STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORESVILLE CENTER	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156		1/23/15

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

Electronically Signed | 01/22/2015

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funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview and resident interview, the facility failed to prominently display required and accurate information relating to the state agency contact information, ombudsman contact information, and location of survey results in a location accessible to residents. The information was located in an area that was rarely used by residents. The findings included: The Resident Council President (Resident #111) was coded on her most recent Minimum Data Set (MDS) dated 11/07/14 as being cognitively intact (scoring a 15 out of 15 on the brief interview for mental status). She was interviewed on 01/07/15 at 9:55 AM and stated she did not know where the information related to the survey results, ombudsman information and the state regulatory agency was located in the facility. She stated that she thought the information of how to contact the state agency and ombudsman was given out in a council meeting and that the survey results were accessible but she could not say where they were located. Resident #148's most recent MDS dated 11/08/14 coded her as being cognitively intact (scoring a 15 out of 15 on the brief interview for mental status). During an interview on 01/08/15 at 1:16 PM, Resident #148 stated she did not know where the survey results were or any other posted information. She stated her granddaughter had all the information.	F 156	For those affected: Poster was immediately relocated to the main corridor For those potentially affected: Poster was immediately relocated to the main corridor, residents will be notified of location of posting by Activity Director on 1/23/15. Systemic changes: Staff was educated on assuring the poster remains in the corridor where more resident traffic occurs. An audit will be done weekly times 3 weeks then monthly times 3 months to assure placement of the poster in the main corridor QA and monitoring: Audits will be completed weekly times 3 weeks, and monthly times 3 months. Audits will be reviewed in monthly QA meetings times 3 Months.	

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Resident #101's most recent MDS dated 12/18/14 coded her as being cognitively intact (scoring a 15 out of 15 on the brief interview for mental status). During an interview on 01/08/14 at 1:32 PM she revealed she had no idea where the survey results were or any information related to the ombudsman contact, state agency contact or any other postings of information for residents to review. She stated she attended resident council but could not recall this information being reviewed in these meetings.

Resident #155's most recent MDS dated 11/08/14 coded her as being cognitively intact (scoring a 14 out of 15 on the brief interview for mental status). She revealed during interview on 01/08/14 at 1:32 PM that she attended resident council meetings but could not say she knew where the postings were located including the survey results location, ombudsman information and or the state agency information.

Resident #28's most recent MDS dated 10/31/14 coded him as being cognitively intact (scoring a 13 out of 15 on the brief interview for mental status).

A joint interview with the Activity Director and Assistance Activity Director was conducted on 01/08/14 at 1:48 PM. This discussion revealed that the information relating to the ombudsman's program was discussed in a recent resident council meeting. Neither could recall if the residents were reminded as to the location of postings including the location of survey results or state agency numbers. The Activity director stated that at each resident council meeting she reminded residents who each department director

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F 156	Continued From page 4 was, the location of their office and what their responsibilities included. She also questioned each resident about being able to express any concerns or complaints to any staff person in the facility. Observations made on 01/08/15 at 1:59 PM revealed two areas of postings of information. Just inside the corridor to the resident rooms were the resident rights which included the "Ombudsman Program" and 1-800 number, with no ombudsman name listed, and the grievance policy. The other posting location was inside the front entrance vestibule between the front door to the outside and the second door leading into the lobby area of the facility. All the required postings were posted in the vestibule, however, the ombudsman's name and phone number was incorrect. Interview with the receptionist at the front desk on 01/08/15 at 2:05 PM revealed she worked 5 days a week. She stated few residents ever entered the vestibule from the lobby where all the postings were located. The administrator stated on 01/08/15 at 2:23 PM during interview, that the postings had been in the same location for years. She further stated that the vestibule was open to the lobby until the double door was added inside, enclosing the vestibule. She further stated she was aware that the ombudsman listed in the vestibule was no longer the ombudsman who came to the facility.	F 156		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities,	F 242		1/22/15

