| | - | ID HUMAN SERVICES | | | | FOR | M APPROVED | | |
|---------------|--|---|---------|-----------------------|---|-------|-----------------------|--|--|
| | S FOR MEDICARE & | MEDICAID SERVICES | | | | | <u> </u> | | |
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | PLE CONSTRUCTION | COM | E SURVEY PLETED | | |
| | | 345126 | B. WING | | | | C / 03/2018 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| | | | | 228 SMITH CHAPEL ROAD | | | | | |
| | | | | | | | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTIO | N | (X5) | | |
| PREFIX | | Y MUST BE PRECEDED BY FULL | PREF | | (EACH CORRECTIVE ACTION SHOULD | | COMPLETION DATE | | |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION) | | TAG | j | CROSS-REFERENCED TO THE APPROP DEFICIENCY) | RIATE | DATE | | |
| | | | | | | | | | |
| F 656 SS=D | CFR(s): 483.21(b)(1) | | F | 65 | i6 | | 10/30/18 | | |
| | §483.21(b) Comprehe | | | | | | | | |
| | | cility must develop and | | | | | | | |
| | | nensive person-centered | | | | | | | |
| | | sident, consistent with the | | | | | | | |
| | | th at §483.10(c)(2) and | | | | | | | |
| | §483.10(c)(3), that inc | | | | | | | | |
| | | ames to meet a resident's | | | | | | | |
| | - | mental and psychosocial | | | | | | | |
| | | ied in the comprehensive | | | | | | | |
| | assessment. The con | nprehensive care plan must | | | | | | | |
| | describe the following |] - | | | | | | | |
| | (i) The services that a | are to be furnished to attain | | | | | | | |
| | or maintain the reside | ent's highest practicable | | | | | | | |
| | physical, mental, and | psychosocial well-being as | | | | | | | |
| | required under §483.2 | 24, §483.25 or §483.40; and | | | | | | | |
| | (ii) Any services that | would otherwise be required | | | | | | | |
| | under §483.24, §483. | 25 or §483.40 but are not | | | | | | | |
| | provided due to the re | esident's exercise of rights | | | | | | | |
| | under §483.10, incluc | ling the right to refuse | | | | | | | |
| | treatment under §483 | 8.10(c)(6). | | | | | | | |
| | (iii) Any specialized se | ervices or specialized | | | | | | | |
| | rehabilitative services | the nursing facility will | | | | | | | |
| | provide as a result of | PASARR | | | | | | | |
| | recommendations. If | a facility disagrees with the | | | | | | | |
| | findings of the PASAF | RR, it must indicate its | | | | | | | |
| | rationale in the reside | ent's medical record. | | | | | | | |
| | (iv)In consultation with | h the resident and the | | | | | | | |
| | resident's representat | | | | | | | | |
| | (A) The resident's goa | | | | | | | | |
| | desired outcomes. | | | | | | | | |
| | | eference and potential for | | | | | | | |
| | future discharge. Fac | | | | | | | | |
| | | s desire to return to the | | | | | | | |
| | | ssed and any referrals to | | | | | | | |
| | - | - | | | | | | | |
| | | s and/or other appropriate | | | | | | | |
| | entities, for this purpo | | | | | | | | |
| | (C) Discharge plans i | n the comprehensive care | | | | | | | |
| | DIRECTOR'S OR PROVIDER/S | SUPPLIER REPRESENTATIVE'S SIGNATUR | RE | | TITLE | | (X6) DATE | | |

Electronically Signed

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.

