

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/16/2015
NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF CUMBERLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306		
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F 322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to assure one of two sampled residents (Resident #5) with gastrostomy tubes received tube feedings at the physician ordered administration rate. The findings included: Record review revealed Resident # 5 was admitted to the facility on 11/06/15 with a diagnosis of dementia. Review of the resident ' s Minimum Data Set assessment, dated 11/13/15, revealed: the resident was severely cognitively impaired; weighed 99 pounds; measured 65 inches in</p>	F 322	<p>The Statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction.</p> <p>F322 How corrective action will be</p>	1/8/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/04/2016

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 322	<p>Continued From page 1</p> <p>height; and received nutrition via a gastrostomy tube in addition to meals.</p> <p>A care plan dated 11/18/15 specified Resident #5 required a tube feeding to maintain an adequate nutritional status. Interventions included on the care plan were to administer the tube feeding as ordered and to consult the registered dietician (RD) as ordered.</p> <p>A problem listed on the resident ' s care plan, dated 11/18/15, was identified as, " The resident requires tube feeding of Jevity 1.2. " One of the facility ' s goals for the resident was she would maintain an adequate nutritional status. Two of the interventions on the care plan were to administer the tube feeding as ordered and to consult the registered dietician (RD).</p> <p>Review of the physician orders revealed the current tube feeding order, dated 12/2/15, was for Jevity 1.2 to be administered at 55 cc/hour continuously for a 24 hour period. Additional review of the physician orders revealed the resident was ordered to receive a Regular diet of pureed texture in addition to the continuous enteral feeding. There were no orders for the resident ' s tube feeding to be placed on hold for the resident to eat meals.</p> <p>The resident was observed on 12/15/15 at 10:33 AM as Nurse # 1 restarted the resident ' s enteral tube feeding which had been on hold for personal care. The nurse restarted the feeding at 60cc/ hour rather than the ordered 55 cc/ hour. Nurse # 1 was interviewed at 12/15/15 at 10:35 AM.</p> <p>Nurse # 1 stated the resident ' s feeding was held during the evening meals when she was served a meal tray.</p> <p>The resident was observed again on 12/16/15 at 9:35 AM with the Director of Nursing (DON). The resident ' s feeding was observed again to be infusing at 60 cc/ hour rather than the ordered 55</p>	F 322	<p>accomplished for those residents found to have been affected by the deficient practice;</p> <p>Resident #5's tube feeding rate was adjusted to match physician's orders for administration on 12/16/2015.</p> <p>How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice;</p> <p>An audit was conducted by the Registered Dietician of all tube feeders requiring tube feeding via pump to ensure administration rate matched physician's orders. 12/29/2015</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur;</p> <p>All staff nurses were in-serviced on policy and procedure, administering intermittent/continuous tube feeding and use of feeding pump. 01/08/2016</p> <p>All newly hired staff nurses will be in-serviced during orientation. No staff nurse will be allowed to work until in-service id complete. 01/08/2016</p> <p>The Registered Dietician will audit the tube feeding rates to ensure they match the physician's order, 5 times per week, Monday-Friday, for 4 weeks, weekly for 4 weeks, monthly x 3 months, quarterly x 3 quarters and as needed. 01/08/2016</p> <p>The Registered Dietitian will evaluate enteral nutrition rates and schedules to ensure residents are receiving their estimated nutrition needs over 22 hours to allow for enteral nutrition to be held during</p>		

