident's gray pants and a strong odor of urine was noted. An interview was conducted with Nurse Aide (NA) #1 on 06/25/18 at 12:23 PM. NA #1 stated she did serve Resident #43's lunch tray in her room. The NA added she did not notice a urine odor nor did she observe the residents's pants with the dark areas. The NA stated she had been sent to Resident #43's hall to assist with meal trays. If she had noticed Resident #43's clothing was soiled, she would have provided incontinence care before the resident was served lunch. An interview was conducted with the Director of Nursing (DON) on 06/28/18 at 3:06 PM. The DON stated she expected residents were clean and dry when they ate their meals.	F 677	On 6-25-18, NA #1 was helping pass out food trays on hall that NA #1 was not assigned to on that day. Due to the anxiety of the state survey and the desire to perform well, an oversight was made by NA #1 and she did not determine that resident #43 needed incontinence care prior to lunch. On 6-28-18, the DON and the ADON conducted rounds of dependent residents to identify residents in need of incontinence care prior to meals. No other discrepancies were identified. On 07-23-18, the DON and ADON will inservice CNA□s on incontinence care before a meal when the incontinence care product in use indicates the resident is due for a change. The CNAs□ knowledge and understanding will be assessed by a post-test. Make-up inservices will be provided by 7-27-18. Any CNA on leave will be required to make up the inservice prior to return to duty. Newly hired CNA□s will be oriented on incontinence care before meals by the RN Supervisor. New hire and annual skill check list will be updated to include demonstration of the appropriate technique for incontinence care prior to meals. Random audits of residents will be conducted by the DON, the ADON, and the Nursing Supervisor for incontinence care before meals weekly for 4 weeks or	

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F 677	Continued From page 17	F 677	longer until substantial compliance is achieved and maintained as determined by the QA Committee. Any discrepancies identified during the audit will receive corrective action. The Administrator will monitor for compliance and oversee that the DON reports the weekly results to the QA committee. The QA committee will review audit findings and monitor for any trends or patterns. The QA committee will direct and institute corrective action with supervision from the Administrator as necessary when trends and/or patterns are identified. The Administrator will be responsible for implementing this plan of correction.	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure 9 of 60 resident room doors and 3 of 60 resident bathroom doors were free of holes, uneven edges, and staples to prevent resident injury (resident room doors 149, 146, 145, 141, 138, 113, 117, 123 and 124 and	F 689	During the tour, the hole in the bathroom door in room 166 was repaired and the staples in the door of room 141 were removed by maintenance staff. Room doors 149, 146, 145, 138, 113, 117, 123 and 124 have been sanded, filled, and	7/26/18

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F 689	Continued From page 18 resident bathroom doors in rooms 143, 138, and 166). The findings included: Observations of doors to resident rooms and bathrooms were conducted 06/29/18 starting at 9:42 AM and ending 10:14 AM. The following room doors 149, 146, 145, 138, 113, 117, 123, and 124 contained areas on the edge of the door below the door knob extending approximately 16 inches from the floor with rough edges and missing wood. These areas were rough to the touch and could produce splinters. The door to room 141 contained staples that protruded from the face of the door. The staple on the right midline of the door face extended out so that it felt sharp and could tear skin if a resident rubbed a hand against it. The bathroom door in room 143 contained 2 holes mid door on the hinge side of the door. One hole was lime size and shape the other walnut size and shape. The holes appeared to have been patched but not painted. The patch material was intermittently removed exposing wood in the doorframe. The bathroom door in room 138 contained a hole in middle of lower door about walnut size. The hole was observed with rough edges on the top and bottom edges of the hole and felt rough to the touch with possible splinters. The bathroom door in room 166 contained a hole approximately 2 x 2 inches. An interview and tour of the identified doors was conducted with the Maintenance Director (MD) and the Director of Facility Services (DFS) on 06/29/18 from 10:26 AM until 11:00 AM. The MD stated he made routine observations of resident rooms that included lights, call bells, water temperatures, and residents' wheel chairs. Room	F 689	painted, leaving smooth surface edges, by maintenance staff. The bathroom doors in room 138 and 143 will be repaired by 7-17-18 by maintenance staff. The process that led to the deficiency cited can be contributed to the daily wear and tear on the doors, caused by wheelchairs, Geri-chairs, carts, etc. bumping/hitting the door edges going in and out of rooms, which led to them to becoming rough to the touch which could lead to the potential for harm. All doors in the facility will be audited for damages and repairs will be made by sanding, filling and painting any damages. This process will be done by the Maintenance Dept. and will be completed by 7-26-18. The Director of Facility Services and the Maintenance Director audited all doors in the facility and compiled a list of repairs needed. Work began on 7-16-18 to make the repairs. An ongoing audit of the condition of the doors will be added to the weekly preventative maintenance program which is completed by maintenance staff. Staff will be inserviced on 7-23-18 in regards to reporting any observed damages to the doors immediately to the Maintenance Dept. and repairs will be made promptly. The Administrator will monitor for compliance and report the audit results to the QA Committee. The QA Committee will review audit findings and monitor for any trends or patterns.	

