STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345185	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	**106 CAMERON STREET LAKE WACCAMAW, NC 28450**

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to develop a Care Plan for transfers with the use of a mechanical lift for 1 of 3 residents reviewed for transfers (Resident #2). The findings included: Resident #2 was admitted to the facility on 3/19/15 and re-admitted to the facility on 5/21/15. The resident had diagnoses of Cerebrovascular Accident (Stroke), Advanced Dementia, and Chronic Debility. The computerized Kardex Report was a list of interventions to inform the NAs (nursing assistants) about the resident ' s specific care	F 279	The Care Plan and Kardex for resident #2 was reviewed and revised immediately upon being made aware of the resident transfer concerns raised by the surveyor. All other residents' Care Plans and Kardex's who have the same potential to be affected have been reviewed for accuracy. Inservices were held with all nursing department staff regarding the importance of verifying the current transfer status, if unknown, of residents prior to transferring them and proper	7/24/15

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

Electronically Signed | 07/17/2015

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F 279	Continued From page 1 needs. The Kardex Report for Resident #2 with the admission date of 5/21/15 under Transferring read: " Assist with locomotion and transfers. " The Kardex did not specify how the resident was to be transferred. Review of a Functional Transfer Assessment form dated 6/14/15 revealed Resident #2 was to be transferred with a mechanical lift with the assistance of 2 persons. A Significant Change Minimum Data Set (MDS) Assessment dated 6/18/15 revealed Resident #2 had severe cognitive impairment. The MDS revealed the resident was total assist with 2 persons for transfers, was not ambulatory and had impairment in range of motion of the lower extremities. The Care Area Assessment (CAA) for Falls dated 6/19/15 revealed the resident remained total assist for transfers with the use of a mechanical lift and two staff persons for all transfers. On 7/1/15 at 11:20AM, MDS Nurse #1 stated in an interview that Resident #2 was supposed to be transferred with a mechanical lift with the assistance of 2 persons. The MDS Nurse stated each time a quarterly or full assessment was done, a transfer assessment was also done. The MDS Nurse stated she had just completed a significant change assessment on the resident and according to the transfer assessment, the resident was still to be transferred with a mechanical lift with 2 person assist. The MDS Nurse was observed to review the resident ' s Care Plan and Kardex Report. The Nurse stated the method of transfer was not on the Care Plan or on the Kardex but should have been on both. The MDS Nurse could not explain why the information was not on the Care Plan and the Kardex. On 7/2/15 at 10:12AM an interview was	F 279	transfer techniques. Also, where to locate the current transfer status of residents. The transfer status of all residents will be determined upon admission and as necessary per facility policy and the MDS Coordinator or designee will ensure that the information is placed in the Care Plan and on the Kardex. A Transfer Audit has been developed and implemented to monitor that transfers are being performed appropriately to ensure safety and that appropriate transfer status is being placed on the NACP, Care Plan and Kardex. These Transfer Audits were done q 2 hours x's 3 days by charge nurses on identified residents, then continued x's 1 week by charge nurses on random residents found to be at risk for the same deficient practice. Random audits will continue by DON or designee weekly x's 4 weeks. Charge Nurse will be responsible for ensuring appropriate transfer status is placed on the temporary NACP upon new resident admission. MDS Coordinator or designee will be responsible for ensuring appropriate transfer status is documented on the Care Plan and Kardex. Staff Development Coordinator or designee will audit all new admissions for transfer assessment and information input on NACP, Care Plan and Kardex x's 1 month. Results of audits will be forwarded to the Quality Assurance Committee for further recommendations.	

