STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345222	A. BUILDING: ______ B. WING ______	**1/30/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	**307 OAKLAND AVENUE DREXEL, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 159	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:
Based on record review, resident and staff interviews, the facility failed to provide a cognitively intact resident with a personal funds statement for 1 of 3 sampled residents. (Resident #121).
Findings included:
A review of a most recent quarterly Minimum Data Set dated 12/09/14 revealed Resident #121 was coded as cognitively intact for daily decision making.
On 01/26/15 at 11:20 AM an interview was conducted with Resident #121 and she said the facility had not provided a personal funds statement.
A review of Resident #121's medical record revealed a family member was identified as the responsible representative. A review of the December, 2014 Resident Trust Fund statement revealed the statement had been mailed only to the responsible party.
On 01/29/15 at 4:37 PM an interview was conducted with the Business Office Representative. She revealed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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upon admission residents have been given an option to sign an agreement for a personal trust fund account. The Business Office Representative stated statements for resident accounts have been mailed monthly to the financial representative listed in the medical record. The Business Office Representative said Resident #121's monthly statement had been sent to her responsible party. The Business Office Representative had been unaware Resident #121 should have received a monthly statement. She revealed she had always sent the statement to the responsible party.

On 01/29/15 at 4:51 PM an interview was conducted with the Social Worker. She revealed that Resident #121's family member was listed as health care and financial representative. The Social Worker said the trust fund statements have been sent to the responsible party listed in the record. She revealed that if a resident was coded as cognitively intact, such as Resident #121, the resident should have received a statement.

On 01/29/15 at 5:28 PM an interview was conducted with the Administrator. She stated the expectation was a trust fund statement should be sent to the resident when the resident had been coded as cognitively intact.

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	345222	A. BUILDING ______ B. WING ______	01/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 000	INITIAL COMMENTS	F 000		

483.65 (F 441) at K
Immediate Jeopardy began on 10/25/14 when the facility failed to effectively implement a systemic infection control program by not following policies and procedures for cohorting for Resident # 85 diagnosed with MRSA and not implementing contact precautions to prevent the spread of infection.
Immediate Jeopardy began on 01/14/15 for Resident # 39 when the facility failed to effectively implement a systemic infection control program by not following policies and procedures to identify and implement contact precautions to prevent the spread of infection (MRSA).
Immediate Jeopardy began on 01/22/15 for Resident # 97 when the facility failed to effectively implement a systemic infection control program by not following policies and procedures to identify and implement contact precautions for MRSA.

Immediate Jeopardy was removed on 01/30/15 at 4:59 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility will remain out of compliance at a lower scope and severity E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems put in place are effective.

483.75 (o)(1) (F520) at K
Immediate jeopardy began on 10/25/14 when Resident #85 was diagnosed with MRSA and allowed to remain in the same room with Resident #129 and on 11/10/14 the Western

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/20/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Region Quality Assurance Nurse in-serviced the Director of Nursing and Assistant Director of Nursing on following the proper guidelines for co-horting residents with Methicillin-resistant Staphylococcus aureus (MRSA) and the Quality Assurance Committee failed to identify the need for implementing a plan of action to prevent reoccurrences in breaks in infection control with residents diagnosed with MRSA. After the in-service on 11/10/14 three other residents were identified as not having contact precautions implemented for MRSA upon receipt of positive culture (Resident #s 39, and 97). Immediate jeopardy was removed on 01/30/15 at 4:59 PM when the facility implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity Level E (a pattern deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place. An amended Statement of Deficiencies was provided to the facility on 03/26/15 because of the results of the facility's Informal Dispute Resolution (IDR). Example #4 was deleted from tag F-441 and information about Resident #117 was deleted from tag F-520 during the facility's IDR. Event ID #899S11.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		2/9/15

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F 323	Continued From page 2	F 323		

This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews and record review the facility failed to secure ½ side rails to residents' beds to prevent injuries for 3 of 6 beds (Resident #s 77, 45 and 57).

The findings included:

1. Resident #77 was admitted to the facility on 08/26/14 with diagnoses that included falls with fractures, altered mental status and others. The most recent Minimum Data Set (MDS) dated 11/10/14 specified she had severely impaired cognition and required extensive assistance with bed mobility.

On 01/28/15 at 10:30 AM Resident #77 was observed in bed with the left ½ side rail locked and in the up position.

On 01/28/15 at 11:20 AM the Maintenance Director was interviewed regarding side rails in the facility. He explained that most all the beds in the facility had ½ side rails attached to both sides. He added that some of the rails were old, made of metal but that the facility was working to replace them. He reported that he and his two assistants performed a "system check" twice a year in each resident room that involved a "floor to ceiling" review to identify concerns or needed repair. He added that side rails were checked during the twice annual room audit to verify that side rails were in good working order. The Maintenance Director defined good working order to be secured tightly to the bed, able to lock in

This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.

It is facility policy that the resident environment should remain as free from accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. One way this has been achieved is having a process in place to identify hazards and risks such as loose side rails.

Residents # 77, #45, and #57 did not have any negative outcomes as a result of the alleged deficiency.

Because all residents are potentially affected by the cited deficiency, the Maintenance Director conducted a 100 % audit on all bed rails on 1/29/15. Any identified concerns were immediately corrected. Results of the audit were documented and reviewed by the Administrator.

All Maintenance staff was re-trained by

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Continued From page 3

place and had no evidence of being bent or broken. He said that because of daily use and the age of the side rails, they easily became loose from the bed. He explained that when a side rail became loose he expected staff to notify him via a work order or verbal communication and that he would tighten them immediately. He stated that he did not have a schedule for checking side rails. The Maintenance Director was unaware of the when the last side rail audit was performed.

During the interview with the Maintenance Director random beds were audited for side rail safety. On 01/28/15 at 11:40 AM Resident #77's left side rail was checked. The Maintenance Director confirmed that the rail was loose, able to be pulled away from the bed greater than 4 inches. The Maintenance Director tightened the rail and after tightening the rail, it was still loose. He explained that because the rail was old it would not be able to fit securely to the bed. The Maintenance Director reported that the rail was one of the older rails in the facility and he would look into replacing the rail.

On 01/28/15 at 4:00 PM Nurse Aide (NA) #3 was interviewed and reported that Resident #77 used her side rails to turn in bed.

On 01/29/15 at 4:35 PM the Administrator was interviewed and reported that the Maintenance Director was responsible for completing audits and checks of the facility. She stated that checking side rail placement was an item that she expected to be checked monthly.