10/24/2018

PRINTED: 11/05/2018

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | | RM APPROVE 10. 0938-039 |
|--------------------------|---|---|--------------------|-----|---|--|----------------------------|
| TATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 345126 | B. WING | | | | C 0/03/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | 0/03/2010 |
| | | | | | 28 SMITH CHAPEL ROAD | | |
| MOUNT O | LIVE CENTER | | | | NOUNT OLIVE, NC 28365 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ЗE | (X5) COMPLETIO DATE |
| F 656 | Continued From page | e 1 | F | 656 | | | |
| 1 000 | plan, as appropriate, requirements set forth section. This REQUIREMENT | in accordance with the h in paragraph (c) of this Γ is not met as evidenced | | 000 | | | |
| | by: Based on observation, staff and physician interviews, and record reviews the facility failed to correctly implement a plan of care by not following appropriate hand hygiene during care to avoid contaminating a resident 's bathing water with stool during a bed bath and using a contaminated, wet glove to adjust a pressure ulcer dressing for 1 of 3 resident reviewed for providing care according to resident care plans. (Resident #3) Findings included: Resident #3 was admitted to the facility on 1/25/18. Resident #3 's active diagnoses | | | | This Plan of Correction is prepared ar submitted as required by law. By submitting this Plan of Correction, Mor Olive Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statement findings, facts, or conclusions that forr the basis for the alleged deficiency. T Center reserves the right to challenge legal and/or regulatory or administrativ proceedings the deficiency, statement facts, and conclusions that form the bas for the deficiency. F-656 | unt nts, n he in /e s, asis | |
| | hyperplasia, arthritis, accident, functional q posture. | ertension, benign prostatic aphasia, cerebrovascular juadriplegia, and abnormal | | | Resident #3 was affected by this pract Care Plan for Resident # 3 was review for accuracy and Care Card updated to assure resident receives appropriate wound care. | ved | |
| | Review of Resident #3 's most recent minimum data set assessment dated 7/10/18 revealed the resident was assessed as severely cognitively impaired. Resident #3 had no moods or behaviors. Resident #3 was totally dependent on staff for bed mobility, dressing, eating, toilet use, | | | | This practice has the ability to affect al residents. The Care Plan and Care C have been reviewed for all Current residents receiving PU wound care. | | |
| | incontinent of bowel a present during the as one stage II pressure pressure ulcer at the | e. The resident was always and bladder. Pain was not seessment. Resident #3 had e ulcer and one stage III time of the assessment. The g pressure ulcer care. | | | Clinical staff received training by the CNE/NPE/Designee on the importance reviewing and following the resident C Plan to assure listed interventions are being followed. Training completed or 10/2/18, 10/22/18, 10/23/18, and | are | |
| | Review of Resident # | ¢3 ' s skin integrity report | | | 10/24/18. Unit Managers will continue audit Pressure Ulcer care to assure ca | | |

Facility ID: 923344

If continuation sheet Page 2 of 12

| | | | | | | NO. 0938-03 |
|--------------------------|---------------------------|---|---------------------|---|------------------------------|---------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | LE CONSTRUCTION | · · · · | ATE SURVEY OMPLETED |
| | | | A. BUILDING | i | | |
| | | 345126 | B. WING | | | С |
| | | 545120 | B. WING | | | 10/03/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | DE | |
| MOUNT O | LIVE CENTER | | | 228 SMITH CHAPEL ROAD | | |
| | 1 | | | MOUNT OLIVE, NC 28365 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | N SHOULD BE E APPROPRIATE | (X5) COMPLETIO DATE |
| F 656 | Continued From page | e 2 | F 65 | 6 | | |
| | 1.0 | returned from the hospital | 1 00 | is being provided in accorda | nce with the | |
| | | v unstageable wound to | | care plan. All pressure ulcer | | |
| | | p identified upon admission | | will be reviewed with the Uni | | |
| | | 18 the wound was measured | | (UM) in the Clinical At Risk (| • | |
| | to be 4.5 centimeters | long, 6.5 centimeters wide, | | weekly to assure care is beir | | |
| | and less than 0.1 cer | | | as required and care plans w | vill be | |
| | | | | modified as needed. | | |
| | | 3 ' s care plan dated 9/26/18 | | | | |
| | | was care planned for actual | | | | |
| | | ed to pressure areas to | | Care Plan audits for resident | | |
| | | t ankle. The interventions | | pressure ulcers will be comp | | |
| | | n in turning and repositioning nt intervals and provide peri | | the(UM)3 times a week for 3 ensure that interventions are | | |
| | · | e care as needed. He was | | accordingly. Audits will be c | | |
| | | require assistance with | | residents who may develop i | | |
| | activities of daily livin | - | | Results will be reviewed with | | |
| | | 3 | | and Center Nurse Executive | | |
| | During observation of | n 10/2/18 at 12:38 PM Nurse | | QAPI meeting for three mont | | |
| | Aide #1 and Nurse Ai | de #2 were observed | | be extended or otherwise ad | justed based | |
| | | 3 a bed bath and incontinent | | on compliance and any addit | tional | |
| | | s on the right side. A fresh | | findings. | | |
| | | in place on Resident #3 ' s | | | | |
| | left ischium unstagea | | | | | |
| | | ches of the dressing on the ble pressure ulcer had | | | | |
| | - | sident #3 ' s skin leaving a | | | | |
| | | one inch. Nurse Aide #1 | | | | |
| | had one bin of warm | | | | | |
| | | and was using no-rinse | | | | |
| | | had cleaned Resident #3 ' s | | | | |
| | upper body and had l | - | | | | |
| | | se Aide #2 observed that | | | | |
| | | sident #3 's brief and | | | | |
| | | urse Aide #1 then used a | | | | |
| | | er right hand to wipe the | | | | |
| | | nt, folding the washcloth | | | | |
| | - | III amount of stool was Irse #1 ' s glove on her right | | | | |
| | | then reached for a new | | | | |