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F 242	Continued From page 5 schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to assess a resident for a preference regarding time of day for showers for 1 of 4 sampled residents reviewed for choices (Resident #245). The findings included: Resident #245 was admitted on 12/31/14 with diagnoses including generalized weakness and Parkinson's disease. Review of Brief Interview for Mental Status worksheet, completed by the social worker for Resident #245's admission Minimum Data Set, revealed she was cognitively intact. During an interview on 01/05/15 at 2:29 PM Resident #245 stated she had been asked about taking a shower once since she was admitted but she was too tired. Resident #245 further stated she preferred to shower in the morning but no one had asked her when she preferred to shower. An interview was conducted with the Director of Nursing (DON) on 01/08/15 at 9:27 AM. The master shower schedule was reviewed during the interview and it was noted Resident #245's showers were scheduled for Monday and Thursday during the 3:00 PM to 11:00 PM shift.	F 242	For resident affected: Resident number 245 was interviewed and her shower was scheduled per her request on day shift. Potential residents affected: Residents who are able to make decisions regarding their showers were interviewed by the nurse management team for preference Preferences were honored. New admissions will be interviewed by the nursing staff with the form completed and signature of patient obtained for shower preference with preference honored. Systemic changes: Residents who are able to make decisions were interviewed for shower preferences and preferences honored. New Admissions will be interviewed by the nurse management team and their preferences will be honored. Facility will provide residents with a selection form (by unit nurse)to indicate shower preference. Residents	

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F 242	Continued From page 6 The DON stated residents were assigned two showers a week and the days of the week and time of day were determined by the resident's room number. During an interview on 01/08/15 at 9:32 AM Unit Manager (UM) #2 stated residents were told the days of the week and time of day for their showers which was determined by their room number. UM #2 further stated residents would need to communicate with staff if they did not like the day of the week or time of day for their scheduled showers. An interview with Nurse Aide (NA) #5 on 01/08/15 at 2:12 PM revealed she reviewed her assignment sheet daily to see which of her residents were scheduled for a shower on her shift. The interview further revealed when NA #5 asked Resident #245 about getting a shower on 01/05/15 (Monday) during the 3:00 PM to 11:00 PM shift Resident #245 stated she did not feel well and declined.	F 242	signature will be obtained on the form. Audits will be completed (by nurse management) weekly times 3 Weeks, monthly times 3 months and Quarterly times one year to assure current and future residents shower preferences are honored. Audits will be reviewed in QA meeting monthly times 3 months then quarterly times one year. Staff inservices were provided. QA and monitoring: Facility will provide residents with a selection form to indicate shower preference. Residents signature will be obtained on the form. Audits will be completed (by nurse management) to assure current and future residents shower preferences are honored. Audits will be reviewed in QA meeting monthly times 3 months then quarterly times one year.	
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.	F 328		1/22/15

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F 328	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to transport a portable oxygen cylinder in a safe manner for 1 of 1 staff observed transporting an oxygen cylinder. The findings included: On 01/06/15 at 11:44 AM, Nurse #1 was observed in the hall changing out a resident's portable oxygen tank. The resident and nurse were just outside the closet where the full oxygen cylinders were stored. Nurse #1 removed the used oxygen tank, placed it on the floor, unsecured, behind her and proceeded to place a full oxygen tank in the sleeve located on the back of a resident's wheelchair. Once the full tank was secured, turned on and adjusted for the resident, Nurse #1 proceeded to pick up the used oxygen tank and carry it manually around the corner to the soiled utility room. This was approximately 20 to 25 strides from the resident's wheelchair to the utility room. During interview on 01/08/15 at 10:41 AM with Nurse #1, she stated that normally she placed a full oxygen cylinder in a wheeled cart, wheeled it from the storage closet to the resident's room. She continued that after she changed the used oxygen cylinder with the full oxygen cylinder, she used the wheeled cart to transport the used oxygen tank to the soiled utility room where it was placed in a secured cart. Nurse #1 stated she recalled the incident on 01/06/15 when she carried the oxygen cylinder to the soiled utility closet. Nurse #1 stated that normally she changed oxygen cylinders in a resident's room	F 328	Resident affected: 2/2/15 Nurse was provided education on transferring oxygen cylinders in the carts with wheels. Potential residents affected: Nurses were provided inservices by staff development nurse/Nurse Practice Educator for Oxygen cylinder transportation Using the carts on wheels. Systemic changes: Nurses were provided education regarding transport of oxygen cylinders by the staff development coordinator/Nurse Practioner. Wheeled carts are available in the oxygen storage room. Audits will be complete by the nurse managers weekly times 3 weeks and monthly times 3 months QA and monitoring: Wheeled carts are available in the oxygen storage room. Audits will be complete by the nurse managers weekly times 3 weeks, monthly times 3 months and reviewed in monthly QA meeting.	