2. Resident #45 was admitted to the facility on 08/12/14 with diagnoses that included blindness, hypertension and others. The most recent

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the Administrator on 2/9/15 on facility policy for accidents. Training included reviewing the process in place to identify potential hazards and risks such as environmental conditions, and resident equipment including loose side rails.

Nursing staff and Housekeeping staff received training on facility policy for accidents. Training included reporting potential hazards and risks such as environmental conditions and resident equipment such as loose side rails to the Maintenance Department on a Maintenance requisition form.

The RN Supervisors received training from the Administrator to inform the Maintenance Director/designee of any emergency repairs needed to resident care equipment such as side rails.

Effective 2/2/15, a quality assurance program was implemented under the supervision of the Administrator to monitor for potential hazards such as loose side rails to ensure continued compliance. The Maintenance Director/designee conducts the following systemic changes: a weekly audit on bedrails to monitor for loose side rails/other potential hazards. Any deficiencies will be corrected immediately and the findings of the quality assurance check will be reported to the quality assurance committee quarterly for further review and/or corrective action. The Maintenance Director is responsible for monitoring compliance.

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Minimum Data Set (MDS) dated 11/11/14 specified the resident had no impaired cognition, required assistance with bed mobility and had a history of falls.

On 01/28/14 at 10:40 AM Resident #45 was observed in bed with the right ½ side rail in the up position.

On 01/28/15 at 11:20 AM the Maintenance Director was interviewed regarding side rails in the facility. He explained that most all the beds in the facility had ½ side rails attached to both sides. He added that some of the rails were old, made of metal but that the facility was working to replace them. He reported that he and his two assistants performed a "system check" twice a year in each resident room that involved a "floor to ceiling" review to identify concerns or needed repair. He added that side rails were checked during the twice annual room audit to verify that side rails were in good working order. The Maintenance Director defined good working order to be secured tightly to the bed, able to lock in place and had no evidence of being bent or broken. He said that because of daily use and the age of the side rails, they easily became loose from the bed. He explained that when a side rail became loose he expected staff to notify him via a work order or verbal communication and that he would tighten them immediately. He stated that he did not have a schedule for checking side rails. The Maintenance Director was unaware of the when the last side rail audit was performed.

On 01/28/15 at 11:32 AM the Maintenance Director checked the placement of Resident #45's right side rail. He verified that the rail was

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loose, able to be pulled away from the bed greater than 4 inches. The Maintenance Director tightened the rail.

On 01/29/15 at 3:35 PM NA #5 was interviewed and reported that Resident #45 used side rails to turn in bed.

On 01/29/15 at 4:35 PM the Administrator was interviewed and reported that the Maintenance Director was responsible for completing audits and checks of the facility. She stated that checking side rail placement was an item that she expected to be checked monthly.

3. Resident #57 was admitted to the facility on 06/01/10 with diagnoses that included hemiparesis, history of a cerebrovascular accident (CVA) and aphasia and others. The most recent Minimum Data Set (MDS) dated 11/20/14 specified the resident had moderately impaired cognitive skills, required assistance with bed mobility and had not fallen in the facility.

On 01/28/15 at 11:20 AM the Maintenance Director was interviewed regarding side rails in the facility. He explained that most all the beds in the facility had ½ side rails attached to both sides. He added that some of the rails were old, made of metal but that the facility was working to replace them. He reported that he and his two assistants performed a "system check" twice a year in each resident room that involved a "floor to ceiling" review to identify concerns or needed repair. He added that side rails were checked during the twice annual room audit to verify that side rails were in good working order. The Maintenance Director defined good working order to be secured tightly to the bed, able to lock in

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F 323	Continued From page 6 place and had no evidence of being bent or broken. He said that because of daily use and the age of the side rails, they easily became loose from the bed. He explained that when a side rail became loose he expected staff to notify him via a work order or verbal communication and that he would tighten them immediately. He stated that he did not have a schedule for checking side rails. The Maintenance Director was unaware of the when the last side rail audit was performed. On 01/28/15 at 12:17 PM the Director of Nursing (DON) was interviewed in Resident #57's room about side rails. She explained that ½ side rails were used to aid residents with positioning in bed. She added that the rails were to be secured tightly to the bed with minimal movement and she expected nurse aides to check side rails daily to ensure they were as tight as possible. She stated that concerns with side rails were to be reported to the Maintenance Director either verbally or written on a work order. During the interview with the DON she observed Resident #57's left side rail and confirmed that the rail was not secured tightly to the bed. The DON reported that she would have Maintenance tighten the rail. On 01/29/15 at 3:20 PM NA #4 was interviewed and reported that Resident #57 used the side rails to turn in bed. She stated she had not observed the rails to be loose but if she did, she would tighten them herself. On 01/29/15 at 4:35 PM the Administrator was interviewed and reported that the Maintenance Director was responsible for completing audits	F 323		

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F 323	Continued From page 7 and checks of the facility. She stated that checking side rail placement was an item that she expected to be checked monthly.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure a compressed oxygen cylinder during transport during 1 of 1 observations. The findings included: On 01/25/15 at 3:10 PM the Staff Development Coordinator (SDC) was observed carrying a compressed oxygen cylinder by the neck with one hand and swinging it back and forth as she walked down the 400 hall. An interview was conducted on 01/25/15 at 3:30 PM with Nurse #2. She reported compressed oxygen cylinders were to be secured in the rolling cart for transportation. She stated the rolling cart was kept in the medication room but she had not seen it in a couple of days. She further stated it was not in the medication room at the time of the	F 328	It is facility policy to ensure that residents receive proper treatment and care for special services including respiratory care and to handle and transport oxygen tanks in a safe manner. The Staff Development Coordinator who was observed carrying an oxygen tank received training on this policy on 1/28/15. No residents were named in the statement of deficiencies. Because all residents are potentially affected by the cited deficiency, all staff received training on facility policy for handling oxygen tanks including all staff	2/10/15