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F 689	Continued From page 19 and bathroom doors were not included with these observations. During the tour, the hole in the bathroom door in room 166 was repaired and the staples in the door of room 141 were removed. The DFS stated the rough edges and holes on the doors felt rough to the touch and could cause injury to the residents. An interview was conducted with the Administrator on 06/29/17 at 11:04 AM. The Administrator stated checking doors to resident rooms and bathrooms should be included on the facility's preventative maintenance program.	F 689	The Administrator will be responsible for overseeing and directing maintenance staff and for the overall implementation of the plan of correction and he will monitor for compliance. Any deficient practice will be documented and reported by the Administrator to the QA Committee and corrective action will be taken as deemed necessary by the QA Committee. Initial audit of doors, repair of doors and staff education will be completed by 7-26-18	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		7/27/18

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F 690	Continued From page 20 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide adequate catheter care by leaving the bag and tubing placed directly on the floor for 1 of 1 resident reviewed for bowel and bladder (Resident #33). Findings included: Resident #33 was admitted to the facility 04/17/17 with diagnoses of a neurogenic bladder and dementia. The annual Minimum Data Set (MDS) dated 04/11/18 assessed Resident #33's cognition to be moderately impaired. The functional needs included extensive assistance with transfers and toilet use. The bowel and bladder section coded the use of an indwelling catheter. The care area assessment discussed the need for extensive assistance with toileting and the presence of the catheter for the diagnoses of neurogenic bladder and urinary retention. Review of the care plan, effective 04/17/17	F 690	On 6-27-18 and 6-28-18, a Foley catheter bag was noted to be lying on floor and not in privacy bag. This was corrected immediately by a licensed nurse when brought to the Director of Nursing□s attention. Resident #33 Foley drainage bag was replaced with a leg bag per physician□s order by a licensed nurse. Based on the prior performance of CNA #3 and discussion by the DON with CNA #3, this was an oversight at this particular time. Resident #33 has a history of transferring himself without assistance. CNA #3 was educated on the importance of keeping the drainage bag off of the floor due to infection control. CNA #3 voiced that she understood the importance. Residents with Foley catheters in the building were immediately audited by the ADON and RN supervisor. There were no other deficient practices found.	

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F 690	Continued From page 21 identified complications related to the use of a suprapubic catheter placed for the diagnoses of urinary retention and a neurogenic bladder. The goal was to remain free of signs/symptoms of a urinary tract infection as evidence by no chills, fever, nausea, vomiting, pain, cloudy, concentrated urine for 90 days. The interventions included keep tubing free of kinks, keep drainage bag below bladder level at all times, catheter care every shift, secure catheter bag to leg to avoid tension, and provide extra fluids to reduce infection potential. During an observation on 06/27/18 at 9:25 AM, Resident #33 was resting in bed, the catheter bag and tubing were directly touching the floor. During an observation on 06/28/18 at 7:04 AM, Resident #33 was resting in bed. The catheter bag was directly touching on the floor. During an interview on 06/28/18 at 7:15 AM, Nurse Aide (NA) #3 explained at the beginning of her shift, her and the previous shift NA did a visual round of the residents assigned to her including Resident #33. She didn't notice the catheter bag on the floor at that time. She did acknowledge the catheter bag and tubing was directly touching the floor. She explained to prevent contamination and as part of infection control the catheter bag shouldn't be directly touching the floor. She also explained the night shift empty catheter bags on their last round before shift change. During an interview on 06/28/18 at 8:06 AM, NA#3 explained she had worked the 11 PM to 7 AM shift both days the catheter bag was observed on the floor. NA #3 didn't recall exactly	F 690	On 7-23-18, a mandatory in-service will be conducted by the DON to continue to educate and address any concerns regarding infection control and catheter drainage bags. The ADON and RN supervisor will randomly audit residents with indwelling catheters for correct Foley drainage bag placement weekly for 4 weeks or longer until substantial compliance is achieved and maintained by the QA committee and any deficient practice will be brought to the CNA□s attention and immediately corrected at the time of the audit. The weekly audits will be reviewed by the DON and she will schedule and provide additional staff education and monitoring as necessary based on the audit results. The Administrator will monitor for compliance and oversee that the DON reports the weekly results to the QA committee. The QA committee will review audit findings and monitor for any trends or patterns. The QA committee will direct and institute corrective action with supervision from the Administrator as necessary when trends and/or patterns are identified. The Administrator will be responsible for implementing this plan of correction.	