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F 322	Continued From page 2 cc/ hour. Directly following this observation NA (nurse aide) # 1 was interviewed with the Director of Nursing in attendance also. NA # 1 stated Resident #5 ' s tube feeding was turned off for about twenty minutes to an hour every meal time so she could eat. NA # 1 stated the resident rarely ate her meals. The DON and the RD were interviewed on 12/16/15 at 11:15 AM. The DON stated she had not been able to determine why the resident ' s tube feeding was being administered at 60 cc/ hour rather than the ordered 55 cc/ hour. The DON stated routinely facility staff obtained enteral feeding orders from the physician based on the RD ' s assessment of the resident ' s needs. The RD reviewed her notes and stated she had calculated Resident # 5 ' s nutritional needs as being met based on a continuous rate of 55 cc/ hour and had not factored into her calculations any hold times for meals. The RD reviewed Resident # 5 ' s orders and verified the administration rate of 55 cc/ hour had been the recommended and prescribed rate since 11/9/15. The RD stated this 11/9/15 order was rewritten in the computer on 12/2/15 to reflect the same order of administration in different wording and that was why the current order reflected a start date of 12/2/15 in the computer. The RD also clarified there was no order to hold the resident ' s enteral tube feeding during meals. The RD reviewed the resident ' s meal intake which ranged from 0 to 25 % of her meals. The RD stated based on the resident ' s poor meal intake it would be her recommendation the enteral tube feeding not be held for meals.	F 322	patient care/activities of daily living. 01/08/2016 How the facility plans to monitor its performance to make sure that solutions are sustained; Results of the audits will be reviewed in morning meeting 5 times per week, Monday-Friday, for 4 weeks, 1 time per week for 4 weeks, monthly times 3 months, quarterly times 3 quarters and as needed. Audit results will be reviewed in the Quality Assurance meeting monthly times 3 months, quarterly times 3 quarters and as needed.		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		1/8/16	

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F 323	<p>Continued From page 3</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to prevent falls by assuring two nurse aides obtained assistance before repositioning two residents (Residents # 2 and # 3) in bed. The findings included: 1. Record review revealed Resident # 3 was initially admitted to the facility on 4/1/15 and during the time of the survey was hospitalized for medical care. Record review revealed the resident had multiple diagnoses which included the following: cerebrovascular accident (stroke); history of respiratory arrest; history of anoxic brain injury (brain injury secondary to an incident of unoxygenated blood supply); Aphasia (inability to speak); gastrostomy tube placement, tracheostomy, and a pressure sore. Review of the resident ' s quarterly MDS (Minimum Data Set) assessment, dated 11/22/15, revealed the resident rarely or never communicated. The resident was also coded on the MDS assessment as needing two people to provide extensive assistance with bed mobility. Review of the resident ' s care plan, dated 11/23/15, revealed the directive to staff the resident required two people to assist with his bed mobility. Review of the resident ' s progress notes revealed a nurse ' s entry dated 11/24/15 at 7:43</p>	F 323	<p>F323 How corrective action will be accomplished for those residents found to have been affected by the deficient practice; NA#3 involved in resident#3's care at time of fall was given a corrective action and was re-trained on location of documentation (electronic kardex in PCC) of appropriate level of assistance needed for bed mobility and transfers on 11/24/2015 Resident #2 was discharged from the facility on 12/02/2015 All CNAs and nursing staff in-serviced on location of documentation (electronic kardex in PCC) of appropriate level of assistance needed for bed mobility and transfers.</p> <p>How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice; All residents plan of care tasks (electronic kardex in PCC) were audited for the level of assistance needed for bed mobility and transfers. 01/08/2016</p>		

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F 323	Continued From page 4 AM noting the resident rolled out of bed during care and sustained a scratch to the left side of his head. According to the DON (Director of Nursing) on 12/16/15 at 8:35 AM , NA # 3 was the NA who had been repositioning the resident when he fell from bed on 11/24/15. NA # 3 was interviewed on 12/16/15 at 8:40 AM. NA # 3 stated Resident # 3 was a resident for whom she routinely cared. NA # 3 stated the resident could not assist with turning but once he was turned to one side he would attempt to grab on to the top rail. NA # 3 stated Resident # 3 ' s bed did not have any bottom rails. NA # 3 stated on the date of the fall the resident had been incontinent of stool, and she had turned the resident on his left side without obtaining another staff member ' s assistance to provide incontinent care. NA # 3 stated the bed was not in the low position when the resident fell because she had raised it in order to provide care. NA # 3 stated she stood on the opposite side of the bed from which the resident fell because she was cleaning him of stool. NA # 3 stated as she was cleaning the resident and working to remove soiled items from under him, the resident slid out on the opposite side of the bed and fell to the floor. NA # 3 stated although the resident could hold the top rail with his hand there was not enough hand grip strength to provide him stability to avoid a fall. NA # 3 stated she knew on the date of the incident the facility Kardex system had instructions for the NAs to use two people when turning the resident. NA # 3 stated she had also seen in the computer system where she documented her daily nurse aide care that at times other NAs had turned the resident by themselves and therefore she thought it would be okay to do so on the date of the incident since others had indicated it was okay.	F 323	All residents plan of care tasks (electronic kardex in PCC) updated with appropriate level of assistance needed for bed mobility and transfers. 01/08/2016 All CNAs and nursing staff in-serviced on location of documentation (electronic kardex in PCC) of appropriate level of assistance needed for bed mobility and transfers. 01/08/2016 What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; All resident's plan of care tasks (electronic kardex in PCC) were audited for the level of assistance needed for bed mobility and transfers. 01/08/2016 All resident's plan of care tasks (electronic kardex in PCC) updated with appropriate level of assistance needed for bed mobility and transfers. 01/08/2016 All nurses and CNAs were in-serviced on where to locate the information for appropriate assistance with bed mobility and transfers. 01/08/2016 All nurses and CNAs were in-serviced to use 2 person assist with all new admits until level of assistance is assessed and plan of care tasks (electronic kardex in PCC) is populated. 01/08/2016 How the facility plans to monitor its performance to make sure that solutions are sustained; All residents plan of care tasks will be audited monthly to ensure appropriate level of staff assistance is indicated. 01/08/2016 SDC or designee will conduct random		