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F 328	Continued From page 8 but since the resident was already at the nursing desk not far from where the oxygen cylinders were stored she opted to just carry the cylinders. Interview with the Director of Nursing on 01/08/15 at 11:41 AM revealed she expected that staff changing oxygen cylinders, transported both the full oxygen cylinders and used oxygen cylinders via the wheeled carts made available in the storage closets and not manually.	F 328		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to store the ice machine scoop in a clean container and keep the floor of the dry goods storage room clean. The findings included: An initial tour was made of the facility's kitchen on 01/05/15 at 10:00 AM with the Food Service Director (FSD). Observations were made of the kitchen's dry goods storage room. Observations of the storage room floor revealed black, dusty	F 371	Residents affected: Storage room floors were cleaned, Ice scoop holder was immediately removed from service Residents potentially affected: Storage room floors were cleaned, staff was inserviced on cleaning schedules, ice scoop holder was immediately removed from service and replaced with a new one. Ice scoop is now on the daily cleaning	1/22/15

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F 371	Continued From page 9 debris accumulated along the base boards of the stock room floor. In addition, there were food items such as bread bag with sliced bread on the floor, an onion, and opened, spilled sugar packets, a coffee creamer cup and a yellowish spilled substance dried to the floor. The FSD was present for the observations and reported that the stock room floor was cleaned and swept daily and as needed by one of the 1st shift dietary aides. The FSD stated that the floor was dirty and needed to be cleaned. The FSD pulled the cleaning schedule assignments for the week of 12/29/14 through 01/04/15 that revealed the dietary aide assigned to mop the stockroom failed to document completion of the task. He stated that he utilized a cleaning schedule with assignments for cleaning the kitchen. He explained the process that included each staff member was responsible for completing their assigned tasks and initials the form once the task was completed. The FSD was interviewed about the cleaning schedule and reported that he was unaware that the form had not been completed as assigned and stated he would have expected the dietary aide to mop the floor daily as scheduled. During the initial tour made on 01/05/15, the ice scoop was observed at 10:20 AM. The ice scoop, used to service the residents in the facility, was stored in a plastic container mounted to the side of the ice machine. The ice scoop was stored in the plastic container that was visibly dirty. The tip of the ice scoop was submerged in water that was noted to have black debris floating in it. The bottom of the plastic container had black debris that was able to be wiped off. The FSD was present for the observation, removed the ice scoop and plastic container from use.	F 371	schedule Systemic changes: Storage room floors were cleaned, staff was inserviced on cleaning schedules, FSD or designee will review cleaning schedules daily for completion, ice scoop holder was replaced with a new scoop holder, staff was inserviced regarding replacing scoop holder when sealant becomes worn. QA and monitoring: Staff was inserviced on cleaning schedules, FSD or designee will review cleaning schedules daily, audits will be completed daily times 2 weeks, weekly times 3 months and quarterly times one year. Ice scoop holder will be added to the daily cleaning schedules. FSD or designee will assure this item is cleaned with the daily cleaning schedules, Audits will be performed daily times 2 weeks, weekly times 3 months and quarterly times one year. Results of cleaning schedules will be reviewed in monthly QA meetings.	