Facility ID: 923344

If continuation sheet Page 3 of 12

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | D: 11/05/2018 APPROVED D: 0938-0391 |
|--------------------------|-------------------------------|---|-------------------|-----|--|-------------------|---|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | E CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
| | | 345126 | B. WING | | | | C 03/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| MOUNT O | LIVE CENTER | | | | | | |
| | | | 10 | | MOUNT OLIVE, NC 28365 PROVIDER'S PLAN OF CORRECTION | | (15) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREF TAG | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 656 | Continued From page | 93 | F | 656 | 5 | | |
| | | ht hand still having the | | | | | |
| | | nd and a small amount of be smeared on the new | | | | | |
| | washcloth. Nurse Aid | e #1 placed this washcloth | | | | | |
| | | th the glove in the bin of wrung the washcloth out | | | | | |
| | into the bin of water. | At this point, Nurse Aide #1 | | | | | |
| | observed the dressing | | | | | | |
| | - | er had pulled away from the se Aide #1 used her right | | | | | |
| | hand with the same s | oiled glove to reattach the | | | | | |
| | - | Her hand was still wet from en using. Nurse Aide #1 ' s | | | | | |
| | | g fingers were under the | | | | | |
| | - | bandage and her thumb | | | | | |
| | | the adhesive edge of the distribution difference of the skin and | | | | | |
| | replaced it. The band | age was slightly damp I touched the bandage. | | | | | |
| | During an interview 1 | 0/2/18 at 12:50 PM Nurse | | | | | |
| | Aide #1 stated she di | d remember not changing | | | | | |
| | | Resident #3 ' s bowel used the same hand to soak | | | | | |
| | | er back into the basin. She | | | | | |
| | | not notice the feces on her | | | | | |
| | | the next rag. The nurse aide nember which hand she | | | | | |
| | used to replace the p | ressure ulcer bandage. | | | | | |
| | | stated if it was her right | | | | | |
| | | lace the wound dressing she that hand because of the | | | | | |
| | | and infection and it was not | | | | | |
| | - | n 10/2/18 at 12:58 PM the | | | | | |
| | | ated it was her expectation e soiled gloves, wash their | | | | | |
| | hands, and then don | | | | | | |

