STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING ______ B. WING ______	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	**210 ELM STREET** **LOUISA, VA 23093**

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/15/17 through 8/17/17. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. One complaint was investigated during the survey. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 76 at the time of the survey. The survey sample consisted of thirteen current resident reviews (Residents 1 through 13) and two closed record reviews (Residents 14 through 15).	F 000		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records,	F 164		9/8/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/24/2017

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 164	Continued From page 1 regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to provide privacy during a dressing change for one of 15 residents, Resident #1. During an observed dressing change to Resident #1's sacral area, on 08/17/2017, RN (registered nurse) # 4, did not close the window curtain. Findings were: Resident #1 was originally admitted to the facility on 01/23/2017. His diagnoses included but were not limited to: Status post amputation of toe secondary to gangrene, systolic and diastolic heart failure, peripheral vascular disease, atrial	F 164	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated. F 164 1) Resident #1 No longer in facility. 2) All residents are at risk. 3) Staff Development Coordinator or designee will educate all staff responsible	

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F 164	Continued From page 2 fibrillation, hypertension, dementia and cardiomyopathy. He was most recently readmitted on 08/03/2017 after being hospitalized for "Unsalvageable gangrenous bilateral lower extremities." The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 08/11/2017. Resident #1 was assessed as having difficulty with both long and short term memory, as well as being severely impaired with daily decision making skills. On 08/17/2017, this surveyor observed RN #4 during a dressing change to Resident #1's sacral area. Resident #1 was in the "B" bed, next to the window. His room was on the ground level. He was positioned with his face to the doorway. His buttocks was to the window. RN #4 did not pull the window curtain closed. Outside of the window and to the left was an office building with cars in the parking lot. Also, a gentleman was observed walking up and down the side of the facility building past Resident #1's window. During the dressing change, RN #4 removed Resident #1's brief and left his buttocks and scrotum exposed to the window. At the conclusion of the dressing change the open curtain was discussed with RN #4. She stated, "I was just so nervous." At approximately 9:45 a.m., the above information was discussed with the corporate nurse consultant. A copy of any policy regarding resident privacy was requested. He stated, "That is a standard of practice...we don't have a policy	F 164	for providing care on maintaining dignity by drawing shades/curtains when providing care. 4) DON or designee will audit 25 residents, while receiving care for provision of dignity including drawing of curtains/drapes, a week x 2 weeks, then 15 residents a week x 2 weeks, then review at next quarterly QA meeting.	

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F 164	Continued From page 3 about that, but we do have a checklist that is used when we do direct observation of the staff." At approximately 10:00 a.m., a "TREATMENT OBSERVATION Non-Sterile Treatment Technique" form was presented. The check off list included, but was not limited to: "Provide for Privacy." The administrator and the DON were informed of the above information during a meeting on 08/17/2017 at approximately 11:00 a.m. No further information was obtained prior to the exit conference on 08/17/2017.	F 164		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, facility document review and clinical record review, the facility staff failed to assessed one of 15 residents in the survey sample prior to self-administration of a medication. Resident #10, with severe cognitive impairment, was left alone to self-administer a respiratory medication with use of a nebulizer. Resident #10 had no prior physician's order or assessment indicating she was safe to self-administer medications. The findings include: Resident #10 was admitted to the facility on 12/24/13 with a re-admission on 6/1/17.	F 176	F 176 1) Resident #10□s MD/RP made aware of potential missed dose and patient□s inability to self-administer nebulizer treatments. Resident #10 suffered no untoward event due to deficient practice. 2) All residents receiving nebulizer treatments are at risk. 3) Staff Development Coordinator or designee will educate all licensed nursing staff providing nebulizer treatments on remaining with resident during nebulizer administration or completing appropriate assessment for potential self-administration.	9/8/17

