

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

PRINTED: 04/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345521	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2016
NAME OF PROVIDER OR SUPPLIER SNUG HARBOR ON NELSON BAY			STREET ADDRESS, CITY, STATE, ZIP CODE 272 HIGHWAY 70 SEALEVEL, NC 28577		
(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 221 SS=G	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews the facility failed to assess the side rails as a restraint after she fell and received a fractured humerus for 1 of 20 sampled residents (Resident #33) with side rails.</p> <p>The findings included:</p> <p>Resident #33 was admitted to the facility on 2/16/16 with diagnoses of dementia without behaviors, chronic obstructive pulmonary disease and Ataxia.</p> <p>A review of Resident #33's care plan last updated on 2/16/16 revealed she was at risk for falls. As a problem the facility identified her as a fall risk. The goal was identified as preventing serious injury related to falls and the interventions were to have the call bell in reach, attempt to orient her to the call bell system and to notify the physician of any adverse effects with her medications. The four-1/4 raised side rails or the tabs monitor were not addressed in her care plan.</p> <p>A review of the fall risk assessment dated 2/23/16 revealed Resident #33 was disoriented. She was chair bound and had balance problems while standing and she required the use of assistive devices. She was assessed with a total score 11</p>	F 221			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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 221	<p>Continued From page 1</p> <p>with a score of 10 or above revealed she was at a high risk for falls.</p> <p>A review of the initial Minimum Data Set (MDS) dated 2/26/16 revealed Resident #33 was severely cognitively impaired. Resident #33 required total dependence on staff for transfers and bed mobility and had no functional limitation in range of motion for upper and lower extremity. She did not walk during the time of her assessment. She was not coded as having a bed rail as a restraint.</p> <p>A review of the Care Area Assessment (CAA) summary dated 2/29/16 revealed Resident #33 triggered for falls related to not being steady and requiring staff assistance to stabilize. Resident #33 was at high risk for falls and was on psychotropic medications but had no adverse reaction noted.</p> <p>A review of the physician ' s orders on the Medication Administration record for March 2016 revealed the resident was ordered to have four-¼ side rails to be up while the resident was in bed for safety. Review of physician orders revealed there was no medical justification or therapy screen for the use of 4-1/4 rails as a restraint.</p> <p>A review of the Nurse ' s Notes dated 3/12/16 at 8:15 PM revealed Nurse #2 heard the " tabs monitor " (a device placed on the resident to alarm staff that the resident had transferred out of her bed) going off. The nurse entered Resident #33 ' s room and Resident #33 was observed on the floor at the foot of the bed. The physician was notified and the resident was sent to the emergency room with a fracture to the left humerus. Resident #33 ' s arm was placed in a</p>	F 221			

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F 221	<p>Continued From page 2 slung and transported back to the facility.</p> <p>A review of the incident report dated 3/12/16 revealed staff (Nurse #2) heard the tabs monitor and resident was observed on the floor at the foot of the bed. Documentation revealed that the resident had her side rails up during the incident. There was no side rail assessment as part of the incident report. Resident #33 was sent to the Emergency Room for an evaluation. The resident was assessed as being non-compliant and attempting to transfer out of bed unassisted. The corrective action was that the resident was sent to the ER and to have frequent monitoring.</p> <p>During an interview on 4/7/16 at 12:13 PM the resident ' s nursing assistant (NA#1) stated that Resident #33 could get out of bed on her own and was usually talking about wanting to go to work. NA #1 stated the resident was supposed to have four-1/4 side rails up while she is in bed and that she had a tabs monitor on to let staff know when she was getting out of bed unsupervised. NA#1 stated she knew how to care for the resident because the nursing staff would report to her how to care for the resident.</p> <p>On 4/7/16 at 1:47 PM Resident #33 was observed lying in her bed with her four-1/4 side rails in the up position. The side rails at the head of the bed and at the foot of the bed were observed with not enough space for the resident to transfer out of the bed. The space between the upper and lower side rails in the middle of the bed was approximately 12 inches. Resident #33 was observed moving her legs up and down and arms and stating she was trying to get up and go to work.</p>	F 221			