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	345193	A. BUILDING _____ B. WING _____	06/29/2018

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F 690	Continued From page 22 where she placed the catheter bag on 06/27/18. She thought she had placed the catheter bag in a privacy bag attached to the bed frame on 06/28/18. She explained the catheter bag should be off the floor, the floor is contaminated and could contaminate the catheter causing an infection. During an interview on 06/29/18 at 10:43 AM, the Director of Nursing revealed it was her expectation staff would keep Resident #33's catheter bag and tubing off the floor to prevent contamination as part of infection control.	F 690		
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 observations, record review, and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place for three deficiencies. These failures were related to non-compliance on two consecutive annual recertification surveys. A deficiency in the area of accuracy of Minimum Data Set assessments was cited during the facility's 05/04/17 annual recertification survey, and was recited again on the current 06/29/18 annual recertification. A deficiency in the area of activities of daily living for dependent resident was originally cited during the	F 867	Mountain View Manor Nursing Center currently holds and will continue to hold regularly scheduled QA committee meetings a minimum of quarterly. The QA Committee has established a Care Practices Subcommittee to do weekly facility rounds. The subcommittee will consist of 4 teams made up with QA committee members; at least one member of each team will be a nurse. The rounds will include random audits of ADLs, potential hazards, and MDS coding. Any deficient practice will be	7/25/18

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F 867	Continued From page 23 facility's 05/04/17 annual recertification survey and recited again on the current 06/29/18 annual recertification survey. A deficiency in the area of Free of Accident Hazards/Supervision/Devices was cited during the facility's 05/04/17 annual recertification survey, and was recited again on the current 06/29/18 annual recertification. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective QAPI program. Findings included: 1. This tag is cross referenced to: F641 483.20(g): Accuracy of Assessments: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Sets for 2 of 5 residents reviewed for unnecessary medications (Residents #43 and #6), and 1 of 1 resident reviewed for use of a urinary catheter (Resident #33). F641 483.20(g) was originally cited during the May 2017 recertification survey for failing to accurately code the Minimum Data Set to reflect dialysis treatment and for death to reflect prognosis. 2. This tag is cross referenced to: F677 483.24(a)(2): Activities of Daily Living for Dependent Resident: Based on observations, record review, and staff interviews the facility failed to provide incontinence care before a meal to 1 of 5 residents reviewed for activities of daily living (Resident #43). F677 483.24(a)(2) was originally cited during the	F 867	brought to the attention of the Administrator and corrected immediately by either nursing staff or maintenance. The process that led to the deficiency cited can be contributed to human error. Recently hired staff was trained to provide assistance with MDS assessments. However, due to the nature of critical thinking and the volume of information to be learned and processed as required to be accurate on any MDS assessment, human oversight occurred on this task. Staff was counselled and ongoing checks by MDS coordinator will be conducted to clarify accuracy of assessments. A new checklist has been developed and implemented for use by MDS Coordinators when completing assessments. Staff was trained on appropriate ADL care and watching for potential hazards. Audits of systems were not maintained by leadership resulting in oversight of inappropriate ADL care and/or misjudgment of environmental conditions found during survey tour. Initial audits of ADLs, hazards, MDS coding, and staff education will be completed by 7-25-18. A mandatory management inservice given by the Administrator was held on 7-20-18 on the importance of the weekly audits that are necessary to achieve and maintain compliance. All members were present.	