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F 176	Continued From page 4 Diagnoses for Resident #10 included COPD (chronic obstructive pulmonary disease), pneumonia, heart disease and high blood pressure. The minimum data set (MDS) dated 7/16/17 assessed Resident #10 with short and long-term memory problems and severely impaired cognitive skills. On 8/15/17 at 6:45 p.m. during the initial tour of the facility Resident #10 was observed in bed. A nebulizer mask was on the over-bed table in front of the resident with the nebulizer machine running. There were no staff members or family members in the room at the time of this observation. On 8/15/17 at 7:05 p.m. the licensed practical nurse (LPN #1) caring for Resident #10 was interviewed about the resident's nebulizer running and the mask not in position on her face. LPN #1 stated she started the nebulizer treatment on 8/15/17 at 5:30 p.m. When asked who took the nebulizer mask off, LPN #1 stated sometimes the resident's husband took the mask off. LPN #1 stated the resident's husband had visited earlier and might have taken the mask off. When asked why she had not checked on the resident for over an hour since starting the nebulizer treatment for Resident #10, LPN #2 stated the resident's husband was familiar with her care and probably took off the mask. Resident #10's clinical record documented a physician's order dated 8/8/17 for DuoNeb Solution (Ipratropium-Albuterol) 0.5-2.5 mg (milligrams)/3 ml (milliliters), 1 vial to be inhaled orally via nebulizer three times per day for shortness of breath and wheezing related to COPD with acute exacerbation. The clinical	F 176	4) DON or designee will audit 100% of residents receiving nebulizer treatments for appropriateness of self-administration. Then audit 20% of residents receiving nebulizer administrations during med pass to ensure licensed nursing staff remain with resident throughout administration a week x2weeks; then 10% of residents receiving nebulizer administrations during med pass a week x 2weeks, then review at next quarterly QA meeting.	

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F 176	Continued From page 5 record documented no physician's order for the resident to self-administer the nebulizer treatment. The resident's plan of care (revised 8/15/17) had no problems, goals and/or interventions regarding self-administration of medication. On 8/16/17 at 10:05 a.m. the resident's spouse was interviewed about the nebulizer treatments and removal of the nebulizer mask on the evening of 8/15/17. The resident's spouse stated he did not remove the nebulizer mask on 8/15/17. The spouse stated, "She [Resident #10] takes it off herself." The spouse stated it usually took about 10 to 15 minutes for the medication dose to run from the nebulizer. The spouse stated nurses did not always stay with the resident while the nebulizer medication was running. On 8/16/17 at 10:15 a.m. the registered nurse (RN #1) caring for Resident #10 was interviewed about the resident's nebulizer mask being off and the resident left alone to administer the respiratory medication. RN #1 stated it usually took about 10 minutes for the medication to be administered with the nebulizer machine. RN #1 stated Resident #10 was on comfort care and had not been assessed to safely self-administer medications. On 8/17/17 at 8:45 a.m. the registered nurse unit manager (RN #2) was interviewed about Resident #10 left alone with the nebulizer running and the mask being off. RN #2 stated nurses were responsible for starting the nebulizer treatments and then returning to stop the machine and take the mask off. When asked if nurses were required to stay with the resident during the nebulizer treatment, RN #2 stated,	F 176		

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F 176 Continued From page 6 F 176

"No." When asked how nurses ensured the resident received all of the medication, RN #2 stated the nurses had other residents to attend to and would be expected to go back after 10 to 15 minutes and check on the resident. RN #2 stated the resident's husband visited often and possibly could watch the resident take the medication. RN #2 was not sure if there was a facility policy about self-administration of medication.

The facility's policy titled Self-Administration of Medication at Bedside (effective 2/1/15) stated, "A licensed nurse will assess patient's ability to self-administer medication...Verify physician's order in the patient's chart for self-administration of specific medications under consideration...Complete Self-Medication Request/Evaluation form...The Interdisciplinary Team will review the assessment and will document during care plan...Complete the Care Plan for approved self-administered drugs...When a patient becomes unable to self-administer meds [medications], it must be brought to the attention of the appropriate staff via the Shift Report...When a patient is unable to self-administer medication, the meds will be given by nursing staff until the patient can be reassessed by the Interdisciplinary Team."

These findings were reviewed with the administrator, director of nursing and corporate nursing consultant during a meeting on 8/17/17 at 11:00 a.m.

F 309 SS=D 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING F 309 9/8/17

483.24 Quality of life
Quality of life is a fundamental principle that

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F 309	Continued From page 7 applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician's orders for one of 15 residents in the survey sample, Resident # 12.	F 309	F 309 1) Residents #12□s MD/RP made aware of failure to obtain blood pressures for potential administration of PRN clonidine. PRN dose clonidine discontinued by MD.	