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F 323	<p>Continued From page 5</p> <p>The facility provided their documented investigation into the incident. The report included the notation, " CNA (certified nurse aide) was turning patient during care and patient slid off of bed. " Within the provided investigation report there was no documentation showing an investigation into why the NA made the judgement to reposition the resident by herself and an investigation into whether NAs were possibly accessing misleading computer information and/or repositioning the resident by themselves regardless of the Kardex as NA # 3 had indicated.</p> <p>On 12/16/15 at 9 AM and again at 1:15 PM the DON (Director of Nursing) was interviewed regarding the investigation into the fall and any follow up measures which were taken to prevent reoccurrence. The DON provided evidence the resident ' s care plan was updated with a new intervention on 11/24/15 of providing " floor mats. " The DON also stated she had a " Huddle meeting " on the unit where the resident had resided to remind the staff members the Kardex contained directions regarding how many people were needed to assist residents with positioning and it should be followed. Review of the " Huddle Meeting " sign in sheet revealed six nurses and 10 NAs signed as attending on 11/24/15. No further evidence of staff education was provided by the facility related to the incident. The DON was asked about any investigation into whether the NA could have seen any confusing computer information in parts of the system she accessed to enter her care notes. The DON stated she had not looked into it, and stated there could not have been any confusing information the NA would have accessed.</p> <p>2. Review of Resident # 2 ' s record revealed she resided at the facility for six days from the dates</p>	F 323	<p>audits of 10% of total census weekly x 4 weeks, monthly x 3 months, quarterly x 3 quarters and as needed, to ensure staff are following appropriate assistance levels for bed mobility and transfers. 01/08/2016</p> <p>Audit results will be reviewed in morning meeting weekly x 4 weeks, monthly x 3 months, quarterly x 3 quarters and as needed. 01/08/2016</p> <p>Results of these audits will be reviewed in QA meeting monthly x 3 months, then quarterly x 3 quarters, and as needed. 01/08/2016</p>		

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F 323	<p>Continued From page 6</p> <p>of 11/27/15 until 12/2/15. According to the record the resident was admitted to the facility after a hospitalization for Sepsis and Gangrene of both feet. Review of the resident ' s record revealed while hospitalized the resident had undergone an amputation of her right leg below the knee and a left toe amputation.</p> <p>According to the record the resident was admitted at 3:45 PM on 11/27/15 and had arrived via a stretcher and two attendants. The admitting nurse made notations of the following in the resident ' s admission note; the resident had oxygen infusing; the resident had both a wound vac and dressing to an open wound; the resident needed the narcotic Percocet for pain; and the resident required assistance with her activities of daily living.</p> <p>Record review revealed within 14 hours of the resident ' s facility admission she rolled out of bed during personal care. Documentation regarding the incident included the notation that Resident # 2 was found " on her knees on the floor and her arms clinging to her bed side rail " at 5:45 AM on 11/28/15. The investigative report also noted the resident complained of her knees hurting. There was a notation made within the report, " Resident was receiving assistance with care, and when she tried to help with turning she rolled off the bed clinging on to the side rail and kneeling on the floor "</p> <p>Interview with the DON on 12/16/15 at 9 AM revealed newly admitted residents are considered a one to two person assist while rehab staff members assess their needs and determine the extent of assistance they require, and Resident # 2 was receiving care by one nurse aide on the day of the incident. The DON stated following the incident with Resident # 2, directions were placed on her care plan instructing the staff the resident</p>	F 323			