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F 221	<p>Continued From page 3</p> <p>On 4/7/16 at 2:15 PM the MDS Coordinator stated that Resident #33 was coded as having enablers and she did not code the side rails as a restraint. She stated all residents at the facility on admission were ordered 1/4/rails times four for safety. She stated the resident on admission had been coded as being at high risk for falls. She stated the resident did have a fall on 3/12/16 but the investigation revealed that she was non-compliant and got out of bed unassisted and had a fall. The MDS Coordinator further stated staff had not discussed why she got up before her accident and had not considered the ¼ rails as a restraint. She further stated the resident was severely cognitively impaired and could not remember to use her call bell. She stated she had been care planned to have her call bell in reach but she had short term memory and forgot to use her call bell. She stated Resident #33 had tried to transfer out of bed before the 3/12/16 incident and the tabs alarm had been place to notify staff that she was getting out of bed unassisted. The MDS Coordinator was not sure who or when staff had placed the tabs alarm on. She stated the intervention from the investigation on 3/12/16 was to send Resident #33 to the ER and to monitor her more frequently. She was not sure how they were going to monitor her more frequently.</p> <p>During an interview on 4/7/16 at 9:18 PM Nurse #2 stated she had completed the incident report after Resident #33 had transferred out of bed without assistance on 3/12/16. Nurse #2 stated she heard the tabs monitor sounding off on 3/12/16 and ran into Resident #33 ' s room. Nurse #2 stated when she walked into the resident ' s room all four of the ¼ side rails were up and the resident was laying on her side at the</p>	F 221			

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F 221	Continued From page 4 side of the foot of the bed. She stated after she had completed the incident report the interventions were for her to go to the ER and monitor her more frequently. She stated the reason Resident #33 had on the tabs monitor was because she had transferred out of bed unassisted and was unsafe. She was not sure who or when the tabs monitor had been placed on the resident. On 4/8/16 at 1:00 PM Resident #33 ' s assigned nursing assistant (NA #3) stated the resident was always trying to get up out of bed before her accident (3/12/16). She stated she had known the resident before she was admitted and Resident #33 had worked at a restaurant and when she was awake wanted to get up and go to work. NA#33 stated she placed the tabs alarm on and the four ¼ side rails up to keep her from getting out of bed unassisted.	F 221			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who	F 278			

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F 278	<p>Continued From page 5</p> <p>willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately assess 2 of 18 Residents (Residents #24 and #44) for accurate diagnoses under Section I and M and failed to accurately assess 1 of 20 residents (Resident #33) for a bed rail restraint under section P on the Minimum Data Set (MDS).</p> <p>The findings included:</p> <p>1. Resident #24 was admitted to the facility on 10/27/15 with diagnoses including Parkinson ' s disease, Anxiety, Osteoarthritis, Hypertension, Depression, Gastroesophageal Reflux, Insomnia, Neuropathy, Constipation, Hyperlipidemia, Hypothyroidism, Anemia and Chronic Obstructive Pulmonary Disease.</p> <p>Review of the admitting Physician ' s orders revealed Resident #24 was receiving the following medications: Lorazepam for Anxiety, Synthroid for Hypothyroidism, Ferrous Sulfate for Anemia, Lexapro for Depression, Vitamin D for</p>	F 278			

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F 278	<p>Continued From page 6</p> <p>Osteoarthritis, Trazodone for Insomnia and Carbidopa/Levidopa for Parkinson ' s disease.</p> <p>Review of the admission Minimum Data Set (MDS) Assessment dated 11/9/15 did not assess Resident #24 as having Anxiety, Insomnia, Hypothyroidism, Anemia, Depression, Osteoarthritis or Parkinson ' s disease under Section I - Active Diagnoses.</p> <p>During an interview with the MDS Coordinator on 4/8/16 at 2:13PM she stated that she attended the MDS training last year and was under the impression that only the most prominent diagnoses needed to be entered under Section I.</p> <p>During an interview with the Administrator on 4/8/16 at 4:05PM she stated that the facility was unaware that all the diagnoses needed to be listed and this would be corrected.</p> <p>2. Resident #44 was admitted to the facility on 12/14/15 with diagnoses including Pressure Ulcer, stage II.</p> <p>Review of the admission Minimum Data Set (MDS) Assessment dated 12/21/15 and the 14 day MDS Assessment dated 12/28/15 revealed that Section M - Skin Conditions, M0210 unhealed pressure ulcers, was not checked on either assessment.</p> <p>During an interview with the MDS Coordinator on 4/8/16 at 2:13PM she stated it must have been overlooked.</p> <p>During an interview with the Administrator on 4/8/16 at 4:05PM she stated the assessment was inaccurate and would be corrected.</p>	F 278			