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Continued From page 8

The facility staff failed to follow physician's orders for the administration of medication, that included blood pressure parameters.

Findings include:

Resident # 12 was admitted to the facility on 09/18/14. Diagnoses included, but were not limited to: diabetes, increased lipids, anxiety disorder and high blood pressure.

The most current MDS (minimum data set) was a quarterly assessment, dated 08/08/17. This MDS assessed there resident as having a cognitive score of "15", indicating the resident was cognitively intact for daily decision making skills.

On 08/16/17 at approximately 7:40 p.m., during a medication pass and pour observation, RN (Registered Nurse) # 1 prepared and administered medications to Resident # 12.

A medication reconciliation was competed for Resident # 12.

Resident # 12 current physician's orders included an order for, but not limited to: "...CLonidine HCL Tablet 0.1 mg [milligram] Give 1 tablet by mouth every 12 hours as needed for blood pressure related to ESSENTIAL (PRIMARY) HYPERTENSION...Give 1 tablet q [every] 12 hrs [hours] for Systolic b/p [blood pressure] of 170 and over..." The order date was 05/10/17. This order did not have an exact time for administration, only 'every 12 hours.'

Resident # 12's MARs (medication administration records) were then reviewed. The MARs for August 2017 were reviewed. The order for the

F 309

Resident suffered no untoward event due to deficiency.
2) All residents receiving PRN blood pressure medications are at risk.
3) Staff Development Coordinator or designee will educate all licensed nursing staff on obtaining and reviewing blood pressures based on frequency of PRN blood pressure orders, for need of administration.
4) DON or designee will audit 100% of all PRN blood pressure medications for proper frequency of obtaining blood pressures and accuracy of administration based on results, then 20% a week x 2weeks, then 10% a week x 2weeks, then review at next quarterly QA meeting.

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F 309	Continued From page 9 Clonidine 0.1 mg was listed as above with an area to the right of the order that documented, "B/P" for the B/P to be documented; below this was an area that documented, "PRN" for the time of administration of the medication (Clonidine 0.1 mg). This area of the MAR was blank and had no information documented. The resident's vital signs were then reviewed in the clinical record from 05/10/17 up to present. The last documented B/P was on 08/13/17 at 1:53 p.m., with approximately 25 days during that period that no blood pressure was taken and/or documented. At approximately 10:30 a.m. on 08/16/17, RN # 1 was asked to review Resident # 12's medication administration, specifically Clonidine 0.1 mg every 12 hours. RN # 1 looked at the order and was asked how often are B/P being taken on Resident # 12. RN # 1 stated that they were being taken on every shift. The RN was then asked where that is documented. RN # 1 stated that it should be on the MAR, if it isn't on the vital sign record. RN # 1 then looked at the MAR and confirmed that there was no documentation regarding Resident # 12's B/P. The RN then looked in the vital signs section of the record and confirmed that that the last B/P was taken on 08/13/17. The RN was asked how do they (nurses) know when to administer medication like this, if the B/P isn't' taken. RN # 1 stated that she understood what was being said. RN # 1 was then stated, "The last time it was administered was in June." The RN was then asked if the resident's B/P had been taken for today. RN # 1 stated, "...not for today." The nurse was made aware that it was 10:30 a.m. and when is it normally taken. The RN stated that it depending on staff. The RN stated	F 309		

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F 309	Continued From page 10	F 309		

that she would look into the matter.

At approximately 3:00 p.m., Corporate Nurse (CN) # 1 was asked for information to clarify the above findings. CN#1 stated that it was a PRN (as needed) and was not sure how the staff would know to administer the medication if the B/P was not taken daily.

At approximately 4:00 p.m., CN # 1 presented a cancellation order for the medication, Clonidine and stated that the order has now been discontinued.

A 'survey ready' book contained an information sheet regarding "Med Pass Times-Lifeworks." The sheet documented that for medications with a "Q12H" [every 12 hours] time, the medication was to be administered at 8 AM and 8 PM. It was also documented that a medication with a "BID" [twice daily] was to be administered at 8 AM and 8 PM.