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F 328	Continued From page 8 interview. An interview was conducted on 01/28/15 at 3:31 PM with the SDC. She stated she carried the compressed oxygen cylinder down the 400 hall because she was in a hurry trying to help the first shift staff go home and she didn't take the time to find the rolling cart and secure the compressed oxygen cylinder. The SDC stated the compressed oxygen cylinder should always be secured in the rolling cart for transportation. An interview was conducted on 01/29/15 at 8:34 AM with Director of Nursing (DON). She stated she had just had an in-service with direct care staff the week before regarding transportation of compressed oxygen cylinders. The DON stated the compressed oxygen cylinder should always be secured in the rolling cart for transportation.	F 328	named in the statement of deficiencies. Training included transporting oxygen using an oxygen transport cart, and correct procedure for lifting oxygen tanks from the transport cart. A sign was placed in the oxygen storage rooms to alert staff that a transport cart must be used to transport oxygen tanks. To enhance currently compliant operations and under the direction of the Director of Nursing, all new employees receive training on handling and transporting oxygen tanks in a safe manner. Effective 2/10/15 a quality assurance program was implemented under the supervision of the Director of Nursing to ensure continued compliance. The RN Supervisor on duty performs the following systemic changes: conducts an oxygen handling audit daily every shift for 30 days then as needed ongoing. Any concerns will be corrected immediately and the findings of the quality assurance audit will be documented and reported to the quality assurance committee quarterly for further review and/or corrective action. The DON is responsible for monitoring compliance.	
F 441 SS=K	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		2/25/15

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F 441	Continued From page 9 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, physician, resident, and staff interviews, and record reviews, the facility failed to effectively implement a systemic infection control program by not following policies	F 441	It is the policy of this facility to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease	

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F 441	Continued From page 10 and procedures for cohorting for 1 of 1 resident diagnosed with Methicillin Resistant Staphylococcus Aureus (MRSA) (Resident #85), not having an effective system in place to identify and implement contact precautions for 3 of 3 residents diagnosed with MRSA (Residents #85, #39 and #97), failing to wash hands between catheter care and wound care for 1 of 1 resident (Resident #39), and failing to clean or disinfect supplies for 1 of 1 resident observed receiving wound care (Resident #39). Immediate Jeopardy began on 10/25/14 when the facility failed to effectively implement a systemic infection control program by not following policies and procedures for cohorting for Resident # 85 diagnosed with MRSA and not implementing contact precautions to prevent the spread of infection. Immediate Jeopardy began on 01/14/15 for Resident # 39 when the facility failed to effectively implement a systemic infection control program by not following policies and procedures to identify and implement contact precautions to prevent the spread of infection (MRSA). Immediate Jeopardy began on 01/22/15 for Resident # 97 when the facility failed to effectively implement a systemic infection control program by not following policies and procedures to identify and implement contact precaustion for MRSA. Immediate Jeopardy was removed on 01/30/15 at 4:59 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility will remain out of compliance at a lower scope and severity E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring	F 441	and infection. Residents #39 and #85 were placed on contact isolation on 1/30/15. The residents in contact isolation were informed by the ADON they were in contact isolation related to an infection and staff and visitors will wear appropriate personal protective equipment upon entering room. Responsible parties/family members were notified of the resident□s isolation on 1/30/15 by the ADON. Because all residents have potential to be affected by the cited deficiency, a 100 % audit was conducted on 1/30/15 by the ADON and the Administrator of all cultures and sensitivities since January 1, 2015. No other residents were affected by the cited deficiency. The DON and ADON received re-education from the Administrator on 1/30/15 on recommendations and procedures for isolation precautions. The following departments were in-serviced on infection control practices for contact isolation by the Director of Nursing on 1/30/15: therapy department, Housekeeping, Dietary, Maintenance, Activities, direct care staff includes nurse aides, licensed nurses and Administrative nurses. Licensed nurses received education regarding initiating contact precautions when indicated and procedure for informing the Infection Control Nurse of infections. All nursing staff was required to receive in-service	

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systems put in place are effective.

The findings included:

A review of a facility infection control policy dated 11/01/13 revealed it was the policy of this facility to provide a safe and sanitary environment and to help prevent the development and transmission of disease and infection. The policy specified the facility develops, implements, and maintains an Infection Control Program in order to prevent, recognize, and control, to the extent possible the onset and spread of infection within this facility. Facility components of the Infection Control Program include an Infection Control Nurse who is a Registered Nurse to serve as the coordinator of this facility's Infection Control Program. Responsibilities of the Infection Control Nurse outlined in the policy included review of cultures and other diagnostic test results consistent with potential infections and to detect clusters and trends. The policy identified Methicillin Resistant Staphylococcus Aureus (MRSA) as a multiple drug resistant organism and specified the facility would initiate transmission-based precautions for residents who were actively infected with these organisms. The policy revealed that depending on the situation, residents on contact precautions may include the following: a private room, cohorting, or sharing a room with a roommate with limited risk factors (e.g., without indwelling devices, without pressure ulcers and not immunocompromised). The policy further included the infection control program will prevent and control outbreaks and cross-contamination using transmission-base precautions in addition to standard precautions and implement hand hygiene (hand washing) practices consistent with accepted standards of practice to reduce the

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education for the system in place for contact isolation and residents with active signs of infection prior to being allowed to work.

The ADON/Infection Control Nurse was re-educated by the Administrator on 2/9/15 in the following areas: requirements of this regulation, the facility infection control policy and procedure, review of the NC Statewide Program for Infection Control & Epidemiology manual.

To enhance currently compliant operations and under the direction of the Director of Nursing, all staff will receive in-service training on infection control including standard precautions and procedures to prevent spread of infection such as proper hand hygiene. Licensed nurses will receive in-service training on infection control policy and procedures for preventing spread of infection during wound care.
Staff will attend a directed in-service training on Infection Control and Quality Assurance and Assessment provided by Mountain Area Health Education Center on 2/25/15.

Effective 1/30/15, a quality assurance program was implemented under the supervision of the Administrator to monitor infections requiring isolation precautions including MRSA. Systematic changes implemented to ensure compliance include the following: 1)The admitting nurse initiates proper isolation precautions based on current treatment, labs, and

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spread of infections and prevent cross-contamination. The policy specified facility surveillance would ensure reusable equipment was appropriately cleaned or disinfected. The policy identified person-to-person contact as a mode of transmission of infections. The policy specified to prevent the transmission of infection within the facility, pertinent signage would be posted on the resident's door and verbal reporting would be conducted between staff.

1. Resident #129 was admitted to the facility on 10/10/14 for short term rehabilitation following a total knee replacement. The most recent MDS dated 10/17/14 specified the resident was cognitively intact. Resident #129 discharged home on 10/30/14.

Resident #85 was admitted to the facility on 10/15/14 into a semi-private room with a roommate (Resident #129). Resident #85's diagnoses included a venous stasis leg ulcer, Diabetes Mellitus, congestive heart failure and others. The Minimum Data Set (MDS) dated 10/22/14 specified the resident was cognitively intact and had one venous/arterial ulcer.