| | | | 0.00 | | |
|--------------------------|-------------------------------|--|---------------------|---|-------------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | | A. BUILDING | | с |
| | | 345126 | B. WING | | 10/03/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| | | | | 228 SMITH CHAPEL ROAD | |
| MOUNT O | LIVE CENTER | | | MOUNT OLIVE, NC 28365 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE COMPLETIC |
| F 656 | Continued From page | e 4 | F 65 | 6 | |
| | | further stated the reason | 1 00 | 0 | |
| | | iff to not touch bandages | | | |
| | - | as because of the risk for | | | |
| | infection to the woun | | | | |
| | | | | | |
| | | on 10/2/18 at 2:29 PM | | | |
| | - | ician stated it was best ot touch wound dressings | | | |
| | | e further stated in the facility | | | |
| | | n wound dressings not be | | | |
| | touched by contamin | - | | | |
| F 677 | ADL Care Provided for | or Dependent Residents | F 67 | 7 | 10/30/18 |
| SS=D | CFR(s): 483.24(a)(2) |) | | | |
| | 8483 24(a)(2) A resid | lent who is unable to carry | | | |
| | | living receives the necessary | | | |
| | | good nutrition, grooming, and | | | |
| | personal and oral hy | | | | |
| | This REQUIREMENT | Γ is not met as evidenced | | | |
| | by: | | | | |
| | | on, staff interviews, and | | F-677 | |
| | record review the fac | dent 's bathing water with | | Resident #3 was affected by this pra Wound was immediately cleansed a | |
| | | a resident 's bed bath for 1 | | new dressing applied. Resident #3 v | |
| | | ents reviewed for activities of | | given a new bath to assure cleanline | |
| | daily living care. (Res | | | | |
| | | | | This practice has the ability to affect | |
| | Findings included: | | | residents. Dependent residents are | |
| | Pesident #3 was ada | nitted to the facility on | | receiving ADL care as required and care planned. | as |
| | | nitted to the facility on agnoses included aphasia, | | | |
| | | dent, functional quadriplegia, | | Clinical staff received training by the | e |
| | and abnormal postur | | | CNE/NPE/Designee on infection co | |
| | | | | practices, such as hand washing, do | |
| | | <i>t</i> 3 ' s most recent minimum | | and removing gloves, total bed bath | |
| | | dated 7/10/18 revealed he | | pericare, aseptic technique, dressin | |
| | | verely cognitively impaired. | | changes and care cards with return | |
| | He had no moods or | behaviors. Resident #3 was | | demonstration at time of in-servicing | a. I |

Facility ID: 923344

If continuation sheet Page 5 of 12

| STATEMENT (| DF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | LE CONSTRUCTION | (X3) DA | 10. 0938-039 FE SURVEY MPLETED |
|--------------------------|---|--|---------------------|--|---|--------------------------------------|
| | CONTRECTION | BENTI IOATION NOWBEN. | A. BUILDING | i | | C |
| | | 345126 | B. WING | | 1 | 0/03/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | I | | STREET ADDRESS, CITY, STATE, ZIF | | |
| MOUNT | | | | 228 SMITH CHAPEL ROAD | | |
| MOUNTO | LIVE CENTER | | | MOUNT OLIVE, NC 28365 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETIOI DATE |
| F 677 | Continued From page | e 5 | F 67 | 7 | | |
| | totally dependent on a dressing, toilet use, a was always incontine Review of Resident # revealed he was care assistance with activi interventions included Resident #3 for toileti During observation of Aide #1 and Nurse Ai providing Resident #3 care. Resident #3 wa Aide #1 had one bin of bedside, multiple was no-rinse soap. Nurse Resident #3 's upper remove the resident ' observed that there w brief and removed the used a damp washcle the stool from the res multiple times. A sma observed to be on Nu hand. Nurse Aide #1 washcloth with her rig same glove on the ha stool was observed to washcloth. Nurse Aid and her right hand wi warm water and then into the bin of warm wa | staff for bed mobility, ind personal hygiene. He int of bowel and bladder. 3's care plan dated 9/26/18 e planned to require ties of daily living care. The d to provide total care to ing and bathing. In 10/2/18 at 12:38 PM Nurse de #2 were observed a bed bath and incontinent s on his right side. Nurse of warm water at the sh cloths, and was using Aide #1 had cleaned body and had begun to s brief. Nurse Aide #2 vas stool in Resident #3 's e brief. Nurse Aide #1 then oth in her right hand to wipe ident, folding the washcloth ill amount of stool was urse #1 's glove on her right then reached for a new ght hand still having the and and a small amount of o be smeared on the new e #1 placed this washcloth th the glove in the bin of wrung the washcloth out Nurse Aide #1 used the ter to complete the resident ' d feet. She did not replace | | Training completed on 10 10/23/18, and 10/24/18. J ulcers will be added to the interventions. Unit Manage check on care provided to procedures are being foll on results weekly at the 0 Infection Control Audits to by the Unit Managers 3 to months. Audits to include total bed baths, pericare, removing gloves, care ca on their person, aseptic to verbalization of process of Results will be reviewed Managers and Center Nut the QAPI meeting for the based on compliance and findings. | All pressure e care cards with gers will randomly o assure proper lowed and report CAR Meeting. o be completed imes a week for 3 e hand washing, donning and ard observation echnique and with dressings. with the Unit urse Executive at ee months and erwise adjusted | |
| | | 0/2/18 at 12:50 PM Nurse d remember not changing | | | | |