At 5:15 p.m., the administrator, DON (director of nursing), and the corporate nurses were made aware of the above information. The DON stated that the expectation was to obtain a B/P to see if the medication needed to be administered, but stated that she would have to look at the times.

A policy was presented on 08/17/17 at approximately 10:15 a.m. by CP # 1.

The policy titled, "Medication Pass Observation" documented, "...Administer meds correctly...When indicated, take and record vital signs before giving meds..."

No further information and/or documentation was

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F 309	Continued From page 11 presented prior to the exit conference on 08/17/17.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to follow infection control practices during dressing changes for one of 15 residents, Resident #1. During an observed dressing change of Resident #1's bilateral heels, on 08/16/2017, RN (registered nurse) #1 did not wash her hands, change gloves, clean her bandage scissors or use a barrier to prevent cross contamination. During observation of a dressing change to Resident #1's sacral pressure ulcer on	F 314	F 314 1) Resident #1 is no longer in facility. 2) All residents receiving wound dressing changes are at risk. 3) Staff Development Coordinator or designee will educate all licensed nursing staff on: a. On appropriate hand washing during dressing changes b. On appropriate time to change gloves during dressing changes c. On appropriate cleaning of bandage scissors prior/during dressing changes d. On appropriate use of barriers to	9/8/17

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LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

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F 314	Continued From page 12 08/17/2017, RN #4 was observed turning the faucet off with her bare hand. Findings were: Resident #1 was originally admitted to the facility on 01/23/2017. His diagnoses included but were not limited to: Status post amputation of toe secondary to gangrene, systolic and diastolic heart failure, peripheral vascular disease, atrial fibrillation, hypertension, dementia and cardiomyopathy. He was most recently readmitted on 08/03/2017 after being hospitalized for "Unsalvageable gangrenous bilateral lower extremities." The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 08/11/2017. Resident #1 was assessed as having difficulty with both long and short term memory, as well as being severely impaired with daily decision making skills. On 08/16/2017 at approximately 8:00 a.m., this surveyor approached RN (registered nurse) #1 who was standing at a treatment cart in the hallway. RN #1 was asked if she was doing dressing changes for Resident #1. She stated that she would be getting to him in about 20 minutes. At approximately 8:20 a.m. RN #1 was observed gathering supplies for Resident #1's dressing change. The supplies, Dakin's solution, wound cleanser, gloves, telfa, gauze, kerlix and crushed Flagyl were placed in a small plastic basket to be carried to Resident #1's room. RN #1 stated, "We just started using the Flagyl today...we are putting it on the wounds to	F 314	prevent cross contamination during dressing changes 4) DON or designee will audit 100% of licensed nursing staff on: a. On appropriate hand washing during dressing changes b. On appropriate time to change gloves during dressing changes c. On appropriate cleaning of bandage scissors prior/during dressing changes d. On appropriate use of barriers to prevent cross contamination during dressing changes Then 3 licensed nursing staff during a dressing change a week x 2weeks, observing for items a, b, c, d, then 2 licensed nursing staff during a dressing change a week x 2 weeks, then review at next quarterly QA meeting.	

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help with the odor." RN #1 picked up a pair of bandage scissors from the top of the treatment cart and placed them in the pants pocket of her scrubs.

This surveyor accompanied RN #1 to Resident #1's room to observe the dressing changes to his bilateral heels. Resident #1 was observed lying on an air mattress, supine in bed. He had pillows between and underneath his knees. There were prevelon boots on both of his feet. RN #1 removed the boots and the pillows.

RN #1 did not wash her hands upon entry to the room. She donned a pair of nonsterile gloves, removed the bandage scissors from her pocket, and began to cut the outer kerlix dressing from Resident #1's left foot. She stopped, looked around and stated, "Where is the trash can?" She then walked over to the sink and used her gloved hand to pull the trash can to the bedside. She did not change her gloves. She finished removing the outer dressing from the left foot and placed it in the trash can. She then picked up the wound cleanser. She sprayed the inner telfa pad stuck to the wound with dark serosanguinous dried drainage. She used wound cleanser to loosen and remove the dried dressing. The dressing was removed and placed in the trash can. RN #1 then picked up a telfa pad and gauze. She poured Dakin's solution on the gauze and used her gloved hand to squeeze the excess fluid from the gauze. She then placed the gauze on a telfa pad and laid in on the bedsheets. She picked up the crushed Flagyl and at that time the DON (director of nursing) knocked on the door and asked RN #1 if she needed assistance. She stated, "Yes, she needed someone to hold the resident's foot so she could apply the Flagyl."