Review of Resident #85's medical record revealed a nurse's entry dated 10/21/14 that the resident's right lower extremity was red, swollen, warm and painful to touch and the physician was notified. On 10/22/14 the physician ordered a wound culture from the right lower leg and started Resident #85 on antibiotics for an infection in the right lower leg.

Review of Resident #85's medical record revealed a document titled "Laboratory Result Summary" dated 10/25/14 at 3:01 PM that

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active symptoms after reviewing admission paperwork, 2)the admitting nurse is responsible for implementing the required isolation precautions when required by placing a sign on the door, and an isolation cart with appropriate personal protective equipment outside the resident�s room, 3) residents with new onset infection with active symptoms will be placed on isolation precautions pending culture results, 4)the nurse on duty who implements isolation precautions communicates to the Infection Control Nurse by completing an Infection Tracking form, 5)The ADON/DON reviews the Physician Orders Within A Specified Duration report five days weekly and the RN Supervisor is responsible for reviewing this report on the weekends to review all cultures ordered. All pending cultures are listed on the pending culture list and the ADON/DON follows up for the finalized culture report in 48-72 hours to ensure proper precautions are initiated when required per policy.

An Isolation Precautions Audit is completed by the ADON/DON which audits all residents who require isolation precautions to ensure compliance with infections requiring isolation precautions. The audit is completed five days per week for one month then three times weekly ongoing.
The DON/designee audits facility staff five days a week x 4 weeks for adherence/compliance for appropriate personal protective equipment and procedures for isolation precautions. Then

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F 441	Continued From page 13 specified Resident #85 had heavy growth of Methicillin-resistant Staphylococcus aureus (MRSA). Further review of Resident #85's medical record revealed a nurse's entry made by Nurse #1 dated 10/25/14 that specified Resident #85's wound continued to have bloody drainage and that the physician ordered to continue the antibiotic for the wound infection and start intravenous (IV) Vancomycin (antibiotic) for MRSA in the leg wound. Further review of the physician's orders and nurses' entries did not specify Resident #85 was placed on isolation precautions related to the diagnosis of MRSA on 10/25/14. A nurse's entry dated 10/28/14 specified Resident #85 was on contact precautions for MRSA. A nurse's entry dated 10/29/14 specified Resident #85's ace wrap to the right lower leg was changed due to "excessive weeping" of plaster from the Unna boot (a protective covering worn on the foot). Review of Resident #85's "admission/transfer/discharge" report and review of Resident #129's "admission/transfer/discharge" report, the residents remained in the same room until 10/29/14 when Resident #85 was moved to a private room. On 11/11/14 the physician ordered a wound culture to the right lower leg. The wound culture report dated 11/14/14 specified that the wound did not have growth of MRSA. Resident #85 was discharged home on 12/19/14.	F 441	audits facility staff 2 x weekly x 2 weeks, then audits facility staff weekly at random x 3 months. Any deficiencies will be corrected immediately, and the findings of the quality assurance audits will be documented and submitted to the quality assurance committee quarterly for further review and/or corrective action. The Director of Nursing is responsible for monitoring compliance. Findings of quality assurance checks/audits are submitted at the quarterly Quality assurance committee meeting for further review and recommendations as indicated.	

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F 441	Continued From page 14 On 01/30/15 at 4:55 PM Nurse #1 was interviewed and reported that he remembered Resident #85 but could not recall details of her admission to the facility. He stated that he did not recall receiving the laboratory report confirming that Resident #85 had MRSA in her leg wound on 10/25/14 or that the resident was on contact precautions. He stated that he was trained that when he received laboratory results of a resident with MRSA he would contact the physician for orders and implement contact precautions if ordered to do so. On 01/29/15 at 9:35 AM the Assistant Director of Nursing/Infection Control Nurse (ADON) was interviewed and reported that if a wound infected with MRSA had heavy drainage the resident was placed in a private room if possible or placed in a room with another resident with similar diagnoses. The ADON stated that a resident with MRSA would not be allowed to share a room with a resident that had a fresh surgical wound. The ADON was questioned about Resident #85's diagnosis of MRSA and she reported that she was not notified on 10/25/14 of Resident #85's laboratory culture because of lack of communication. She stated that Resident #85 was in a semi-private room with Resident #129 that had a fresh surgical wound. The ADON stated that the residents remained in the same room from 10/25/14 through 10/29/14. She stated that she was not involved in the room change but added that the residents should not have been allowed to stay in the same room because of Resident #85's weeping wounds and Resident #129's fresh surgical wound. The ADON stated that the room change should have occurred on 10/25/14 when the facility became aware of Resident #85's MRSA.	F 441		

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On 01/30/15 at 10:00 AM the Administrator was interviewed and reported that it was not ideal for the residents to share a room but it was the only option at the time until a private room became available. The Administrator added that contact precautions were implemented and she felt staff followed the required precautions.

On 01/30/15 at 10:10 AM the Western Region Quality Assurance Nurse (QA Nurse) was interviewed and reported that she expected facilities to reference the North Carolina Statewide Program for Infection Control and Epidemiology (SPICE) guidelines for handling residents with MRSA and deciding when to implement contact precautions. She stated that in the case of Resident #85 and Resident #129 the residents should have been separated on 10/25/14 when Resident #85 was diagnosed with MRSA because Resident #129 had a fresh surgical wound. She stated that she educated the DON and ADON regarding this practice.

On 01/30/15 at 10:20 AM the DON was interviewed and reported that Resident #85 was placed on contact precautions on 10/25/14 but allowed to share a room with Resident #129. The DON stated that the residents were allowed to remain in the same room because a private room was not available for Resident #85 to move to.

On 01/30/15 at 11:20 AM Resident #129 was interviewed on the telephone and reported that she was admitted to the facility into a semi-private room. She explained that the facility informed her that she was going to get a roommate that she identified as Resident #85. Resident #129 added that one day her roommate was started on IV

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antibiotics. Family members of Resident #85 informed Resident #129 that Resident #85's IV antibiotics were to treat an infection called MRSA. Resident #129 stated that she was scheduled for an appointment with her physician on 10/29/14 and she notified him that she was sharing a room with a resident with MRSA. She stated that the physician contacted the facility requesting a room change for the resident because of her recent knee surgery. Resident #129 stated that a room change occurred the same day as her appointment and that she discharged home a few days later. Resident #129 reported that she was not diagnosed with MRSA.