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F 867	Continued From page 24 May 2017 recertification survey for failing to check for incontinence for residents who were dependent upon staff for toileting and incontinence care. 3. This tag is cross referenced to: F689 483.25(d)(1)(2): Free of Accident Hazards/Supervision/Devices: Based on observations and staff interviews the facility failed to ensure 9 of 60 resident room doors and 3 of 60 resident bathroom doors were free of holes, uneven edges, and staples to prevent resident injury (resident room doors 149, 146, 145, 141, 138, 113, 117, 123 and 124 and resident bathroom doors in rooms 143, 138, and 166). F689 483.25(d)(1)(2) was originally cited during the May 2017 recertification survey for failing to provide a hazard free environment by leaving a bottle of fingernail polish remover in the bathroom of a secured unit. During an interview on 06/29/18 at 12:44 PM, the Administrator explained meetings were held monthly with the department heads of the facility. He confirmed parts of the system had broken down for there to be repeat citations. He explained a root cause of analysis would be done to determine what changes need to be implemented.	F 867	The Care Practices Subcommittee will turn in their weekly audits for 12 weeks or until substantial compliance is maintained to the Administrator and they will be reviewed in the weekly facility department head meeting. The results of the rounds will be brought to the QA committee at the quarterly meeting. The QA committee will discuss any deficient practices found in these results and whether corrective action is necessary, including the use of disciplinary procedures. The Administrator will review the activities and findings of the subcommittee rounds weekly and bring it to the attention of QA Committee. The QA Committee will be responsible for identifying issues addressed by utilizing this system to ensure corrective actions are taken to achieve and maintain compliance. The Administrator will be responsible for implementing this plan of correction. Initial audits of ADLs, hazards, MDS coding, and staff education will be completed by 7-25-18.	
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 designed to provide a safe, sanitary and	F 880		7/27/18

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F 880	Continued From page 25	F 880		

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 least restrictive possible for the resident under the

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F 880	Continued From page 26 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, and physician interviews the facility failed to implement contact precautions for a diagnoses of Methicillin-Resistant Staphylococcus Aureus (MRSA) (an infection caused by a type of bacteria that ' s resistant to many different antibiotics) transmitted infection for 1 of 1 resident reviewed for contact precautions (Resident #84). Findings included: Review of facility's contact precautions policy last revised 07/09/17 read in part the intent of the facility was to use contact precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident	F 880	On 4-9-18, Resident #84 was admitted to this facility. He had a right hip incision that was cultured prior to admission and grew out Methicillin-Resistant Staphylococcus Aureus (MRSA). The facility□s Infection Preventionist (IP) was made aware of these findings. Upon review of the admission paperwork and interview with Resident #84 on admission, Resident #84 was determined to not need Contact Precautions based on the following: A) Facility policy that The decision to place residents with infected wounds on precautions will be determined on a case by case basis depending on if wound	

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F 880	Continued From page 27 contact or by contact with items in the resident's environment. Any resident with suspected or confirmed infectious disease will be placed on contact precautions. The decision to place a resident with infected wounds on precautions will be determined on a case by case basis depending on if wound secretions can be contained or not. Review of Resident #84's hospital discharge summary notes dated 04/09/18 read in part a right hip incision wound culture tested positive for MRSA. 04/06/18 wound cultures continued to grow bacteria and antibiotics were continued for 4 weeks. Resident #84 was admitted to the facility 04/09/18 with diagnoses including a multiple drug resistant organism and pneumonia. Review of the resident's care plan, effective date 04/09/18 identified the problem of an antibiotic resistant infection (MRSA) of a right hip prosthesis. Interventions included contact precautions per the Medical Doctor's order. Review of the nursing notes dated 04/10/18 included the assessment of the surgical site with a right hip incision with 17 staples. The dressing was clean, dry, and intact. Review of the Medical Doctor's (MD) progress note dated 04/19/18 discussed Resident #84 was newly admitted to the facility and assessed for sepsis due to an unspecified organism with antibiotic treatment to continue. Review of the nursing note dated 04/24/18 read in part the right hip incision was open to air with no	F 880	secretions can be contained or not. - Resident #84 wound secretions were able to be contained. B) Resident #84 was relatively healthy (in that he was not dependent on staff for ADLs) and any drainage was contained. Additionally, the Centers for Disease Control (CDC) urges long term care facilities to modify Contact Precautions as able to allow residents to enter common areas and participate in group activities. https://www.cdc.gov/infectioncontrol/guidelines/mdro/index.html C) There was no ongoing transmission of MRSA in facility, this facility is not an acute care setting, and wound drainage was contained. https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/type-duration-precautions.html D) Resident #84 was cognizant, compliant, clean, and drainage was contained, which appear to be SPICE□s guidelines to determine need for contact precautions. http://spice.unc.edu/wpcontent/uploads/2018/06/Identifying-and-Responding-to-MDROs.pdf In summary, the Infection Control Preventionist used CDC and SPICE guidelines when developing and implementing the facility□s infection control policies and procedures. These	