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F 279	Continued From page 2 conducted with the Staff Development Coordinator (SDC), Director of Nursing and the Administrator. The SDC stated she did the functional transfer assessments and the MDS Nurse was supposed to transfer that information to the Care Plan and the Kardex.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide incontinence care for 1 of 3 sampled residents (Resident #2) and failed to clean the resident's perineum for 1 of 3 resident's observed during incontinence care (Resident #2). The findings included: 1a. Resident #2 was admitted to the facility on 3/19/15 and re-admitted to the facility on 5/21/15. The resident had diagnoses of Cerebrovascular Accident (Stroke), Advanced Dementia and Chronic Debility. The Care Plan dated 3/27/15 for Resident #2 contained an entry for activities of daily living (ADLs) that included the following intervention: " Provide incontinent care on each CNA (Certified Nursing Assistant) round and prn (as needed). " A Significant Change Minimum Data Set (MDS) Assessment dated 6/18/15 revealed the resident had severe cognitive impairment, required total	F 312	To address the issue of failure to assist a resident with incontinent care, the CNA(s) identified by the surveyors were given 1:1 instruction and counseling regarding proper incontinent care and timely rounding. Audits were performed by nursing staff via staff observation every 2 hours for 3 days on resident #2 to ensure proper and timely incontinent care was being provided. Random audits will continue by Administrative Nursing and charge nurse staff to ensure proper and timely incontinent care is being provided to resident #2 daily, q shift for 2 weeks, then randomly by DON or designee x's 2 weeks. To ensure all other residents with the same potential to be affected are given appropriate assistance, all other nursing	7/24/15

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F 312	Continued From page 3 assistance for toileting and extensive assistance for personal hygiene. The MDS revealed the resident was incontinent of bowel and bladder. The Care Area Assessment (CAA) for Urinary Incontinence dated 6/19/15 revealed the resident was always incontinent. The CAA revealed the resident was unaware of the need to toilet due to the diagnosis of Dementia. The CAA revealed the resident was checked with each CNA round and changed as needed. On 7/1/15 at 5:35AM, NA (Nursing Assistant) #2 was observed to provide incontinence care for Resident #2. The NA removed the resident ' s incontinent brief and the brief was observed to be 100% saturated with urine with an approximately four inch in diameter circle of urine on the sheet beneath the resident. There were no dried brown rings on the sheet to indicate dried urine on the sheets. NA #2 stated in an interview on 7/1/15 at 5:40AM she checked the resident during her first rounds about 2:00AM and the resident was dry. The NA stated she had not checked the resident for incontinence since that time because she had gotten behind due to answering call lights and bed alarms. An interview was conducted with the Administrator, Director of Nursing (DON) and the Staff Development Coordinator (SDC) on 7/2/15 at 10:12AM. The DON stated the NA should have checked the resident before the brief was saturated. 1b. Resident #2 was admitted to the facility on 3/19/15 and re-admitted on 5/21/15. The resident had a diagnosis of Advanced Dementia. The resident ' s Care Plan for ADLs (activities of daily living) dated 3/27/15 directed staff to provide incontinent care on each NA (nursing assistant) round and as needed.	F 312	department staff have been inserviced on proper incontinent care and timely rounding. Additional inservices were provided utilizing an anatomically correct male and female manikin in order for CNA's to provide return demonstration when performing perineal care. All residents found to be at risk for the same deficient practice have been identified and are being monitored by charge nurses for proper peri-care randomly via CNA observation and auditing to be performed q shift (7a-7p) and (7p-7a), x's 2 weeks. SDC will be responsible for reviewing audit results and providing 1:1 instruction if concerns are raised regarding proper peri-care after incontinent episodes. Random audits will be performed by DON or designee 3 x's per week for 4 weeks. Results will be forwarded to the QA Committee for further recommendations.	

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F 312	Continued From page 4 A Significant Change Minimum Data Set (MDS) Assessment dated 6/18/15 revealed the resident had severe cognitive impairment, required total assistance with toileting and extensive assistance with personal hygiene. The Care Area Assessment (CAA) dated 6/19/15 for Urinary Incontinence revealed the resident was always incontinent and required total assist with toileting. The CAA revealed the resident was unaware of the need to toilet related to a diagnosis of Dementia. On 7/1/15 at 5:35AM, NA #2 was observed to provide incontinent care for Resident #2. The NA was observed to remove the resident ' s incontinent brief which was observed to be 100% saturated. The NA used pre-moistened wipes and wiped the resident ' s buttocks and peri-rectal area, applied a barrier cream to the resident ' s buttocks and applied a dry incontinent brief. The NA did not clean the resident ' s perineal area. NA #2 stated in an interview on 7/1/15 at 5:50AM that she would clean the perineal area if the resident was soiled. On 7/2/15 at 10:12AM an interview was conducted with the Administrator, Director of Nursing (DON), and the Staff Development Coordinator. The DON stated the NA should have cleaned the entire perineum including the vaginal area. The DON stated if there was that much urine, it was everywhere.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314		7/24/15