2. Resident #39 was admitted to the facility 12/09/14 with diagnoses which included anemia, diabetes mellitus, and a lower back (sacral) pressure ulcer.

A discharge summary from the hospital dated 12/09/14 specified cultures obtained from the sacral wound grew Escherichia (E.) coli which required antibiotic therapy.

A care plan effective 12/09/14 identified Resident #39 with an infectious process as evidenced by a need for antibiotics and a pressure ulcer on the sacrum. The care plan goal specified the infection would be resolved with no complications within the next 30 days. Interventions included observe for signs and symptoms of infection and treatment of pressure ulcer on sacrum as ordered by the physician.

An admission Minimum Data Set (MDS) dated 12/16/14 indicated the resident's cognition was intact. The MDS specified the resident required

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F 441	Continued From page 17 extensive staff assistance with transfers, bed mobility, dressing, and toilet use. The MDS further specified the resident was admitted with an indwelling urinary catheter, experienced occasional bowel incontinence, and had 1 unstageable pressure ulcer. A Care Area Assessment (CAA) described Resident #39 as alert and oriented, had an unstageable pressure ulcer, and experienced occasional episodes of bowel incontinence. A review of Resident #39's medical record revealed a report written by the Wound Care Physician on 01/09/15. The report specified some areas of exposed bone were noted in the sacral wound. Further review revealed a biopsy of this bone was obtained and sent to the laboratory (lab) for culture and sensitivity. Additional medical record review revealed a lab result summary was faxed to the facility 01/14/15 at 3:01 PM. The report specified this was the final report from the culture and sensitivity. The report included documentation of moderate growth of MRSA was obtained and contact precautions were required for residents in healthcare facilities. This report was initialed by Resident #39's attending physician in the facility indicating the physician had been informed of these findings. There was no physician's order to implement contact precautions in the resident's medical record. An observation was conducted of the Staff Development Coordinator (SDC) providing urinary catheter care and a dressing change for the sacral wound for Resident #39 on 01/28/15 at 9:33 AM. Upon entering Resident #39's room, no contact precaution sign was observed on the door	F 441		

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F 441	Continued From page 18 and no personal protective equipment was provided. Resident #39 was observed wearing a disposable brief which was removed. The SDC washed her hands, donned gloves, and properly performed catheter care first. She changed her gloves without washing her hands and proceeded with the dressing change to the sacral wound. The old dressing was in place and was observed not completely covering the sacral wound. The outside of the dressing contained smears of drainage which appeared clear with some streaks of red. An area approximately the size of a deck of cards of the same color drainage was observed on the resident's disposable brief. The SDC removed the old dressing. The wound was observed to be approximately the size of a small grapefruit. After removing the dressing, the SDC changed gloves and proceeded to clean the wound with cleanser that was in a non disposable spray bottle. As she positioned the bottle to spray all areas of the wound, the bottle made contact with a pad under the resident. The SDC placed the bottle directly on the resident's over bed table when she had completed the cleansing process. The SDC was observed following the physician's orders for the dressing change. When the process was complete, the SDC was observed removing her gloves, washing her hands, and gathering up supplies including the spray bottle from the resident's over bed table. The SDC proceeded to the treatment cart located in the hallway outside the resident's room. She was observed pulling open a plastic zip bag she had removed from a treatment cart drawer. She was observed holding the spray bottle of cleanser over the bag with the intent of placing it into the bag. When asked if she was going to clean the bottle first, she stopped and wiped the reusable spray cleanser bottle with a disposable disinfectant	F 441		

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wipe.

An interview was conducted with the SDC immediately following this dressing change. The SDC stated she knew the resident had an infection in the sacral wound but did not know what organism caused the infection. She stated if a sign indicating contact precautions had been posted on the resident's door, she would have worn a disposable gown.

An additional interview was conducted with the SDC on 01/28/15 at 10:53 AM. The SDC stated she assessed all facility wounds every other week. She added she made rounds with the Wound Care Physician that visited Resident #39 every Friday. The nurses on the halls were responsible for providing wound care on a daily basis.

An interview was conducted via phone with the attending physician on 01/28/15 at 3:21 PM. He stated if his initials were on the lab results report, he had seen it. The physician explained the facility usually initiated contact precautions as needed.

An interview was conducted on 01/28/15 at 3:53 PM with the Assistant Director of Nursing (ADON) who also functioned as the Infection Control Nurse. The ADON stated Resident #39 was admitted to the facility on an antibiotic. She stated she was aware that Resident #39 had an infection but she was not sure what kind of infection. The ADON checked her infection tracking book and stated there was no documentation explaining why the resident was on the antibiotic. She added she was not aware of the actual culture that was obtained on

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F 441	Continued From page 20 01/09/15 and she was not aware the culture identified MRSA in the sacral wound. The ADON stated each morning she reviewed lab report books at the nursing station and talked with the floor nurses to gather information regarding initiation of antibiotics on previous day. She stated she got a report at the end of the month generated by the pharmacy of all residents in the facility on antibiotics. The ADON stated she had been told the facility did not use contact precautions on known MRSA infections unless the wound had copious amounts of drainage. She explained if the drainage could be contained, contact precautions would not be needed. The ADON explained she had been in this position for 2 months. The previous ADON came to the facility once a week to help her learn her duties which included infection control. An interview was conducted with the Director of Nursing (DON) on 01/28/15 at 4:26 PM. The DON stated contact precautions were not used in this facility for MRSA if the drainage could be contained. The DON added if the attending physician had wanted contact precautions when he reviewed the lab results dated 01/14/15, he would have ordered those precautions. The DON stated the wound cleanser container should not have been placed back in the treatment cart without being disinfected first. An additional interview was conducted with the ADON on 01/29/15 at 3:17 PM. The ADON stated she expected hands were washed and gloves were changed when going from urinary catheter care to attending to a dressing change for a wound. An interview was conducted with the	F 441		

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Housekeeping Supervisor (HS) on 01/29/15 at 4:31 PM. The HS stated a resident's room with a sign for contact precautions alerted the housekeepers that an active infectious process was going on in that room. She stated the housekeeper would clean the room first thing in the morning and again around mid day. The HS added after cleaning the room, the mop water and mop head would be changed before going on to the next resident's room.

An interview was conducted with the Regional Director of Operations (RDO) on 01/29/15 at 4:47 PM. The RDO stated the nurse that received the laboratory report identifying MRSA should have contacted the attending physician to request contact isolation and ask if any new treatments should be started. The RDO added contact precautions should have been initiated at that time. The RDO stated the lab results should have been reported to the ADON, the Infection Control Nurse, at this time.