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F 278	<p>Continued From page 7</p> <p>3. Resident #33 was admitted to the facility on 2/16/16 with diagnoses of dementia without behaviors, chronic obstructive pulmonary disease (COPD) and Ataxia.</p> <p>A review of the initial Minimum Data Set (MDS) dated 2/26/16 revealed Resident #33 was severely cognitively impaired. Resident #33 required total dependence on staff for transfers and had no functional limitation in range of motion for upper and lower extremity. She did not walk during the time of her assessment. She was not coded as having a bed rail as a restraint.</p> <p>A review of the physician ' s orders on the Medication Administration record for March 2016 revealed the resident was ordered to have four-¼ side rails to be up while the resident was in bed. Review of physician orders revealed there was no medical justification or therapy screen for the use of 4-1/4 rails.</p> <p>A review of the Nurses ' Notes dated 3/12/16 revealed Nurse #2 heard the tabs monitor going off. The nurse entered Resident #33 ' s room and the resident was observed on the floor at the foot of the bed. Resident #33 was sent to the ER and review of the X-ray revealed her left humerus was fractured.</p> <p>On 4/7/16 at 2:15 PM the MDS Coordinator stated that Resident #33 was coded as having enablers and she did not code the side rails as a restraint. She stated all residents at the facility on admission were ordered ¼ rails times four for their safety and just did not look at the four ¼ rails as restraints. The MDS coordinator stated the</p>	F 278			

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F 278	Continued From page 8 resident did have a tabs monitoring due to her transferring out of bed unassisted and had not thought to assess her for a restraint after fracturing her left humerus.	F 278			
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (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 (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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain proper positioning for 1 of 1 sampled resident receiving a tube feeding. (Resident # 3) The findings include:	F 322			

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F 322	<p>Continued From page 9</p> <p>Resident #3 was admitted to the facility on 9/9/15 with diagnoses including Dysphagia and Gastrostomy status.</p> <p>Review of the most recent Quarterly Minimum Data Set (MDS) Assessment dated 2/27/16 identified Resident #3 as severely cognitively impaired and having a Gastrostomy tube (GT).</p> <p>Review of the Care Area Assessment (CAAs) Summary dated 11/23/15 triggered in the area of feeding tube use related to Gastrostomy tube, resident being NPO (nothing by mouth) and the GT being the source of nutrition.</p> <p>Review of the Care plan dated 2/16/16 for aspiration risk documented to keep the head of the bed up 45 degrees.</p> <p>Review of the most recent Physician ' s orders for the month of April 2016 documented Resident #3 was receiving Jevity 1.5 via GT four times per day, to elevate the head of the bed to 45 degrees at all times, Resident #3 was a high risk for aspiration and choking and was on aspiration precautions.</p> <p>During an observation on 4/7/16 at 1:40pm Resident #3 had the bed positioned with the center low and the feet and the head of the bed flat. Resident #3 was observed to have a cough. The SA (State Agency) did locate Nurse #1 and she confirmed the head of the bed was down and needed to be raised.</p> <p>During an interview with Nurse #1 on 4/7/16 at 1:42PM she stated that the head of the bed</p>	F 322			

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F 322	<p>Continued From page 10 should be raised.</p> <p>During an interview with NA #1 on 4/7/16 at 2:15PM she stated after lunch she positioned Resident #3 in bed with her feet and head even and the middle of the mattress lower to help keep the resident in bed. She stated the resident will get out of bed by herself to use the bathroom.</p> <p>During an observation on 4/7/16 at 4:40pm Resident #3s bed was flat, the door was closed shut. The SA located NA #1.</p> <p>During an interview with Nursing Assistant #1 on 4/7/16 at 5:00pm she stated that when she put Resident #3 back to bed she lowered the bed and pulled her blankets up because this resident prefers to sleep this way. She further stated she has never seen the resident use the bed controls to lower or raise the head of the bed.</p> <p>Observations on 4/8/16 at 8:56AM and 10:53AM revealed Resident #3 in bed, the head of the bed up; however, the resident had slid down to the flat part of the bed and was asleep in her right side in a fetal position.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 4/7/16 at 4:55 PM she stated that Resident #3 does have an order to keep the head of the bed raised at all times. She stated if the head of the bed is raised then the resident tends to slid down to the flat part of the bed and sleep. She stated the facility had not investigated interventions that would assist in keeping the head of the bed up.</p> <p>During a follow up interview with the ADON on 04/08/2016 2:22 PM she stated it was expected</p>	F 322			