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F 314	Continued From page 5 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to notify the nurse of a new pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident #2) and failed to provide incontinence care for a resident with a pressure ulcer for 1 of 3 residents observed during incontinence care (Resident #2). The findings included: 1a. Resident #2 was admitted to the facility on 3/19/15 and re-admitted on 5/21/15. The resident had diagnoses of Cerebrovascular Accident (Stroke), Advanced Dementia and Chronic Debility. The resident ' s Care Plan dated 3/27/15 revealed an entry that the resident was at risk for skin breakdown related to decreased bed mobility and incontinence of bowel and bladder. The interventions directed staff to assess skin for red areas and report to the nurse. A Significant Change Minimum Data Set (MDS) Assessment dated 6/18/15 revealed the resident had severe cognitive impairment, required extensive assistance with bed mobility, was incontinent of bowel and bladder and was at risk for pressure ulcers. The Care Area Assessment (CAA) dated 6/19/15 for Pressure Ulcer revealed the potential for development of pressure ulcers because the resident required extensive assist for bed mobility and was incontinent of bowel and bladder. The CAA revealed the resident ' s skin was assessed	F 314	Observations related to Resident #2 was assessed and appropriate treatment initiated by Wound Nurse upon notification . Audits were conducted on Resident #2 every 2 hours for 3 days to ensure proper incontinence care and assistance with ADL's was provided. No new developing areas have been noted. Since all other residents who need assistance with ADL's have the same potential to be affected, these residents have been identified and audits have been initiated to be performed by charge nurses of 2 random residents, and will continue daily q shift, 7a-7p and 7p-7a, for 2 weeks to ensure the same practice does not recur. SDC or designee will perform random audits on identified residents 2 x's per week for 2 weeks. DON or designee will monitor wound reports weekly x's 4 weeks and then monthly on an ongoing basis to determine if issues may alledgedly be related to failure to provide incontinence care and address as appropriate. Inservices have been conducted with all nursing department staff regarding proper incontinence care and assistance with ADL's, including notification of nursing	

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F 314	Continued From page 6 during each brief change and bath. The CAA revealed no skin breakdown noted during the 7 day assessment period. Review of a weekly skin assessment for Resident #2 dated 6/19/15 read: Skin intact, no open areas. There was not a weekly skin assessment found on the clinical record between 6/19/15 and 7/1/15. On 7/1/15 at 8:26AM Nurse #1 stated in an interview she did the resident ' s skin assessment on 6/25/15 but forgot to document it. The Nurse stated the resident had no skin breakdown at that time. On 7/1/15 at 5:35AM, NA #1 was observed to provide incontinence care for Resident #2. A small pink, open area was observed on the resident ' s mid sacral area. The NA applied barrier cream to the resident ' s sacral area and buttocks prior to applying a clean incontinent brief. On 7/1/15 at 3:22PM the Treatment Nurse stated in an interview that NA #1 came to her early this morning (Wednesday) and told her the resident had an area on her sacrum. The Treatment Nurse stated she went in and assessed the area and the resident had a small Stage II pressure area and would continue to apply barrier cream to the area. Review of the nursing progress notes dated 7/1/15 at 4:28PM revealed the NA had asked the Treatment Nurse to look at the resident ' s sacrum this AM and a 1cm (centimeter) by 0.5cm Stage II was noted on the resident ' s sacral area. The note revealed the physician and the resident ' s responsible party were notified. NA #1 stated in an interview on 7/2/15 at 7:45AM she saw the area on the resident ' s sacrum this past weekend (thinks it was Sunday) and put barrier cream on it as this was usually how they	F 314	staff regarding any new or developing issues. Results or audits will be forwarded to the QA Committee and further recommendations made if necessary.	