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F 371	Continued From page 10 The FSD was interviewed about the cleaning of ice scoop and he reported that the ice machine scoop was scheduled to be cleaned daily by a dietary aide. He explained that it was scheduled on the daily cleaning log for staff to follow. The FSD reviewed the cleaning schedule for the week of 12/29/14 through 01/04/15 that revealed the dietary aide assigned to clean the ice scoop failed to document completion of the task. The FSD was interviewed about the cleaning schedule and reported that he was unaware that the form had not been completed as assigned and stated he would have expected the dietary aide to clean the ice scoop as scheduled.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		1/22/15

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F 441	Continued From page 11 (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, record review, and staff interviews the facility failed to disinfect a blood glucose meter after use per the manufacturer's specification for a resident diagnosed with a clostridium difficile infection (Resident #123). The findings included: Review of the facility's blood glucose meter policy last revised on 12/08/14 stated blood glucose meters will be disinfected before patient use according to the manufacturer's guidelines. Review of the manufacturer's guidelines for disinfection on the bleach germicidal wipes label revealed instructions to use enough wipes for the treated surface to remain visibly wet for the contact time listed on the label. The listed contact time was 3 minutes for clostridium difficile.	F 441	Residents affected: Glucose monitoring machine was cleaned immediately and wrapped in the cleansing cloth. Residents potentially affected: Glucose monitoring machines will be cleansed and wrapped in the cleansing cloth to assure they are moist times 3 minutes for CDiff residents. Systemic changes: Inservices were provided by the staff development coordinator/nurse practice educator to nursing staff to clean glucose monitoring machines and wrap them in the cleansing cloth to assure they are moist times 3 minutes for CDiff residents.	

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F 441	Continued From page 12 Review of Resident #123 ' s medical record revealed a physician's order dated 10/30/14 to start contact precautions until c-diff was cleared. During an observation beginning on 01/05/15 at 12:08 PM Nurse #2 was observed knocking on Resident #123's door which had contact precautions signage affixed to the outside of the door. Nurse #2 had already donned a gown and gloves and was holding a blood glucose meter in her hand. Nurse #2 entered Resident #123's room and was overheard telling him she was going to check his blood sugar before she closed the door. At 12:12 PM Nurse #2 exited Resident #123's room with the blood glucose meter wrapped in a paper towel. She then removed a premoistened wipe from a container at the medication cart and was observed wiping the surface of the blood glucose meter for approximately 10 seconds. Nurse #2 placed the blood glucose meter in a cup on top of the medication cart at 12:13 PM. At 12:14 PM observations of the blood glucose meter revealed all surfaces of the meter were dry. An interview was conducted with Nurse #2 on 01/05/15 at 1:04 PM. During the interview Nurse #2 stated she had been trained to disinfect the blood glucose meters by wiping the meters with a bleach germicidal wipe after each use and allow the meter to air dry for 3 minutes. Nurse #2 confirmed Resident #123 was on contact precautions due to a c-diff infection. The interview revealed Nurse #2 was not aware the surface of the blood glucose meter needed to remain visibly wet for 3 minutes to disinfect after use for a resident with a c-diff infection. An interview with the Director of Nursing (DON)	F 441	Audits will be completed weekly times one month, monthly times 3 months and quarterly times one year. Results will be reviewed in monthly QA meetings QA and monitoring: Inservices were provided by the staff development coordinator/nurse practice educator to nursing staff to clean glucose monitoring machines and wrap them in the cleansing cloth to assure they are moist times 3 minutes for CDiff residents. Audits will be completed weekly times one month, monthly times 3 months and quarterly times one Year. Results will be reviewed in monthly QA meetings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 13 on 01/05/15 at 1:11 PM revealed nurses were instructed to follow the directions on the label for the germicidal wipe regarding the length of time the surface needed to remain wet to kill the specific bacteria or virus. The interview further revealed she expected nursing staff to use the bleach germicidal wipes to disinfect blood glucose meters after use for a resident with a c-diff infection and for the surface of the meter to remain wet for 3 minutes. During an interview on 01/08/15 at 11:08 AM the Staff Development Coordinator (SDC) stated there had been no staff education specific to disinfecting blood glucose meters after use for a resident with c-diff.	F 441		