If continuation sheet Page 6 of 12

| | MENT OF HEALTH AN S FOR MEDICARE & I | | | | | FORM | D: 11/05/2018 APPROVED 0. 0938-0391 |
|--------------------------|--|--|---------------------|-------------------------------|--|-------------------------------|---|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
| | | 345126 | B. WING | | _ | C 10/03/2018 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | S | TREET ADDRESS, CITY, STA | ATE, ZIP CODE | | |
| MOUNT O | LIVE CENTER | | | 28 SMITH CHAPEL ROAD | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 677 F 880 SS=D | and wring out the wate She further stated she her glove prior to getti stated she should hav she had contaminated continued giving his b contaminated and she water following incont gloves. During an interview or Director of Nursing sta staff members remove hands, and then don r continuing care. She f the bath with a soiled contaminated the wate the resident 's bath a new bin of water be re- the bath. Infection Prevention & CFR(s): 483.80(a)(1)(§483.80 Infection Cor The facility must estat infection prevention al designed to provide a comfortable environm development and tran- diseases and infection p program. The facility must estat | the resident 's bowel used the same hand to soak er back into the same basin. a did not notice the feces on ing the next rag. She further ve changed gloves and that d the water and then the soiled gloves, wash their the w gloves prior to further stated by continuing glove Nurse Aide #1 er she used for the rest of nd it was her expectation a the water and to continuing the water and to help prevent the the semission of communicable the semission of communicable the semission of control the blish an infection prevention IPCP) that must include, at | F 677 | | | | 10/30/18 |

Facility ID: 923344

If continuation sheet Page 7 of 12

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | MAPPROVED 0. 0938-0391 | |
|--------------------------|--|---|---------|--|--|-------------------|---------------------------|--|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED | |
| | | 345126 | B. WING | | | C 10/03/2018 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | | • | Ś | STREET ADDRESS, CITY, STATE, ZIP CODE | - | | |
| MOUNT O | LIVE CENTER | | | | 228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | | |
| F 880 | Continued From page §483.80(a)(1) A syster reporting, investigation and communicable di staff, volunteers, visite providing services un arrangement based un conducted according accepted national star §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility (ii) When and to whor communicable disease reported; (iii) Standard and trart to be followed to prev (iv)When and how is co- resident; including bu (A) The type and durated depending upon the in involved, and (B) A requirement that least restrictive possile circumstances. (v) The circumstances must prohibit employed disease or infected se- contact with residents contact will transmit the | e 7 em for preventing, identifying, ig, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following ndards; e standards, policies, and ogram, which must include, llance designed to identify ble diseases or c can spread to other ; m possible incidents of se or infections should be asmission-based precautions rent spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the s under which the facility ees with a communicable kin lesions from direct s or their food, if direct | | 880 | DEFICIENCY) | | | |
| | by staff involved in di | rect resident contact. | | | | | | |