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F 314	Continued From page 7	F 314		

treated it. The NA stated she had intended to tell the nurse but it slipped her mind. The NA stated the area looked the same on Sunday as it did yesterday (7/1/15).
On 7/2/15 at 10:12AM an interview was conducted with the Administrator, Director of Nursing (DON) and the Staff Development Coordinator (SDC). The SDC stated if a NA finds an open area on a resident the NA should go immediately to the nurse and let her know so the nurse could implement measures to prevent it from getting worse and call the physician. The DON stated the NA could also document in the computer a custom alert that would go to the nurse ' s dash board and the treatment nurse would be notified who would then assess the wound.
1b. Resident #2 was admitted to the facility on 3/19/15 and re-admitted on 5/21/15. The resident had diagnoses of Cerebrovascular Accident (Stroke), Advanced Dementia and Chronic Debility.
The resident ' s Care Plan dated 3/27/15 revealed an entry that the resident was at risk for skin breakdown related to decreased bed mobility and incontinence of bowel and bladder. Interventions included: Provide incontinent care on each NA (nursing assistant) round and as needed and Apply barrier cream with each incontinence episode.
A Significant Change Minimum Data Set (MDS) Assessment dated 6/18/15 revealed the resident had severe cognitive impairment, was incontinent of bowel and bladder and was at risk for pressure ulcers.
The Care Area Assessment (CAA) dated 6/19/15 for Urinary Incontinence revealed the resident was always incontinent and required total assist with toileting. The CAA revealed the resident was

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F 314	Continued From page 8 unaware of the need to toilet related to a diagnosis of Dementia. The CAA revealed the resident was at risk for skin breakdown due to incontinence. The CAA revealed the resident did not have skin breakdown at the time of the assessment. On 7/1/15 at 5:35AM, NA #2 was observed to provide incontinence care for Resident #2. The NA removed the resident ' s incontinent brief and the brief was observed to be 100% saturated with urine with an approximately four inch in diameter circle of urine on the sheet beneath the resident. There were no dried brown rings on the sheet to indicate dried urine on the sheets. NA #2 stated in an interview on 7/1/15 at 5:40AM she checked the resident during her first rounds about 2:00AM and the resident was dry. The NA stated she had not checked the resident for incontinence since that time because she had gotten behind due to answering call lights and bed alarms. An interview was conducted with the Administrator, Director of Nursing (DON) and the Staff Development Coordinator (SDC) on 7/2/15 at 10:12AM. The DON stated the NA should have checked the resident before the brief was saturated.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315		7/24/15

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F 315	Continued From page 9 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to clean the perineal area during incontinence care for 1 of 4 sampled residents observed to receive care (Resident #1). 1. Resident #1 was admitted to the facility on 3/31/15 with diagnoses including urinary tract infection (UTI), Chronic Kidney Disease, and hyper tonicity of the bladder. The Annual Minimum Data Set (MDS) Assessment dated 4/7/15 revealed the Resident was cognitively intact and required extensive assistance with toileting and personal hygiene. The MDS revealed the Resident was incontinent of bowel and bladder. The Care Area Assessment (CAA) dated 4/7/15 for Urinary Incontinence revealed the resident required extensive assistance with toileting. She was unable to ambulate to the restroom or bedside commode due to being unable to bear weight or pivot. The resident ' s Care Plan for ADLs (activities of daily living) dated 4/7/15 directed staff to provide incontinent care on each NA (nursing assistant) round and as needed. On 7/1/15 at 6:55 AM, NA #5 was observed to provide incontinent care for Resident #1. The NA was observed to remove the resident ' s incontinent brief which was wet and soiled with stool. The NA used pre-moistened wipes and cleaned the resident ' s buttocks and rectal area, applied a barrier cream to the resident ' s buttocks and applied a dry incontinent brief. The NA did not clean the resident ' s perineal area.	F 315	To address the issue of failure to perform proper perineal care with incontinent episodes, the CNA(s) identified by the surveyors were given 1:1 instruction and counseling regarding proper perineal care. Audits were performed by nursing staff every 2 hours for 3 days on resident #1 to ensure proper perineal care was being provided. Audits will be performed by charge nurse staff daily on each assignment on 2 random residents identified as needing assistance with ADL's, specifically incontinent care, q shift, 7a-7p & 7p-7a for 2 weeks to ensure proper perineal care is being provided. Inservices have been provided to all CNA's utilizing an anatomically correct male and female manikin in order for CNA's to provide return demonstration when performing perineal care. SDC or designee will randomly observe perineal care 3 x's per month x's 3 months. Annual inservicing will be conducted to ensure compliance on an ongoing basis. Facility statistics will be monitored monthly for 3 months by SDC or designee to review for results that may potentially be related to improper perineal	