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F 323	Continued From page 7 needed two people to assist her with positioning. Review of the resident ' s care plan revealed the start date was 11/30/15 for the problem identified as " The resident is at risk for falls r/t confusion. " The care plan contained the directive " two person bed mobility. " There was no documentation in the provided investigative report showing the facility staff investigated why the direct care staff did not identify Resident # 2 needed two people to assist her in mobility prior to 11/30/15 and how they made the determination on 11/29/15 to proceed with one person in attendance for care.	F 323			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure it was free of significant medication errors in relation to one (Resident # 2) of two sampled residents ordered to receive antibiotic therapy. The findings included: Record review revealed Resident # 2 resided at the facility from 11/27/15 until 12/2/15. Hospital records located on the resident ' s facility chart revealed the following documentation regarding the resident ' s hospital history prior to her transfer for care at the facility: The discharging physician noted the resident was to be discharged to the facility on 11/27/15. He also noted the resident had a history of diabetes, chronic kidney disease, severe peripheral arterial	F 333	F333 How corrective action will be accomplished for those residents found to have been affected by the deficient practice; Nurse #2 was given a coaching/counseling for failing to follow facility policy/procedure for ordering, receiving, and administering medications. 01/08/2016 Nurse #2 was in-serviced on facility policy/procedure for ordering, receiving, and administering medication. 01/08/2016 How corrective action will be accomplished for those residents having	1/8/16	

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F 333	<p>Continued From page 8</p> <p>disease, osteomyelitis (infection of the bone), and she had initially been admitted to the hospital on 11/14/15 with " severe sepsis and gangrene in both feet. " The physician further noted the resident had undergone an amputation of her right leg below the knee and also an amputation of one left toe while hospitalized. The physician also noted within the discharge records the infectious disease physician had recommended the resident be switched from intravenous antibiotics to the oral antibiotic Bactrim DS. Review of the prescribed list of discharge medications for the resident on 11/27/15 included " Bactrim DS (Double Strength) 800 mg (milligrams)-160 mg tablet to be given twice per day.</p> <p>Review of the hospital 11-27-15 MAR (Medication Administration Record), located with the resident ' s transfer paperwork, revealed the resident had received Intravenous Vancomycin at 10:15 AM on the date of her transfer. No other antibiotic was documented as given after 10:15 AM prior to Resident # 2 ' s discharge to the facility.</p> <p>Review of the hospital records revealed the hospital physician had been monitoring the resident ' s WBC (white blood count) secondary to her infection and she was scheduled to follow up with an infectious disease physician following discharge. Review of the resident ' s lab work revealed the resident ' s WBC was 19.0 on the day of transfer (11/27/15) with a normal WBC range noted by the lab as 4.5 to 12.5.</p> <p>Review of the resident ' s facility record revealed a facility nurse documented the resident was admitted to the facility at 3:45 PM on 11-27-15. The nurse documented the following notes within</p>	F 333	<p>potential to be affected by the same deficient practice</p> <p>All new admissions since, 01/08/2016 were audited to determine if medications were given appropriately after admission, by the Director of Nursing, Staff Development Coordinator and Unit Managers. 01/08/2016</p> <p>All licensed nursing staff have been in-serviced on facility policy/procedure for ordering, receiving, and administering medications. 01/08/2016</p> <p>All newly hired licensed nurses will receive in-service training on facility policy/procedure for ordering, receiving, and administering medications at orientation. 01/08/2016</p> <p>What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur</p> <p>Medication orders, received before 5pm, for new admissions, will be entered into the electronic record queue by the Director of Nursing or designee, Monday-Friday. The charge nurse will be responsible for confirming the orders with the physician, and obtaining the medications per policy and procedure, when the patient arrives at the facility. After 5 pm and on weekends, the charge nurse will be responsible for entering the medication orders into the electronic medical record within 2 hours of the patient's arrival to the facility and obtaining the medications for administration per policy and procedure. The charge nurse will notify the Director of</p>		