An additional interview was conducted with the SDC on 01/30/15 at 2:03 PM. The SDC stated it was her normal practice to wash her hands between urinary catheter care and wound care. She stated she just forgot the day she was being observed. The SDC added she normally cleaned reusable supplies with a disinfectant before returning them to the plastic bag in the treatment cart. She explained each resident had their own labeled plastic bag with their supplies in it. She added the plastic bag did not go into the resident's room, only the supplies that were required to provide wound care.

An interview was conducted via phone with Nurse Supervisor (NS) #2 on 01/30/15 at 4:00 PM. NS

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F 441	Continued From page 22 #2 stated she did not recall receiving the lab results faxed to the facility on 01/14/15 that contained information of MRSA in Resident #39 s sacral wound. She stated her usual practice when she received a lab report requiring contact precautions was to make a copy of the report and give it to the floor nurse to initiate contact precautions. NS #2 added she did not visually check to see if the nurse followed through. She added she would fax the report to the attending physician. NS #2 stated if the ADON was not there, she would not report the lab results identifying MRSA in the wound to her. 3. Resident #97 was readmitted to the facility on 03/20/14 with diagnoses which included pneumonia, chronic obstructive pulmonary disease, and history of lung cancer. A quarterly Minimum Data Set (MDS) indicated the resident's cognition was moderately impaired. The MDS coded the resident required limited assistance for activities of daily living and independent with locomotion on and off the unit. Medical record review revealed a laboratory (lab) report faxed to the facility on 01/22/15 at 3:01 PM. The report specified this was the final analysis of the culture of a sputum specimen obtained 01/19/15. The report indicated the culture grew a moderate amount of MRSA. The report contained instructions that contact precautions were required in healthcare facilities. A tour of the hall where Resident #97 resided was conducted on 01/26/15 at 9:43 AM. No observations were made of contact precaution signs or containers for personal protective equipment on that hall.	F 441		

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An interview was conducted with the Housekeeping Supervisor (HS) on 01/29/15 at 4:31 PM. The HS stated a resident's room with a sign for contact precautions alerted the housekeepers that an active infectious process was going on in that room. She stated the housekeeper would clean the room first thing in the morning and again around mid day. The HS added after cleaning the room, the mop water and mop head would be changed before going on to the next resident's room.

An interview was conducted with the Regional Director of Operations (RDO) on 01/29/15 at 4:47 PM. The RDO added contact precautions should have been initiated when the lab report indicating MRSA was received via fax. The RDO stated the lab results should have been reported to the ADON, the Infection Control Nurse, and the physician should be called for any additional orders.

An interview was conducted on 01/30/15 at 9:37 AM with the Assistant Director of Nursing (ADON) who also functioned as the Infection Control Nurse. The ADON stated if MRSA was identified and could be contained, it would not be necessary to initiate any isolation precautions. The ADON explained contained meant the infected area was protected by a dressing, brief, or was not exposed to air where other people could handle or touch it. She added if sputum could not be contained and was cultured to have MRSA, the resident would be placed in a private room if available. The ADON further stated residents with MRSA in sputum could cohort with another non infected resident if that resident did not have a fresh surgical wound or was not

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F 441	Continued From page 24	F 441		

otherwise compromised.

An interview was conducted with Nurse Supervisor (NS) #1 on 01/30/15 at 1:31 PM. NS #1 stated he did receive the faxed lab report that noted Resident #97's sputum culture was positive for MRSA on 01/22/15. NS #1 stated he did notify the physician and initiate contact precautions at that time. He stated the instructions documented on the lab report made him think contact precautions were needed. NS #1 added he was unable to recall if he notified the ADON, who served as the Infection Control Nurse.

An additional interview was conducted with the DON on 01/30/15 at 1:52 PM. The DON stated Resident #97 was placed on contact precautions when the lab report of 01/22/15 identified MRSA in the resident's sputum. She stated the resident was monitored over the weekend. The resident was observed to contain his sputum in a cup so the contact precautions were removed.

An interview was conducted with Resident #97 in the resident's room on 01/30/15 at 3:30 PM. A contact precaution sign was observed on the resident's room door. Resident #97 was observed in the bed by the window with the curtain pulled between his bed and his roommate's bed. He stated facility staff had not worn the mask and disposable gown until today. The resident pointed to a disposable cup on his over bed table. He stated when he coughed up sputum he spit it in the cup.

An additional interview was conducted with the ADON on 01/30/15 at 4:24 PM. She stated she did not receive notification from the nursing staff that Resident #97's sputum was identified to

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F 441	Continued From page 25 contain MRSA. Autumn Care of Drexel Credible Allegation of Compliance (01/30/2015) F 441 1 a. Resident # 39 was admitted to facility on 12/09/2014. Diagnosis on admission: Stage IV Sacral Decubitus ulcers s/p debridement. Wound culture 1/09/15. Final report 1/14/15 reveals moderate growth Methicillin Resistant Staph Aureus (MRSA). b. Resident # 117 was admitted to facility on 12/01/2014. Diagnosis: Diabetes with severe diabetic neuropathy, left foot osteomyelitis, diabetic foot ulcer, MRSA infected left foot ulcer diabetic. Wound culture 12/12/14 resulted moderate growth MRSA. Wound culture result 12/31/14 reveals Light growth MRSA. Hospitalized from 12/18/19 -12/19/14 with left foot infection. c. Resident # 97 admitted to facility 11/12/2013. Diagnosis: COPD, pneumonia. Sputum culture 9/5/14 squamous epithelial cells. Sputum culture January 19/15 results 1/22/15 reveals moderate growth MRSA. d. Resident # 85 admitted to facility 10/25/14: Diagnosis: Cellulitis of leg, vascular wounds. Wound culture 10/28/2014 revealed MRSA. She was discharged from the facility to home 12/19/2014. This resident was placed on contact isolation on 10/24/2014, and transferred to private room on 10/29/14 when the room became available. Wound culture of 11/11/14 reveals negative for MRSA. Resident did not discharge on antibiotics. Residents #39, 117 and 85 were placed on contact isolation on 01/30/15. The residents in contact isolation were informed by the Assistant Director of Nursing (ADON) they were in contact	F 441		