If continuation sheet Page 8 of 12

PRINTED: 11/05/2018

| CENTER | S FOR MEDICARE & | | | | | OMB NC | 1 APPROVE 0. 0938-039 |
|--------------------------|---|--|-----------------------|--|---|--------|----------------------------|
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | SURVEY LETED |
| | | 345126 | B. WING | | | | C 03/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| MOUNT O | LIVE CENTER | | 228 SMITH CHAPEL ROAD | | | | |
| | | | | M | IOUNT OLIVE, NC 28365 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | IATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 880 | Continued From page | e 8 | F | 880 | | | |
| | 1.0 | em for recording incidents | | 000 | | | |
| | | acility's IPCP and the | | | | | |
| | | , , | | | | | |
| | §483.80(e) Linens. Personnel must hand | dle, store, process, and | | | | | |
| | | s to prevent the spread of | | | | | |
| | infection. | | | | | | |
| | §483.80(f) Annual re- | view. | | | | | |
| | The facility will conduct an annual review of its | | | | | | |
| | | ir program, as necessary. F is not met as evidenced | | | | | |
| | by: | i is not met as evidenced | | | | | |
| | - | on, staff and physician | | | F-880 | | |
| | | d reviews the facility failed to | | | Resident #3 was affected by this prac | | |
| | - | a resident 's bathing water | | | Wound was immediately cleansed an | | |
| | • | ed bath and failed to avoid | | | new dressing applied. Resident #3 wa | | |
| | | nated, wet glove to adjust a ing for 1 of 3 resident | | | given a new bath to assure cleanlines | SS. | |
| | - | n control. (Resident #3) | | | This practice has the ability to affect a | all | |
| | | | | | residents. Audits completed on all cu | | |
| | Findings included: | | | | residents with PU⊡s to see if any of t | hem | |
| | Posidont #3 was adn | nitted to the facility on | | | have infections in their wounds □ 10/23/18. | | |
| | 1/25/18. Resident #3 | - | | | 10/23/18. | | |
| | | nasia, cerebrovascular | | | Clinical staff received training by the | | |
| | | uadriplegia, and abnormal | | | CNE/NPE/Designee on infection cont | rol | |
| | posture. | | | | practices, such as hand washing, dor | • | |
| | Deview of Deside 11 | 40 La alcia integrito esta | | | and removing gloves, total bed baths | | |
| | | #3 's skin integrity report t returned from the hospital | | | pericare, aseptic technique, dressing changes and care cards with return | | |
| | | w unstageable wound to the | | | demonstration at time of in-servicing. | | |
| | | entified upon admission on | | | Training completed on 10/2/18, 10/22 | | |
| | | the wound was measured to | | | 10/23/18, and 10/24/18. All pressure | * | |
| | 9/25/18. 01 9/25/18 | | | | · · · | | |
| | be 4.5 centimeters lo | ong, 6.5 centimeters wide, | | | ulcers will be added to the care cards | | |
| | | ong, 6.5 centimeters wide, | | | - | domly | |