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F 314	Continued From page 14 The unit manager, RN #2 came into the room. He held Resident #1's left leg. RN #1 sprinkled the Flagyl on the left heel. She then picked the Dakin's prepared gauze up off the bed and placed in on Resident #1's heel. RN #2 stated, "You need a barrier." RN #1 then wrapped the foot and heel to secure the dressing. After RN #1 completed the dressing on the left foot, she removed her gloves for the first time since starting the dressing change. She went to a cabinet and obtained a pad to place on the bed to use as a barrier while doing the dressing change to the left foot. The barrier was placed on the bed. RN #1 donned a pair of nonsterile gloves. She did not wash her hands or use hand sanitizer between glove changes. RN #1 then picked her bandage scissors up from the bedside table and removed the outer dressing from Resident #1's right foot. The inner dressing on this heel was also adhered to the wound. RN #1 used the dermal wound cleanser to loosen and remove the telfa inner dressing. She did not change gloves. She then poured Dakin's solution on a gauze pad, squeezed out the excess and placed the it on a telfa pad on the barrier she had set up on the bed. She then poured the remaining crushed Flagyl into her gloved hand and patted it on Resident #1's heel. The Dakin's prepared gauze was then placed over the wound and the foot was wrapped with Kerlix. RN # 1 then removed her gloves. After the dressing change was completed this surveyor asked RN #1 about her technique. RN #1 was asked why she had not washed her hands or used hand sanitizer during the dressing change, when she entered the room or when	F 314		

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going from one wound to the other. She stated, "I normally wash my hands" RN #1 was asked about the laying the gauze prepared with the Dakin's solution on the bedsheet. She stated, "I normally use a barrier." RN #1 was asked about her bandage scissors. She did not respond.

The above information was discussed during an end of the day meeting with the administrator, the DON and the corporate nurse consultants on 08/16/2017 at approximately 5:15 p.m. They were asked if it was normal procedure not to change gloves or wash hands during a dressing change. Both nurse consultants stated, "No." A copy of the facility policy on handwashing during dressing changes was requested.

On 08/17/2017, at approximately 8:00 a.m., the corporate nurse consultant presented a policy on hand hygiene and policy regarding wound care. The "Wound Care" Policy contained the following: "Licensed nurses will follow recognized standards of practice regarding dressing change(s)." The policy, "Handwashing Requirements" contained the following: "Hand Hygiene: The following is a list of some situations that require hand hygiene:...before and after changing a dressing...Hand Washing with Antimicrobial Soap and Water: ...Dry hands thoroughly with a disposable paper towel, turning the faucet on the hand sink with the disposable paper towel...Gloves: Change gloves during patient care if moving from a contaminated body site to a clean body site..."

On 08/17/2017, this surveyor observed RN #4 during a dressing change to Resident #1's sacral area. Resident #1 was in the "B" bed, next to the window. His room was on the ground level. He

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F 314	Continued From page 16 was positioned with his face to the doorway. During the dressing change, RN #4 washed her hands a total of four times. Three of those times she washed her hands, turned of the faucet and then dried her hands. Per the facility policy cited above, RN #4 should have used a disposable paper towel to turn off the faucet. At the conclusion of the dressing change the open curtain and the handwashing technique were discussed with RN #4. She stated, "I was just so nervous." At approximately 9:45 a.m., the above information was discussed with the corporate nurse consultant. A copy of any policy regarding resident privacy was requested. He stated, "That is a standard of practice, just like the handwashing...we don't have a policy about that, but we do have a checklist that is used when we do direct observation of the staff." At approximately 10:00 a.m., a "TREATMENT OBSERVATION Non-Sterile Treatment Technique" form was presented. The check off list included, but was not limited to: "Provide for Privacy." The administrator and the DON were informed of the above information during a meeting on 08/17/2017 at approximately 11:00 a.m. No further information was obtained prior to the exit conference on 08/17/2017.	F 314		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program.	F 441		9/8/17