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F 441	Continued From page 26 isolation related to an infection and staff and visitors will wear appropriate PPE upon entering rooms 1/30/2015. Responsible parties/family members were notified of the residents' isolation 1/30/15 by the ADON. Contact isolation: gowning, gloving, bagging at source, donning PPE before entering room. Doff prior to leave room, wash hands, individual equipment: i.e.: dedicated stethoscope, sphygmomanometer, and wound equipment. The following departments have been in-serviced Infection control practice for contact isolation, by the Director of Nursing on 1/30/15: Therapy department, Environmental services, Dietary, Maintenance, Activities, Direct care staff, including aides, licensed nurses, administrative nurses in-serviced for infection control specifically contact isolation for residents with active symptoms and positive cultures for MRSA: Policy and procedure for contact isolation, infection control, precautions. Licensed nurses are re- trained to place residents in appropriate isolation the day a positive culture report is received or upon identified active symptoms with pending culture as well as co-horting residents with MRSA, not placing MRSA residents with new post op residents, immunocompromised residents, residents with wounds, trachs, catheters, and invasive devices. The ADON was inserviced 01/30/2015 by the administrator for: 1. Contact isolation recommendations and procedures including proper technique when to initiate contact precautions. 2. When to initiate a room change for a resident with active symptoms and or a positive culture report. 3. If available place resident in a private room.	F 441		

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F 441	Continued From page 27 4. Do not co-hort with immunosuppressed residents, residents with open wounds, catheters, ostomies. 5. Do not co-hort post op residents with surgical wounds with resident compromised with MRSA. This should be an immediate room change when a room is available preference being a private room. 6. Apply knowledge and training for contact isolation, co-horting residents, private rooms, ensuring training new systems is enforced. 7. The ADON was inserviced to print the physicians order report for a specified duration from the electronic healthcare record in order to monitor all culture orders. 8. ADON after reviewing the report, audits resident room to ensure proper contact isolation sign on door and isolation cart placed outside room. ADON ensures treatment equipment is placed in resident room and staff are aware and implement appropriate procedure per policy for contact isolation. 9. ADON re-educated to transcribe all pertinent data from report to the infection control line list for follow up. 10. ADON instructed that any resident with active signs of MRSA is placed in contact isolation pending culture report. All residents have potential to be affected therefore a 100% audit of all cultures and sensitivities since January 1, 2015 was completed by the Administrator and Infection Control Nurse on 1/30/15. 3 residents with MRSA were identified and have been placed in contact isolation. New system in place: 1. On admission the admitting nurse reviews admission paper work to identify residents with an infection. The admitting nurse initiates the proper	F 441		

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F 441	Continued From page 28 isolation based on current treatment, diagnosis, labs, and active symptoms. 2. The admitting nurse also communicates to ADON by initiating the infection "tracking form # V01" which is available at each nurse's station in Electronic medical record. 3. The admitting nurse is responsible for implementing the required isolation precautions for infection control measures by placing isolation sign on door, and isolation cart outside room. 4. Residents with new onset infection, resident will be placed on isolation in compliance with active symptoms pending culture results. 5. The ADON pulls the "Physician orders within a specified duration," report 5 days weekly and the RN supervisor pulls the "Physician orders within a specified duration" on the weekends. Review of this report reveals all physician orders transcribed in the previous 24 hours. When any cultures are ordered the ADON will document the orders on the infection control line list. 6. The ADON will follow up for the finalized report in 48-72 hours. Any residents displaying active symptoms will be placed in appropriate isolation pending results of the culture report. 7. All nursing staff must receive inservice education for the current system in place for contact isolation and residents with active signs of infection prior to being allowed to work. Immediate Jeopardy was removed on 01/30/15 at 4:59 PM when the facility provided evidence of additional in-service training for all nursing staff related to proper implementation of infection control precautions. The Administrator and Assistant Director of Nursing provided additional evidence of the new notification system to alert the ADON of a resident with MRSA.	F 441		
F 520	483.75(o)(1) QAA	F 520		2/25/15

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F 520 SS=K	Continued From page 29 COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to develop a plan of action for preventing reoccurrences of breaks in infection control precautions after a resident diagnosed with Methicillin-resistant Staphylococcus aureus (MRSA) was allowed to share a room with a resident with a new post-operative wound as part of the quality assurance review process. The facility failed to	F 520	This facility has a corporate policy to maintain a quality assurance and assessment committee. (This may be known as Quality Improvement or QAPI - Quality Assurance Process Improvement) and serves as an on-going process, multi-level, and facility-wide. The purpose of the QAA is continuous	

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establish proper infection control precautions for 4 residents diagnosed with Methicillin-resistant Staphylococcus aureus (MRSA) (Residents #39, 97 and 85) .

Immediate jeopardy began on 10/25/14 when Resident #85 was diagnosed with MRSA and allowed to remain in the same room with Resident #129 and on 11/10/14 the Western Region Quality Assurance Nurse in-serviced the Director of Nursing and Assistant Director of Nursing on following the proper guidelines for co-horting residents with Methicillin-resistant Staphylococcus aureus (MRSA) and the Quality Assurance Committee failed to identify the need for implementing a plan of action to prevent reoccurrences in breaks in infection control with residents diagnosed with MRSA. After the in-service on 11/10/14 three other residents were identified as not having contact precautions implemented for MRSA upon receipt of positive culture (Resident #s 39 and 97). Immediate jeopardy was removed on 01/30/15 at 4:59 PM when the facility implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity Level E (a pattern deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place.

The findings included:

Cross refer F 441.

On 01/29/15 at 4:35 PM the Administrator and Assistant Director of Nursing (ADON) were interviewed about the facility's Quality Assurance Program (QA). The Administrator explained that

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evaluation of facility systems with specific objectives. This committee meets at least quarterly and consists of the director of nursing, medical director, and at least 3 other members of facility staff as required per state and federal regulation. It is the policy of this facility the QA committee, develops, implements appropriate plans of action to correct identified quality deficiencies.