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F 322	Continued From page 11 that if the Physician ' s orders read for the head of the bed to be up 45 degrees at all times it should be up.	F 322			
F 323 SS=G	During an interview with the Administrator on 04/08/2016 2:29 PM she stated she would expect the head of the bed to be up as ordered. 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, medical record review and staff interviews the facility failed to put interventions into place after a resident fell and received a fractured humerus for 1 of 20 sampled residents (Resident #33) with side rails. The findings included: Resident #33 was admitted to the facility on 2/16/16 with diagnoses of dementia without behaviors, chronic obstructive pulmonary disease and ataxia. A review of Resident #33's care plan dated 2/16/16 revealed she was at risk for falls. As a problem the facility identified her as a fall risk. The goal was identified as preventing serious	F 323			

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F 323	<p>Continued From page 12</p> <p>injury related to falls and the interventions were to have the call bell in reach, attempt to orient her to the call bell system and to notify the physician of any adverse effects with her medications. The four-1/4 raised side rails or the tabs monitor were not addressed in her care plan.</p> <p>A review of the fall risk assessment dated 2/23/16 revealed Resident #33 was disoriented. She was chair bound and had balance problems while standing and she required a wheelchair for mobility. She was assessed with a total score of 11. A total score of 10 or above revealed she was at high risk for falls.</p> <p>A review of the initial Minimum Data Set (MDS) dated 2/26/16 revealed Resident #33 was severely cognitively impaired. Resident #33 was totally dependent on staff for transfers and bed mobility and had no functional limitation in range of motion for upper and lower extremity. She did not walk during the time of her assessment. She was not coded as having a bed rail as a restraint. A review of the resident ' s fall history revealed the facility was unable to determine a history of falls.</p> <p>A review of the Care Area Assessment (CAA) summary dated 2/29/16 revealed Resident #33 triggered for falls related to not being steady and requiring staff assistance to stabilize. Resident #33 was at high risk for falls and was on psychotropic medications but had no adverse reaction noted.</p> <p>A review of the physician ' s orders on the Medication Administration record for March 2016 revealed the resident was ordered to have four-1/4 side rails to be up while the resident was in bed</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345521	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2016
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F 323	<p>Continued From page 13 for safety.</p> <p>A review of the Nurse ' s Notes dated 3/12/16 at 8:15 PM revealed Nurse #2 heard the " tabs monitor " (a device placed on the resident to alarm staff that the resident had transferred out of her bed) going off. The nurse (Nurse #2) entered Resident #33 ' s room and Resident #33 was observed on the floor at the foot of the bed. The physician was notified and the resident was sent to the emergency room with a fracture to the left humerus. Resident #33 ' s arm was placed in a sling and transported back to the facility.</p> <p>A review of the incident report dated 3/12/16 revealed staff (Nurse #2) heard the tabs monitor and the resident was observed on the floor at the foot of the bed. Documentation revealed that the resident had her side rails up during the incident. There was no side rail assessment as part of the incident report. Resident #33 was sent to the Emergency Room for an evaluation. The resident was assessed as being non-compliant and attempting to transfer out of bed unassisted. The corrective action was that the resident was sent to the ER and to have frequent monitoring.</p> <p>During an interview on 4/7/16 at 12:13 PM the resident ' s nursing assistant (NA#1) stated that Resident #33 could get out of bed on her own and was usually talking about wanting to go to work. NA #1 stated the resident was supposed to have four-1/4 side rails up while she is in bed and that she had a tabs monitor on to let staff know when she was getting out of bed unsupervised. NA#1 stated she knew how to care for the resident because the nursing staff would report to her how to care for her.</p>	F 323			