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F 315	Continued From page 10 NA #5 stated in an interview on 7/1/15 at 7:50 AM that she knew to clean the entire perineal/rectal area from front to back every time a resident had a bowel movement to prevent urinary tract infections. The NA stated that she was nervous and forgot to do the care correctly. On 7/1/15 at 3:15 PM an interview was conducted with the Director of Nursing (DON), and the Staff Development Coordinator. The DON stated the NA should have cleaned the entire perineum including the vaginal area.	F 315	care and addressed as appropriate. Results will be forwarded to the QA Committee for additional recommendations as necessary.	
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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to transfer residents with a mechanical lift per the Functional Transfer Assessment for 2 of 3 residents observed during transfers (Resident #2 and Resident #1). 1. Resident #2 was admitted to the facility on 3/19/15 and re-admitted to the facility on 5/21/15. The resident had diagnoses of Cerebrovascular Accident (Stroke), Advanced Dementia, and Chronic Debility. Review of a Functional Transfer Assessment form dated 6/14/15 revealed Resident #2 was to be transferred with a mechanical lift with the	F 323	To ensure that the resident environment remains as free of accident hazards as is possible, the CNA working with Resident #2 was given 1:1 instruction and counseling related to proper transfer techniques, as well as, where to locate current transfer status of each resident. Transfers for Resident #1 and #2 were observed for 36 hours by charge nurses to ensure proper transfer was practiced per current transfer assessment. A list of all residents who have the same	7/24/15

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F 323	Continued From page 11 assistance of 2 persons. A Significant Change Minimum Data Set (MDS) Assessment dated 6/18/15 revealed Resident #2 had severe cognitive impairment. The MDS revealed the resident was total assist with 2 persons for transfers, was not ambulatory and had impairment in range of motion of the lower extremities. The Care Area Assessment (CAA) for Falls dated 6/19/15 revealed the resident remained a total assist with the use of a mechanical lift and the assistance of two staff members for all transfers. On 7/1/15 at 8:16AM, Resident #2 was sitting in a wheelchair while NA #1 was brushing the resident ' s hair. The NA stated Resident #2 was transferred manually with one person assist. On 7/1/15 at 10:45AM, NA#1 was observed to pick the resident up from her wheelchair and manually transfer the resident over the edge of a winged mattress and place the resident on the bed. MDS Nurse #1 stated in an interview on 7/1/15 at 11:20AM that Resident #2 was to be transferred with a mechanical lift and 2 person assist. The MDS Nurse stated with each quarterly or full assessment a transfer assessment was done. The MDS Nurse was observed to review the resident ' s Care Plan and the Kardex Report and stated the method of transfer was not on the Care Plan or the Kardex. On 7/1/15 at 2:00PM, NA #1 stated in an interview that all transfers with a mechanical lift were done with 2 persons. The NA stated when Resident #2 was first admitted she was transferred with a mechanical lift but she thought the Occupational Therapist told her the resident could be transferred with one person physical assist. Occupational Therapist #1 stated in an interview	F 323	potential to be affected by the same practice was accumulated and reviewed for accuracy and to ensure that the current transfer status was included on the resident electronic care plan, NACP and/or Kardex. To ensure that all new admissions' transfer status is communicated to Nurses and CNA's, a hard copy of the NACP will be filed in a book located at the nursing stations until the information is transferred to the electronic Care Plan and Kardex. DON or designee will audit NACP's, Care Plans and Kardex on all new residents x's 1 month to ensure that transfer status is properly added to each as assessed. All nursing staff have been inserviced on proper transfer status and where to locate current transfer status of each resident. SDC or designee to randomly inquire of staff where to locate current transfer status of residents 3 to 5 x's per week x's 2 weeks. Random staff observation of actual transfers utilizing the mechanical lift will be performed q shift, 7a-7p and 7p-7a, x's 2 weeks, then 2 transfers weekly by DON or designee for an additional 2 weeks. Results will be forwarded to the QA Committee for further recommendations if necessary.	