To achieve compliance with the alleged cited repeat deficiencies the following has been initiated:

The QA Committee has been retrained by the Administrator on 2/13/15 for the QA process using the following QAPI 5 elements: (summary of training below)

Design/scope: program must be ongoing and comprehensive, deals with full range of services offered by facility, including full range of departments. Addresses systems of care and management practices, including clinical care, quality of life, and resident choice. Aims for safety, high quality with clinical interventions.
Governance and Leadership: governing body develops culture involving leadership and seeks input from staff, residents, and families or representatives. Designates 1 person responsible for QAPI developing leadership and facility wide training, sets expectations around safety, quality rights, choice, and respect.
Feedback: data systems & monitoring: Incorporate feedback systems, monitors care processes, outcomes, reviews,

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F 520	Continued From page 31 the ADON was new in her role and still in training but would be expected to lead the QA committee and requested that she participate in the interview. The Administrator reported that a "core group" consisting of herself, the Director of Nursing (DON), ADON, the Medical Director, Pharmacist and Staff Development Coordinator met monthly to review newly identified problems, review current action plans and develop new action plans for identified areas of concerns. The Administrator reported part of the QA process was to review audits from departments to determine if acceptable thresholds were being met and if not, the committee worked to determine if a plan of action was needed to achieve compliance. The Administrator added that the ADON presented infection control reports to the QA committee. The Administrator reported that infection control was a topic that was discussed at each QA meeting but that she was not aware of any recent significant issues with breaks in infection control that required a plan of action. The Administrator provided the QA Committee's sign-in sheets and minutes discussed. Review of the sign-in sheets and minutes revealed that the QA committee met November 2014, the committee did not meet in December 2014 but met January 2015. On 01/30/15 at 10:10 AM the Western Region Quality Assurance Nurse (QA Nurse) was interviewed about the infection control concerns related to the facility's failure to implement infection control precautions timely. She reported that she became aware of a concern with Resident #129, investigated and determined that the facility allowed the Residents #85 and #129 to share a room and educated the DON and ADON on 11/10/14 on the guidelines for separating	F 520	tracks, and investigates implements plans to prevent recurrence. Performance improvement Projects(PIPS): concentrates on particular problems, gathers information, monitors, care process, outcomes, and tracks, and investigates. Systematic analysis and systemic action: develops policies annual procedures, demonstrates proficiency in cause analysis, reviews systems to prevent recurrence and promote sustained improvement. Focus on continual learning and continuous improvement The quality assurance committee meets at least quarterly and consists of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, and Pharmacist and other facility staff as assigned. It is the policy of this facility that the QA committee develops, implements appropriate plans of action to correct identified quality deficiencies. To achieve compliance with the alleged cited deficiency, the following systematic changes have been made to assure that the practice does not recur: 1)The DON and ADON were retrained on 1/30/15 by the Administrator on contact isolation recommendations and procedures including proper technique when to initiate isolation precautions, 2)the ADON/QA Nurse received training on 2/9/15 by the Administrator on state and federal requirements of the QA committee, purpose of the committee, and facility	

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residents with infections.

On 01/30/15 at 10:35 AM the Administrator and Director of Nursing (DON) were notified of immediate jeopardy. The facility provided an acceptable credible allegation of compliance on 01/30/15 at 4:59 PM. The following interventions were put in place by the facility to remove the Immediate Jeopardy.

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Credible Allegation of Compliance (01/30/2015) F 520

On 11/10/2014, the DON and ADON were re-in-serviced, by the Regional Nurse Consultant for co-horting residents with Methicillin Resistant Staph Aureus. Reviewed North Carolina state recommendations per statewide program for infection control epidemiology (SPICE). Private room if available, do not co-hort with immunosuppressed residents, no residents with open wounds, catheters, ostomies, etc. Additionally instructed to immediately initiate room change when a post op patient is in room with a resident who has a tested positive with a culture or active symptoms for MRSA.

The DON and ADON were retrained on 01/30/15 by the facility administrator for the following: (The ADON serves as the Infection Control Nurse.) The QA committee consists of the Administrator, DON, ADON, SDC, Medical Director, and Pharmacist, each of whom will be in-serviced by the administrator prior to next QA committee meeting.

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policy and procedure on Quality Assurance & Performance Improvement, 3)the QA Committee has been re-trained on the state and federal requirements of the QA committee, purpose of the committee, and policy and procedure on Quality Assurance & Performance Improvement, 4)the DON/ADON review infection tracking forms five days per week for accuracy in identifying infection and adherence to policy and procedure for implementing appropriate and timely isolation precautions, 5)the ADON/DON reviews the Physician Orders Within A Specified Duration report five days weekly and the RN Supervisor is responsible for reviewing this report on the weekends to review all cultures ordered. All pending cultures are listed on the pending culture list and the ADON/DON follows up for the finalized culture report in 48-72 hours to ensure proper precautions are initiated when required per policy.
Any deficiencies will be corrected immediately, and the findings of the quality assurance audits will be documented and submitted to the quality assurance committee quarterly for further review and/or corrective action.

Staff will attend a directed in-service training on Infection Control and Quality Assurance and Assessment provided by Mountain Area Health Education Center on 2/25/15.

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F 520	Continued From page 33 Contact isolation recommendations and procedures including proper technique when to initiate contact precautions. 1. When to initiate a room change for a resident with active symptoms and or a positive culture report. 2. If available place resident in a private room. 3. Do not co-hort with immunosuppressed residents, residents with open wounds, catheters, ostomies. 4. Do not co-hort post op residents with surgical wounds with resident compromised with MRSA. This should be an immediate room change when a room is available preference being a private room. 5. Apply knowledge and training for contact isolation, co-horting residents, private rooms, ensuring training new systems is enforced. New system in place: 1. The DON and or ADON will review infection tracking forms 5 days per week for accuracy in identifying infection and adherence to policy and procedure for implementing appropriate and timely contact isolation precautions. 2. The DON and or ADON will print the physicians order report for a specified duration from the electronic medical record 5 days a week Monday- Friday in order to review all culture orders to ensure proper adherence to policy and procedure for implementing appropriate and timely contact isolation precautions. 3. The RN supervisor will print the physician order report for a specified duration from the electronic healthcare record on the weekend. Once the RN Supervisor reviews the report it is placed in the DON communication box located at the nurse's station. The DON and or ADON will	F 520		

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AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE DREXEL, NC 28619

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F 520	Continued From page 34 audit the report to ensure adherence to policy and procedure for applying contact isolation precautions when indicated. 4. The DON and or ADON will audit facility staff weekly for adherence/compliance for appropriate personal protective equipment and procedures for contact isolation. 5. The ADON will transcribe any pertinent data to the infection control line list. 6. The DON and or ADON will report findings to the quality assurance committee quarterly for review. Any further corrective action will be immediately implemented by the QA committee. Immediate Jeopardy was removed on 01/30/15 at 4:59 PM when the facility provided evidence of that all members of the QA Committee will be in-serviced prior to the next QA meeting on reporting, identifying and developing plan of actions for concerns that reflect system failure. The Administrator and Assistant Director of Nursing also provided evidence of knowledge related to the QA system, function of the QA committee and how the QA system monitors for necessary follow up.	F 520		