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

PRINTED: 04/15/2016
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 14</p> <p>On 4/7/16 at 1:47 PM Resident #33 was observed lying in her bed with her four-1/4 side rails in the up position. The side rails at the head of the bed and at the foot of the bed were observed with not enough space for the resident to transfer out of the bed. The space between the upper and lower side rails in the middle of the bed was approximately 12 inches. Resident #33 was observed moving her legs up and down and arms and stating she was trying to get up and go to work.</p> <p>On 4/7/16 at 2:15 PM the MDS Coordinator stated that Resident #33 was coded as having enablers and she did not code the side rails as a restraint. She stated all residents at the facility on admission were ordered 1/4/rails times four for safety. She stated the resident on admission had been coded as being at high risk for falls. She stated the resident did have a fall on 3/12/16 but the investigation revealed that she was non-compliant and got out of bed unassisted and had a fall. The MDS Coordinator further stated staff had not discussed why she got up before her accident and had not assessed the 1/4 rails as a restraint as part of the investigation. She further stated the resident was severely cognitively impaired and could not remember to use her call bell. She stated she had been care planned to have her call bell in reach but she had short term memory and forgot to use her call bell. She stated Resident #33 had tried to transfer out of bed before the 3/12/16 incident and the tabs alarm had been place to notify staff that she was getting out of bed unassisted. The MDS Coordinator was not sure who or when staff had placed the tabs alarm on the resident. She stated the intervention from the investigation on 3/12/16 was to send Resident #33 to the ER and to</p>	F 323			

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

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F 323	Continued From page 15 monitor her more frequently. She was not sure how they were going to monitor her more frequently. During an interview on 4/7/16 at 9:18 PM Nurse #2 stated she had completed the incident report after Resident #33 had transferred out of bed without assistance on 3/12/16. Nurse #2 stated she heard the tabs monitor sounding off on 3/12/16 and ran into Resident #33 ' s room. Nurse #2 stated when she walked into the resident ' s room all four of the ¼ side rails were up and the resident was laying on her side at the side of the foot of the bed. She stated after she had completed the incident report the interventions were for her to go to the ER and monitor her more frequently. Nurse #2 stated the reason Resident #33 had on the tabs monitor was because she had transferred out of bed unassisted and was unsafe. She was not sure who or when the tabs monitor had been placed on the resident and that the tabs monitoring was how she was monitoring her. On 4/8/16 at 1:00 PM Resident #33 ' s assigned nursing assistant (NA #3) stated the resident was always trying to get up out of bed before her accident (3/12/16). She stated she had known the resident before she was admitted and Resident #33 had worked at a restaurant and when she was awake wanted to get up and go to work. NA#33 stated she placed the tabs alarm on and the four ¼ side rails up to keep her from getting out of bed unassisted.	F 323			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441			

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F 441	<p>Continued From page 16</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(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.</p> <p>(c) Linens 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 observations, medical record review</p>	F 441			

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F 441	<p>Continued From page 17</p> <p>and family and staff interviews, the facility failed to provide proper contact isolation precautions to minimize the spread of Clostridium Difficile (C-Diff) by failing to educate a family member about contact isolation and the use of appropriate personal protective equipment when caring for a resident (Resident #53) and by failing to post an isolation sign on residents ' doors for 2 of 2 residents on contact precautions (Resident #53 and Resident #14).</p> <p>The findings included:</p> <p>A review of the facility policy for " Isolation " undated, read in part, " Supply list for isolation,check with nurse before entering room for instructions. " " Visitors check with nurse before entering room. " Supply list for isolation, 2 trash cans *personal Laundry use hamper in bathroom. Put red biohazard bag along with a melt-down bag. "</p> <p>1. Resident #53 was admitted to the facility on 3/23/16 with diagnoses of dementia, irritable bowel syndrome and C-Diff.</p> <p>A review of her admission Minimum Data Set (MDS) dated 3/31/16 revealed Resident #53 was moderately impaired in cognitive skills for daily living. She was coded as frequently incontinent of bladder and bowel and required total assistance for toileting.</p> <p>A review of Resident #53 ' s ADL (Activities of Daily Living) revealed that she used a commode for bladder and bowel.</p> <p>A review of the lab report dated 4/5/16 revealed the resident tested positive for C-Diff.</p>	F 441			