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F 880	Continued From page 28 sign/symptom of infection observed, with intact staples. Review of the MD orders dated 04/24/18 was to continue antibiotics intravenously every 12 hours for 4 weeks. Leave the staples in until the follow up appointment with orthopedic on 05/01/18. There was no MD order for contact precautions. Review of an orthopedic note dated 05/01/18 showed the surgical incision was healed, with no active drainage, redness, or evidence of infection present. The staples were removed and surgical tape strips were applied. During an interview on 06/26/18 at 2:59 PM, the Admission RN explained she reviewed high risk residents and Resident #84 was admitted on 04/09/18 after an infection of his right hip prosthetic was removed. She was not aware of any contact precautions placed for the resident when admitted to the facility on 04/09/18. She explained an MD order for contact precautions would be obtained when there was a known infection such as MRSA with a draining wound. During an interview on 06/28/18 at 12:32 PM, the Infection Control Nurse explained she was informed about Resident #84 having MRSA prior to admission on 04/09/18 to the facility. She stated her decision not to initiate contact precautions were based on the wound drainage was contained, the resident was bed bound, was alert and oriented, and educated relate to the situation. She determined Resident #84 didn't require contact precautions. During an interview on 06/28/18 at 7:42 AM, the Physician Assistant (PA) explained he would	F 880	guidelines were used to determine the need for contact isolation and led to the practice deemed deficient during the state survey. From 7-17-18 onward, residents with active MRSA infection will be placed on Contact Precautions, unless otherwise ordered by the physician. This includes newly admitted residents and existing residents. Nurses will be inserviced on need for Contact Precautions for active MRSA infection by the IP on 7-23-18. The nurses knowledge and understanding will be assessed by a post-test. A mandatory make-up inservice will be provided on 07-27-18. Any nurse on leave will be required to make up the inservice prior to return to duty. The statement The decision to place residents with infected wounds on precautions will be determined on a case by case basis depending on if wound secretions can be contained or not will be eliminated from this facility s policy manual. The Contact Precautions policy will be rewritten to reflect that residents with active MRSA infection are to be placed on Contact Precautions, unless otherwise ordered by the physician. Newly hired nurses will be trained on the facility s revised contact isolation policy procedures at the time of hire and their knowledge and understanding will be assessed by a post-test. The DON will consult weekly for 4 weeks with the IP to determine if there are any	

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F 880	Continued From page 29 expect the nursing staff would have initiated contact precautions for Resident #84 and for those precautions to stay in effect until the staples were removed and the wound was healed and closed with no evidence of active drainage from the wound, or on the dressings when changed. He explained the facility just initiates precautions and couldn't recall writing an order for contact precautions. A second interview on 06/28/18 at 2:14 PM the PA explained he was made aware Resident #84 diagnosis of MRSA, but couldn't recall when. He explained the resident should've been placed on contact precautions with or without the need for dressing changes. During an interview on 06/29/18 at 10:50 AM, the Director of Nursing explained it was her expectation when a resident with MRSA and an existing wound the nurse, or infection control would initiate contact precautions until the wound was healed and closed.	F 880	active MRSA infections in facility and if there are, the DON will conduct an audit to ensure that Contact Precautions have been implemented. The Administrator will monitor for compliance and oversee that the DON reports the weekly results to the QA committee. The QA committee will review audit findings and monitor for any trends or patterns. The QA committee will direct and institute corrective action with supervision from the Administrator as necessary when trends and/or patterns are identified. The Administrator will be responsible for implementing this plan of correction.	