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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 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

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F 441	Continued From page 18 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 program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a clean and sanitary environment for a dressing change for one of 15 residents in the survey sample, Resident # 8. Resident # 8's room environment was not clean and/or sanitary for a dressing change to the sacrum. The resident had a fly in the room, which landed on his pillow, bed and on his shirt several times prior to a dressing change. The resident's bedside table, used for a table for the dressing change supplies was visibly soiled with wet liquid and a dried, unidentified matter.	F 441	F 441 1) Resident #8□s Room has been cleaned and sanitized appropriate for dressing change. Dressing change now completed. MD/RP made aware. Resident suffered no untoward event due to deficient practice. 2) All residents with dressing changes are at risk. 3) Staff Development Coordinator or designee will educate all licensed nursing staff on ensuring a clean and sanitary environment for dressing changes. 4) DON or designee will audit 100% of	

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F 441	Continued From page 19 Findings include: Resident # 8 was admitted to the facility on 01/29/10, with the most recent readmission on 01/17/16. Diagnoses for Resident # 8 included, but were not limited to: anemia, high blood pressure, diabetes, increased lipids, anxiety disorder, psychotic disorder, hallucinations, schizophrenia and a chronic stage four pressure area to the sacrum. The most current MDS (minimum data set) was a quarterly assessment dated 06/06/17. This MDS assessed the resident as having a cognitive score of 15, indicating the resident was cognitively intact in daily decision making skills. This MDS also assessed the resident as requiring extensive to total assistance from at least 2 staff members for all ADL's (activities of daily living), including dressing, toileting, hygiene/bathing, and transfers. On 08/17/17at 10:35 a.m., Resident # 8's pressure ulcer to the sacrum was going to be changed. LPN (licensed practical nurse) # 2 gathered supplies for the dressing change and laid them on a large piece of aluminum foil, folded the supplies up in the aluminum foil and carried them to the room. The LPN placed the aluminum foil on the bedside table and spread it out (supplies laying on top of foil) onto the soiled bedside table. The bedside table was visibly soiled with wet liquid and dried, unidentified matter. The bedside table had not been cleaned and/or sanitized prior to placing the foil with the supplies on the table. The LPN left the bedside and went to wash her hands. The resident was asked about his day, while conversing with the resident a fly was flying around the resident's	F 441	licensed nursing staff prior to a dressing change to ensure a clean and sanitary environment is maintained, then 3 licensed nursing staff prior to a dressing change a week x 2weeks, then 2 licensed nursing staff prior to a dressing change a week x 2 weeks, then review at next quarterly QA meeting.	

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head, face and upper body area. The resident began waving his left hand around his face. The resident was asked what he was doing and he stated, "Flies!"

The LPN returned, along with CNA (certified nursing assistant) #1 to prepare for the resident's dressing change. The fly continued to fly around the resident, landing on the resident's pillow, bed and sheets and then on the resident's shoulder. Neither the LPN, nor the CNA acknowledged that the fly was present. The LPN stated that she had asked the resident prior if he wanted pain medication and the resident stated, no. The CNA turned the resident toward her, with the resident laying on his right side. The LPN then unfastened his brief and again asked the resident if he was ok without medication for the dressing change. The resident voiced that he would like pain medication now, prior to the dressing change.

At this time, the LPN and CNA were both asked if they thought this was a clean and sanitary environment for a pressure ulcer dressing change with the presence of a fly in the immediate area, which was actually on the resident's shirt at this point. The LPN stated, "No." The CNA nodded her head in a 'no' manner, the LPN was asked if the bedside table should have been cleaned and/or sanitized to be free of the visibly soiled areas. The LPN stated, "Yes Ma'am". The LPN stated that she was going to get the resident his medication.

At approximately 11:05 a.m., the DON (director of nursing), the administrator and the CP (corporate nurse) were made aware in a meeting with the survey team.

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F 441	Continued From page 21 No further information and/or documentation was presented prior to the exit conference on 08/17/17.	F 441		