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on 7/1/15 at 2:41PM that with therapy the resident had improved with bed mobility but due to leg contractures the resident could not stand and pivot and was never upgraded and remained a mechanical lift transfer.
On 7/1/15 at 3:26PM NA #1 stated in an interview that she had not checked the Kardex in the computer to see how Resident #2 was supposed to be transferred. When asked if she knew how to view the Kardex in the computer the NA stated: " I do now. "
On 7/2/15 at 10:12AM an interview was conducted with the Staff Development Coordinator (SDC), the Director of Nursing (DON) and the Administrator. The SDC stated she did the transfer assessments and the MDS Nurse was supposed to transfer that information to the Care Plan and the Kardex. The Administrator stated that all the staff had been trained to use the computer system. The Administrator stated if a staff member did not know how to access information in the computer all they had to do was to ask someone and any of the staff would be glad to help them.

2. Resident #1 was admitted to the facility on 3/31/15 with diagnoses of Morbid Obesity, Lumbago, difficulty walking and stiffness in joints and Degenerative Joint Disease.

The Annual Minimum Data Set (MDS) Assessment dated 4/7/15 revealed the resident was cognitively intact and required extensive assistance in transfers with two person assist. The MDS revealed the resident had functional impairment in both lower extremities.

The Care Area Assessment (CAA) dated 4/7/15 for falls revealed the resident was to be

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transferred with the assist of a mechanical lift and 2 staff assist. The CAA revealed the resident was unable to bear weight or pivot.

The Care Plan for falls dated 4/7/15 directed staff to transfer the Resident with a mechanical lift and two person assist.

In an interview with Resident #1 on 7/1/15, she stated that she was participating in therapy twice a day and was not able to stand and transfer from her wheelchair to the bed. She further stated that she cannot remember if anyone has tried to stand and pivot her but that she was usually lifted to her wheelchair unless she was in therapy.

The Physical Therapy (PT)/Occupational Therapy (OT) Program Manager stated in an interview on 7/1/15 at 9:30 AM that the Resident had reached her maximal potential and was now in the restorative program.

In an interview with the Restorative Coordinator on 7/1/15 at 9:40 AM, she stated that Resident #1 was in restorative therapy and could presently transfer to a standing position with the use of grab bars and 2-3 person assistance. She stated that the resident only tolerated standing 10-30 seconds before she would become weak and shaky and have to sit down again in her wheelchair. The recommendation that was given to the staff on the floor was to only transfer her by lift for safety reasons because of her weakness at the present time.

Nurse # 4 stated in an interview on 7/2/15 at 7:30 AM that about a month ago she had heard that Resident #1 had been improving in therapy and thought the resident would be able to stand and

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pivot to transfer. The Nurse stated that on that night between 8:30 to 9:00 PM, she went into the resident ' s room with NA #7 and NA #8 and explained to the resident that they were going to assist her to transfer to the bed. The Nurse stated the wheelchair was positioned next to the bed and they tried to assist the resident to stand but she was not able to stand long enough to transfer to the bed. After 5-6 attempts, the resident was able to stand and pivot and sit on the bed. The Nurse stated she would not attempt to manually transfer this resident this way again because the resident did not have the strength to do so. The Nurse stated that the resident was care planned to be transferred by mechanical lift and one was available at that time.

In an interview with NA #7 on 7/2/15 at 9:01 AM, the NA stated the resident was to be transferred by mechanical lift with 2 person assistance. The NA stated she did recall one instance when she and Nurse #4 was able to get her to stand from her wheelchair and sit on her bed. NA #7 stated that it took several attempts to transfer her from the wheelchair to the bed and the resident did not stumble or fall.

The PT/OT Program Manager stated in an interview on 7/2/15 at 8:30 AM that at no time had the staff on the unit ever been encouraged to try to stand and pivot Resident #1. The Manager stated, " It was barely safe in physical therapy with much assistance and supervision and would never have the floor try it. "

An interview with the Administrator and Director of Nursing on 7/2/15 11:45 AM, it was revealed that the staff should always follow the care plan when providing care.