Facility ID: 923344

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| | | MEDICAID SERVICES | (X2) MEILTIE | PLE CONSTRUCTION | OMB NO. 0938- (X3) DATE SURVEY |
|--------------------------|-----------------------|---|---------------------|---|--|
| | CORRECTION | IDENTIFICATION NUMBER: | ` ' | G | COMPLETED |
| | | | | | с |
| | | 345126 | B. WING | | 10/03/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | |
| | | | | 228 SMITH CHAPEL ROAD | |
| MOUNT O | LIVE CENTER | | | MOUNT OLIVE, NC 28365 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE COMPLE THE APPROPRIATE DAT |
| F 880 | Continued From page | - 0 | , For | | |
| 1 000 | | | F 88 | | |
| | | ide #2 were observed | | on results weekly at the C | AR Meeting. |
| | | 3 a bed bath and incontinent is on the right side. A fresh | | Infection Control Audits to | be completed |
| | | in place on Resident #3 's | | by the Unit Managers 3 tir | |
| | left ischium unstagea | | | months. Audits to include | |
| | - | ches of the dressing on the | | total bed baths, pericare, | U |
| | | ble pressure ulcer had | | removing gloves, care car | |
| | pulled away from Res | sident #3 ' s skin leaving a | | on their person, aseptic te | echnique and |
| | gap of approximately | one inch. Nurse Aide #1 | | verbalization of process w | vith dressings. |
| | had one bin of warm | water at the bedside, | | Results will be reviewed v | |
| | | and was using no-rinse | | Managers and Center Nu | |
| | | had cleaned Resident #3 ' s | | the QAPI meeting for thre | |
| | upper body and had I | - | | may be extended or other | |
| | | se Aide #2 observed that | | based on compliance and | any additional |
| | | sident #3 's brief and | | findings. | |
| | | urse Aide #1 then used a er right hand to wipe the | | | |
| | | nt, folding the washcloth | | | |
| | | all amount of stool was | | | |
| | | urse #1 's glove on her right | | | |
| | | then reached for a new | | | |
| | | ght hand still having the | | | |
| | | and and a small amount of | | | |
| | - | o be smeared on the new | | | |
| | washcloth. Nurse Aid | e #1 placed this washcloth | | | |
| | • | th the glove in the bin of | | | |
| | | wrung the washcloth out | | | |
| | | At this point, Nurse Aide #1 | | | |
| | | g on the stage unstageable | | | |
| | | er had pulled away from the | | | |
| | | se Aide #1 used her right | | | |
| | | coiled glove to reattach the | | | |
| | - | Her hand was still wet from en using. Nurse Aide #1 ' s | | | |
| | | g fingers were under the | | | |
| | | bandage and her thumb | | | |
| | - | f the adhesive edge of the | | | |
| | bandage as she pulle | - | | | |
| | | | | | |

If continuation sheet Page 10 of 12

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 11/05/2018 APPROVED). 0938-0391 |
|--------------------------|--|--|---------------------|--|--|------------------------------------|---|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED C | |
| | | 345126 | B. WING | | | |) 03/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | 5 | STREET ADDRESS, CITY, STATI | E, ZIP CODE | | |
| MOUNT O | LIVE CENTER | | | 228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTI CROSS-REFERENCI | LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY) | | (X5) COMPLETION DATE |
| F 880 | Nurse Aide #1 used the to complete the reside feet. She did not replation incontinent care. During an interview 10 Aide #1 stated she did gloves after cleaning movement and then used further stated she did glove prior to getting the stated she did not remused to replace the pro- Nurse Aide #1 further hand she used to replace the pro- Nurse Aide #1 further hand she used to replace the pro- Nurse Aide #1 further hand she used to replace the pro- Nurse Aide #1 further hand she used to replace the pro- Nurse Aide #1 further hand she used to replace the pro- should not have used risk for contamination During an interview of continuing care. She the expectation Nurse Aid a pressure ulcer band from the skin and it wo nurse aides never to use with dirty gloves and not the reason she would bandages with soiled risk for infection to the During an interview of Resident #3 's Physic practice for staff to not with soiled gloves. He | touched the bandage. The same bin of warm water ent 's bath for his legs and ace the water following 0/2/18 at 12:50 PM Nurse d remember not changing Resident #3 's bowel used the same hand to soak er back into the basin. She not notice the feces on her the next rag. The nurse aide nember which hand she ressure ulcer bandage. stated if it was her right lace the wound dressing she that hand because of the and infection. n 10/2/18 at 12:58 PM the ated it was her expectation e soiled gloves, wash their new gloves prior to further stated it was her de #1 notify the nurse about lage that was pulling away as her expectation the ich pressure ulcer bandages replace it. She further stated expect staff to not touch gloves was because of the e wound. | F 880 | | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | D: 11/05/2018 MAPPROVED D. 0938-0391 | |
|--------------------------|---------------------------|---|-------------|-----|---|-------------------------------|--|--|
| STATEMENT (| DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 345126 | B. WING | | | C 10/03/2018 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | I | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 | | |
| MOUNT O | LIVE CENTER | | | | 228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365 | | | |
| | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF TAG | IX | (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | COMPLETION DATE | |
| | | | | | | | | |
| F 880 | Continued From page | | F | 880 | | | | |
| | in the facility it was hi | n infection. He further stated sepectation wound | | | | | | |
| | dressings not be touc | | | | | | | |
| | gloves. | | | | | | | |
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