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F 441	<p>Continued From page 18</p> <p>A review of the physician's order dated 4/5/16 revealed he ordered enteric precautions and an antibiotic for ten days for treatment of C-Diff.</p> <p>During an observation on 4/7/16 at 9:28 AM there was a sign posted that visitors should check with the nurse before entering. There was no isolation sign posted. There was personal protective gear placed on the left side of the door entrance.</p> <p>During an observation on 4/7/16 at 10:02 AM there was no isolation sign posted.</p> <p>On 4/7/16 at 12:49 PM a visitor was observed in Resident #53 ' s room without gloves or a gown. The resident ' s visitor stated that she came to the facility almost every day and staff had not informed her on wearing gloves or a gown. She stated she had been in Resident #53 ' s room with her Nursing Assistant (NA #2) and the resident had a bowel movement that was observed on the bed spread, the bed linens and the pads underneath the resident. The visitor stated she was not wearing gloves and had gotten stool on her hands while helping to clean the resident. She stated she took all of Resident #53 ' s laundry and had taken the stool soiled clothes home to wash. She stated the facility had not instructed her on how to handle the soiled clothing. She stated she knew Resident #53 was on contact isolation but did not know how to protect herself.</p> <p>On 4/7/16 at 3:36 PM the resident ' s assigned Nursing Assistant (NA#2) stated Resident #53 did have C-Diff and was having a hard time letting staff know when she had a bowel movement (BM). NA#2 stated she knew how to care for the</p>	F 441			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 19</p> <p>resident because she used the ADL sheet that gave her information on her care. NA#2 further stated before entering Resident #53 's room she had put on gloves and a gown. NA#2 stated on 4/6/16 Resident #53 had BMs that kept running out of her brief and that she had changed her 5 times during her shift. NA #2 stated the BM was observed on the bed linen and oozed from her brief out onto the pad and the bed spread. NA# 2 stated the family member had not been instructed to put on a gown or gloves.</p> <p>During an observation on 4/8/16 at 8:40 AM, at 10:54 AM and at 2:47 PM there was no enteric contact precaution sign posted.</p> <p>On 4/8/16 at 3:20pm the Assistant Director of Nursing (ADON)/Staff Development Coordinator (SDC) stated she had a policy for signage on the door and thought she just had to post the minimum amount of information to notify staff and visitors to check with the nurse about what type of precautions they needed to take. The ADON/SDC stated she was not aware that the sign needed to say exactly what the precautions were. She stated she had made orange signs the other day but was not aware that the signs were not observed on the doors. The ADON/SDC stated that families were notified of the type of infection and how the facility was going to implement contact precautions and give suggestions on ways for them to protect themselves. She stated she had nothing written to notify family members of instructions when they visit or how to transport the resident 's laundry home. Staff did not document that they had spoken with the family.</p>	F 441			

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

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F 441	Continued From page 20 2. Resident #14 was admitted to the facility on 6/29/15 with a current diagnosis which included Clostridium Difficile infection. A review of the resident ' s care plan dated 1/25/16 documented the resident was alert, used the bedpan and commode, was incontinent and required assistance with toileting. Review of the Physician ' s orders dated 4/2/16 documented an order for an antibiotic for ten days for the treatment of Clostridium Difficile infection. Observations on 4/7/16 at 9:30 AM during initial tour did not show an isolation sign at the resident ' s door. There was an isolation cart observed at the entrance of the door and a sign reading, " visitors check with nurse before entering room." Observations on 4/8/16 at 2:30 PM did not show an isolation sign at the resident ' s door. During an interview with Nursing Assistant #1 on 4/7/16 at 2:15 PM she stated she usually checked with the nurse to find out what kind of care the resident needed. She stated Resident #14 was occasionally incontinent and wore a brief just in case she had an accident and she always required assistance when toileting. During an interview with the Assistant Director of Nursing/Staff Development Coordinator on 4/8/16 at 3:20 PM she stated that the facility's policy for signage on the door gave the minimal amount of information to notify staff and visitors to check	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 441	Continued From page 21 with the nurse about what type of precautions the resident had. She stated she was unaware that the sign needed to say exactly what the precautions were. During an interview with the Administrator on 4/8/16 at 4:15 PM she stated that she would expect the correct signage to be posted on the resident ' s door.	F 441			