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F 441 SS=D	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. (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.	F 441		7/24/15

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F 441	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to perform hand hygiene after each resident contact while passing out meal trays on 1 of 5 halls (100 Hall). The facility ' s Policy titled Handwashing/Hand Hygiene dated September 2003 under Policy Statement read: " Handwashing/Hand hygiene is regarded by this facility as the single most important means of preventing the spread of infections. " Under Policy Interpretation and Implementation instructions were given to wash hands with soap and water if visibly soiled and other conditions were listed. Under Policy Interpretation and Implementation read: " 3. If hands are not visibly soiled, use an alcohol-based rub for all the following situations: a. Before direct contact with residents. g. After contact with resident ' s intact skin. i. After contact with inanimate objects in the immediate vicinity of the resident. " 1. On 7/1/15 at 11:40AM, NA #4 was observed to pass out lunch trays to residents on the 100 Hall. The NA was observed to remove a tray from the meal cart and enter the room of Resident #7 and place the tray on the over bed table. The resident was observed to be lying in bed and the NA put her arms around the resident ' s upper body and sat him up on the side of the bed. The NA then pushed the table in front of the resident and proceeded to remove the tops of the food containers for the resident to eat. The NA was observed to leave the room and return to the meal cart where she removed a meal tray and entered the room of Resident #8 and sat the tray on the over bed table. The NA #4 asked another NA to help her pull the resident up in the bed. The 2 NAs used the incontinent pad to pull the	F 441	Additional hand sanitizer dispensers were installed throughout the facility on the same day concerns regarding hand washing were brought to the attention of administration. No negative outcomes have developed as a result of this allegation. Since all residents have the same potential to be affected, all facility staff have been inserviced on proper handwashing and when to exercise appropriate handwashing during meal delivery and contact with residents. New/Updated visual reminders have been placed in various areas of the facility for increased awareness. All facility staff have been inserviced on proper handwashing technique and when appropriate handwashing standards should be exercised. Handwashing audits have been implemented to include staff observation for technique and regular practice of handwashing standards. These audits will be performed by Charge Nurse staff daily for 2 weeks on all halls at various times, then audits will be performed by SDC/Infection Control Preventionist or designee 3 x's per week for an additional 2 weeks. Results will be forwarded to the QA Committee for further recommendations.	

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resident up in the bed. The incontinent pad was not soiled. NA #4 then removed the tops of the food containers on the tray and used a spoon with a built up handle on the resident ' s tray to cut up the meat on the tray. The NA left the room and pushed the meal cart to the day room where residents were waiting for their meal tray. The NA had not washed her hands or used hand sanitizer throughout the observation. There were hand sanitizer stations observed on the 100 hall.
On 7/1/15 at 12Noon, NA #4 stated in an interview she should have used hand sanitizer between residents while passing out the meal trays.
On 7/2/15 at 10:12AM an interview was conducted with the Administrator, the Director of Nursing and the Staff Development Coordinator (SDC). The Administrator stated there were hand sanitizer stations up and down the halls for the staff to use. The SDC stated staff should wash their hands or use a hand sanitizer after contact with each resident.
2. On 6/30/15 at 11:48AM, NA #3 was observed to pass out lunch trays to residents on the 100 Hall. The NA was observed to enter the room of Resident #5 and set the food tray on the over bed table. The resident was observed lying in bed towards the left side. The NA pulled the resident to the right and positioned the resident so the resident could eat. The NA pushed the table over the bed in front of the resident and proceeded to remove the tops covering the food containers and placed the resident ' s fork on the plate. The NA was observed to exit the room and enter the room of Resident #6 whose meal tray was already on the over bed table in front of the resident. The NA was observed to re-arrange the items on the resident ' s meal tray and reposition the resident ' s bed covers. The NA walked out of

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F 441	Continued From page 18 the room and returned to the meal cart. The NA did not wash her hands or use a hand sanitizer during the observation. There were hand sanitizer stations observed on the 100 hall. On 7/1/15 at 12:30PM NA #3 stated she was so busy she did not have time to wash her hands. On 7/2/15 at 10:12AM an interview was conducted with the Administrator, the Director of Nursing and the Staff Development Coordinator (SDC). The Administrator stated there were hand sanitizer stations up and down the halls for the staff to use. The SDC stated staff should wash their hands or use a hand sanitizer after contact with each resident.	F 441		