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F 333	<p>Continued From page 9</p> <p>the record, " ...left lower leg red and open areas, 3rd toe amputated. Wound vac to be in placelight greenish area on right leg "</p> <p>Review of the resident ' s November 2015 facility MAR revealed the Bactrim DS antibiotic was placed on an administration schedule of 9 AM and 6 PM. The MAR documentation reflected the Bactrim DS was not administered at the 6 PM evening scheduled time on 11/27/15. This MAR reflected the first dose of Bactrim DS was given at 9 AM on the day following admission (11/28/15). Review of both the hospital records and facility records revealed no documentation the Bactrim DS was to be started on 11/28/15 rather than 11/27/15.</p> <p>Nurse # 2 was the evening shift nurse who admitted the resident to the facility on 11-27-15. Nurse # 2 was interviewed on 12/15/15 at 3:45 PM. Nurse # 2 reviewed her notations and verified the resident had been admitted at 3:45 PM on 11-27-15. The nurse stated there were several things going on with different residents the afternoon Resident # 2 was admitted. Nurse # 2 stated in addition to addressing those issues, she had to verify Resident # 2 ' s admission orders with the physician who was to care for the resident at the facility. Nurse # 2 stated she then entered some of the resident ' s medication orders into the computer and gave some of the resident ' s medications such as her pain medication. Nurse # 2 stated there would have been a record of any medications she gave from the emergency medication supply box. Nurse # 2 stated she additionally had to administer medications to her other assigned residents, and the supervisor had told her she would be over to the unit and assist in completing the order entry</p>	F 333	<p>Nursing or designee if unable to enter the medication orders within 2 hours and/or unable to obtain medications per policy and procedure, for further instruction. Unit Managers will audit all new admission physician's orders 5 times per week for 4 weeks, bi-weekly times 4 weeks, then monthly times 1 month, to ensure compliance with facility policy/procedure for ordering, receiving, and administering medications. 01/08/2016</p> <p>Results of the audits will be reviewed in the Quality Assurance Risk Meeting weekly times 4 weeks, bi-weekly times 4 weeks, and monthly times 1 month. Any areas identified will be corrected immediately and licensed nursing staff will be in-serviced to changes in the current plan.</p> <p>How the facility plans to monitor its performance to make sure the solutions are sustained</p> <p>All results of the physician order audits will be reviewed in the Quality Assurance meeting monthly times 3 months, then quarterly times 3 quarters, and as needed.</p>		

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F 333	<p>Continued From page 10</p> <p>process for Resident # 2. Nurse # 2 stated the supervisor remained busy and did not have the opportunity to come and assist. Nurse # 2 stated she also remained busy and entered the rest of Resident # 2 ' s medication orders into the computer after her evening shift duties. Review of the resident ' s November facility MAR with Nurse # 2 revealed the Bactrim DS order was entered on 11/28/15 at 2:02 AM.</p> <p>The DON (Director of Nursing) was interviewed on 12/15/15 at 1:55 PM regarding the facility ' s pharmacy system. Regarding new admissions, the DON stated if a newly admitted resident arrived before 5 PM then the medications could be obtained from their regular pharmacy. The DON stated the pharmacy would receive the new orders when they were entered into the computer following admission. The DON stated if a resident was admitted after 5 PM then medications could be obtained from a back-up emergency supply and if the medication was not one which was stocked within the emergency supply, then the back-up pharmacy could be called. The DON stated Bactrim DS was a medication which was stocked in the facility ' s emergency supply and would have been available for administration for Resident # 2 ' s evening dose of 11/27/15.</p> <p>Following the interview with Nurse # 2 noted above on 12/15/15 at 3:45 PM, the DON was again interviewed. Interview with the DON revealed the computer access to records showing medications which had been dispensed from the emergency supply was not working. The DON stated when the computer system was accessible again she would provide any documentation showing if the Bactrim DS had been dispensed and administered on 11/27/15 from the</p>	F 333			

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F 333	Continued From page 11 emergency supply. On the dates of 12/15/15 and 12/16/15, no evidence was provided showing the 11/27/15-- 6 PM dose of Bactrim DS had been dispensed and administered to Resident # 2.	F 333			
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	F 441		1/8/16	

