STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews, the facility failed to provide personal care for 1 of 3 residents reviewed for activities of daily living (Resident #182). The findings included: The facility ' s undated Shaving Policy read: "Shaving is a part of the male patient ' s usual daily care. Besides reducing bacterial growth on the face, shaving promotes patient comfort by removing whiskers that can itch and irritate the skin and produce an unkempt appearance." Resident #182 was admitted to the facility on 8/29/17 and had a diagnosis of cerebrovascular accident (stroke) and bipolar disorder. The Admission Minimum Data Set (MDS) Assessment dated 9/5/17 revealed the resident was cognitively intact but had verbal behavioral symptoms toward others and behavioral symptoms not directed toward others for 1-3 days of the 7 day assessment period. The MDS revealed the resident required extensive assistance for personal hygiene and did not reject care. The Care Area Assessment (CAA) dated 9/5/17	F 312	Shaving (ADL Care) was provided to Resident #182 by a certified assistant upon identification on 09/27/17. Facility rounds by the Director of Nursing Services (DON), Assistant Director of Nursing (ADON), and Staff Development Coordinator (SDC) were completed to insure that no other residents in the center were affected by this deficient practice on 9/28/17. It was found that no other residents were found in this manner. Shaving and ADL review of education has been completed by 10/09/17 by the SDC and DON to Licensed nurses and certified nursing assistants. Education regarding shaving and provision of ADL care was provided to Certified Nursing Assistants and Licensed Nurses was provided by the DON, SDC, or ADON; this education was complete by 10/09/17. This training will also be provided to nurse assistants upon hire during orientation and at least annually through a skills review. Ongoing audits by the DON, SDC, or ADON for observation and review of shaving care provided to residents of the	10/10/17

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

Electronically Signed | 10/10/2017

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F 312	Continued From page 1 for Cognitive Status revealed the resident had a diagnosis of encephalopathy (refers to a syndrome of overall brain dysfunction) and bi-polar disorder. The CAA noted the resident was usually able to make his needs known and understood others but did have periods of confusion and paranoia. The CAA for Activities of Daily Living (ADLs) noted the resident had generalized weakness and had required extensive assistance with ADLs. The CAA for Behaviors noted the resident had behaviors to include being verbally abusive towards staff. The Care Plan for Resident #182 dated 9/7/17 revealed the resident had an ADL self care deficit related to generalized weakness and periods of confusion. The Care Plan instructed staff to provide the amount of assistance/supervision needed to meet the resident ' s needs for all ADLs. On 9/26/17 at 8:30 AM, Resident #182 was observed sitting in his room in a wheelchair fully dressed and appeared unkempt with several days growth of facial hair. The resident stated he needed a shave. The resident commented he could not shave himself and did not have a razor anyway. On 9/27/17 at 2:00 PM, the resident was observed sitting in his wheelchair outside in front of the facility. The resident appeared unkempt as he had not been shaved. On 9/27/17 at 3:09 PM an interview was conducted with NA (Nursing Assistant) #2 who was assigned to Resident #182 on the 7 AM to 3 PM shift that day. When asked when the male residents were shaved, the NA stated during	F 312	facility. These audits will be at varied times, on all shifts and conducted 5 days per week for two weeks, then weekly for two weeks, then monthly for three months. These audits will also include no less than 10% of the population of the center, and will also include residents that may not be able to make their needs known or provide their own ADL care. All data will be summarized and presented to the facility Quality Assurance Performance Improvement (QAPI) meeting monthly by the DON or SDC. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.	

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F 312	Continued From page 2 morning care they asked the resident if they wanted to be shaved. The NA further stated she did not ask the resident if he wanted to be shaved that morning and asked "does he want to be shaved." On 9/28/17 at 2:44 PM an interview was conducted with the Administrator and the Director of Nursing (DON). The Administrator stated male residents were shaved according to their preference.	F 312		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the	F 441		10/10/17

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F 441	Continued From page 3	F 441		

facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their

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F 441	Continued From page 4 program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, facility staff failed to sanitize their hands between resident contacts during a meal observation on 1 of 3 unit halls (Unit 1). The findings included: On 9/25/17 at 12:35 PM meal trays were observed to be delivered to the residents in their rooms on Unit 1. NA (Nursing Assistant) #1 was observed to remove a meal tray from the meal cart and take the tray to the resident in room 19. The NA was observed to put a clothing protector on the resident and set up the meal tray for the resident to eat. The NA was observed to return to the meal cart, removed another tray and entered room 22 and placed the tray on the resident ' s over bed table. The NA placed the palms of both hands on the over bed table, one on either side of the meal tray and had a conversation with the resident. The NA was then observed to exit the room and enter room 20 and covered a resident with a sheet. The NA was observed to exit the room and return to room 19, sit down beside the resident ' s bed and assisted the resident to eat. During the observation, the NA did not wash her hands or use a hand sanitizer. On 9/25/17 at 1:06 PM, NA #1 stated in an interview she knew she was supposed to wash her hands between residents but was in a hurry. On 9/28/17 at 2:49 PM an interview was conducted with the Administrator and the Director of Nursing (DON). The Administrator and the DON stated the NA should have washed her	F 441	Education was provided to NA #1 by the Director of Nursing Services (DON) and Staff Development Coordinator (SDC) on September 25, 2017 to reduce the potential risk of infection control and to reinforce the facility policy and procedure related to hand hygiene. CNA□s and Licensed nurses were educated on proper hand hygiene by the SDC no later than 10/09/17 regarding the facility□s hand hygiene policy and procedure. Nursing assistants have been educated by the SDC or DON by 10/09/17 through return demonstration and/or education on proper hand hygiene. This training will be provided to all nurse assistants upon hire during orientation and at least annually through skills review. Licensed nurses will observe and document observation of meal service on varying units of the facility to ensure the center is meeting the expectation of hand hygiene between meal tray deliveries. These audits will occur five days per weeks for two weeks, then weekly for two weeks, then monthly for three months. All data will be summarized and presented to the facility Quality Assurance Performance Improvement (QAPI) meeting monthly by the DON or SDC. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will	

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F 441	Continued From page 5 hands or used a hand sanitizer between resident contacts.	F 441	be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services.	