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F 441	<p>Continued From page 12</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to assure a staff member washed her hands between assisting with incontinent care and obtaining linen from the clean linen supply room for one (Resident # 5) of two sampled residents observed during direct care. The findings included. Resident # 5 was observed on 12/15/15 at 10:10 AM as NA (nurse assistant) # 2 assisted another NA to provide incontinent care for the resident whose disposable brief was heavily soiled with stool. During the care some of the stool also got on the draw sheet as the NAs worked to care for the resident. NA # 2 removed and disposed of her gloves in preparation to go get a clean draw sheet. The NA did not wash her hands after removing her gloves, exiting the room, entering the clean linen room, obtaining a clean draw sheet, and returning to the room to continue care with a new set of gloves she then donned. Following the care NA # 2 was interviewed on 12/15/15 at 10:30 AM about hand washing. The NA did not have an explanation why she had not washed her hands between caring for the soiled resident and entering the clean linen room.</p>	F 441	<p>F441 How corrective action will be accomplished for those residents found to have been affected by the deficient practice; NA #2 was given a corrective action and was in-serviced on policy #401, Hand washing Requirements on 12/31/2015</p> <p>How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice; All staff in-serviced on policy #401, Hand washing Requirements 01/08/2016</p> <p>What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur; All staff in-serviced on policy #401, Hand washing Requirements 01/08/2016 All newly hired staff will be in-serviced on policy #401 during orientation. No staff member will be allowed to work until in-service completed. 01/08/2016 SDC or designee will conduct random audits of 10% of total census every week x 4 weeks, monthly x 3 months, then quarterly x 3 quarters and as needed, to ensure staff are following appropriate hand washing guidelines.</p>		

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F 441	Continued From page 13	F 441			
F 520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as</p>	F 520	<p>How the facility plans to monitor its performance to make sure the solutions are sustained Results of the hand washing audits will be reviewed in morning meeting weekly times 4 weeks, monthly times 3 months, quarterly times 3 quarters. Results of the hand washing audits will be reviewed in the Quality Assurance meeting monthly times 3 months, quarterly times 3 quarters and as needed.</p>	1/8/16	

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F 520	<p>Continued From page 14 a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in July 2015. This was for one recited deficiency which was originally cited in July of 2015 on a complaint investigation and on the current complaint survey. The deficiency was in the area of providing supervision to prevent accidents. The continued failure of the facility during two federal surveys within a yearly survey cycle shows a pattern of the facility ' s inability to sustain an effective Quality Assurance Program.</p> <p>Findings included:</p> <p>This tag is cross referred to:</p> <p>F323: Supervision to Prevent Accidents: Based on record review and staff interviews the facility failed to prevent falls by assuring nurse aides obtained assistance before repositioning two residents (Resident # 2 and # 3) in bed.</p> <p>The facility demonstrated deficient practice during the 7/22/15 complaint investigation when they failed to implement effective interventions necessary to prevent a resident who had a tracheostomy from dislodging and removing the tracheostomy tube. The facility was found to have deficient practice during the 12/16/15 complaint investigation when two residents, needing extensive assistance with bed mobility, rolled</p>	F 520	<p>F520 How corrective action will be accomplished for those residents found to have been affected by the deficient practice; F323-See associated tag for individual interventions</p> <p>How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice; Individual actions denoted on said area for citations F323</p> <p>What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur; Education provided to Facility Administration by Corporate Consultant on QA process and it's relation to plan of correction on (date). Administrator, DON, Unit Manager, or designee will ensure completion of audits for F323 on Mondays, Wednesdays and Fridays times 2 months, then every Wednesday times 10 months. Plan of correction for F323 will be reviewed during morning meeting, weekly x 4 weeks, monthly x 3 months, quarterly x 3 quarters and as needed. 01/08/2016</p> <p>How the facility plans to monitor its performance to make sure the solutions</p>		

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F 520	Continued From page 15 from the bed into the floor during personal care. During an interview on 12/16/15 at 9:00 AM, the DON (Director of Nursing) stated the facility had re-educated staff on the unit where Resident # 3 resided after he fell from bed while a nurse aide positioned the resident for care without obtaining another staff member ' s assistance. Review of the education training documentation revealed the training was limited to the staff on Resident # 3 ' s hall. Review of records revealed another sampled resident, Resident # 2, sustained a fall four days following the fall sustained by Resident # 3. Resident # 2 ' s fall was also related to a nurse aide attempting to position and care for the resident without obtaining assistance. There was no documentation in the accident investigation reports noting why the involved nurse aides had decided to attempt the care without obtaining assistance. Review of the residents ' room numbers revealed Resident # 2 resided on a different hall than Resident # 3.	F 520	are sustained Administrator/DON will present audits to QA committee monthly times 12 months for review and revision as needed. This time frame may be extended at the discretion of the Administrator/DON based on results of audits. 01/08/2016		