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	495099	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX REHABILITATION AND NURSING CENTER	10701 MAIN STREET FAIRFAX, VA 22030

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/12/18 through 6/14/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Six complaint(s) were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/12/18 through 6/14/18. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 200 certified bed facility was 166 at the time of the survey. The survey sample consisted of 34 current Resident reviews and 5 closed record reviews.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written	F 565		7/27/18

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

Electronically Signed | 07/13/2018

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 565	Continued From page 1 requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident council group interview, staff interview and resident council group minutes review it was determined the facility staff failed to follow up and communicate a response to resident council grievances/concerns during subsequent meetings of the council. The Findings Included: On June 12, 2018, at 12:50 p.m., the surveyor reviewed the Resident Group Council minutes that had been left in the conference room for the surveyor. The surveyor reviewed the Resident Group Council minutes from March 28, 2018, April 25, 2018 and May 30, 2018. The surveyor noted that follow up was not addressed/documented on the subsequent	F 565	1. Residents had no adverse effects. A review of past Resident Council Meeting minutes was completed. 2.Facility will conduct an audit of previous meeting minutes to insure follow through is documented 3.The Resident Council Meeting minutes format has been revised to include an Old Business section so that follow up is done both verbally and in writing. 4.Resident Council Meeting minutes will be distributed to Department Heads by Director of Activities for follow up and minutes will be updated in writing by	

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F 565	Continued From page 2 Resident Council Group meeting minutes. The March 28, 2018 Resident Council Meeting Minutes documented that the Residents voiced concerns/grievances about Dietary and Nutrition, Environmental Services and Nursing. No follow up was addressed on the April 25, 2018 Resident Council Meeting Minutes. The April 25, 2018 Resident Council Meeting Minutes documented that the Residents voiced concerns/grievances about Activities, Environmental issues. No follow up was addressed on the May 30, 2018 Resident Council Meeting Minutes. On June 13, 2018 at 2 p.m., the surveyor met with the Resident Council. Six alert and oriented Residents attended the Resident Council meeting. The Residents' stated that when they raised an issue/concern or grievance during the Resident Council Meetings no one ever followed up with them regarding any voiced concern/grievance or issue. One Resident stated that she had voiced an issue with the Dietary Department on three separate occasions. The Resident stated that she thought the hamburgers were dry, hard and too thick to eat. On June 13, 2018 at 3:30 p.m., the survey team met with the Administrator (Adm), Director of Nursing and the Assistant Director of Nursing (ADON). The surveyor notified the Administrative Team (AT) that the facility staff had not followed up with voiced Resident Council Group grievances/concerns. No additional information was provided prior to exiting the facility as to why the facility staff failed	F 565	Director of Activities. This corrective action will be completed by July 27, 2018.	

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F 565	Continued From page 3 to follow up with the Resident Council Group meeting grievances/concerns.	F 565		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to complete a Significant Change Minimum Data Assessment (MDS) after the initiation of Hospice Services for 1 of 34 Residents in the sample survey, Resident #27. The Findings Included: For Resident #27 the facility staff failed to complete a Significant Change MDS assessment after the initiation of Hospice Services on 1/4/18. Resident #27 was an 88 year old female who was admitted on 11/30/17. Admitting diagnoses included, but were not limited to: Escherichia coli, chronic embolism and thrombosis of the deep veins, dysphagia, hemiplegia and hemiparesis	F 637	1. Resident #27 had no adverse effects. A significant change assessment was completed for this resident on 3-19-18; however the facility remained deficient in the timeliness of the submission, as the assessment was not completed by 1-28-18, 14 days of a significant change. 2. The facility will conduct a house wide audit to identify residents with active hospice orders to identify all like residents. Immediate corrective actions will be taken. 3. The facility will initiate a daily quality assurance process that involves daily monitoring of all acute condition changes and order review. The MDS staff will attend the daily quality assurance meeting and will be re-educated on accurate	7/27/18

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F 637	Continued From page 4 following cerebrovascular disease affecting the right dominate side, insomnia, major depression anemia and legally blind. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Significant Change MDS assessment with an Assessment Reference Date (ARD) of 3/19/18. The facility staff coded that Resident #27 had a Cognitive Summary Score of 0. The facility staff also coded that Resident #27 required extensive assistance (3/3) with Activities of Daily Living (ADL's). In Section P. Special Treatments, the facility staff coded that Resident #27 was receiving Hospice Services. On June 12, 2018 at 1:30 p.m., the surveyor reviewed Resident #27's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "HOSPICE: Admit to (name of Hospice Vendor withheld) for senile degeneration of the brain with routine level of care. Call (telephone number for Hospice Vendor withheld) for changes in patient condition or death. LEVEL OF CARE: Hospice." (sic) Further review of the clinical record documented that the Hospice Vendor initiated Hospice Services of 1/4/18. Continued review of the clinical record produced the following MDS's with the associated ARD's. A Quarterly MDS with the ARD of 1/2/18 and a Significant Change MDS with an ARD of 3/19/18. The surveyor did not observe a Significant Change MDS assessment around the date of the initiation of the Hospice Services. On June 12, 2018 at 1:35 p.m., the surveyor	F 637	completion of significant change comprehensive assessments. 4. In order to ensure ongoing compliance, the facility will conduct random audits of 5 residents weekly x 4 weeks, then monthly x 4 months. All findings will be submitted to the QAA for review and recommendations. 5. The corrective action will be completed by July 27, 2018	

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F 637	Continued From page 5 asked the Assistant Director of Nursing (ADON) to help the surveyor understand the physician orders on the clinical record. The surveyor and ADON reviewed Resident #27's physician orders. The surveyor pointed out that Resident #27 had a physician order for Hospice Services. The surveyor notified the ADON that Hospice Services started on 1/4/18. The surveyor and ADON reviewed the Hospice Notes. The surveyor then reviewed the MDS's on file in the electronic record. The surveyor notified the ADON that a Significant Change MDS was not completed after the initiation of the Hospice Services. On June 13, 2018 at 3:30 p.m., the survey team met with the Administrator (Adm), Director of nursing (DON) and the ADON. The surveyor notified the Administrative Team (AT) that Resident #27 had a physician order for Hospice Services and that the Hospice services had started on 1/4/18. The surveyor notified the AT that a Significant Change MDS assessment was not done after the initiation of the Hospice Services. No additional information was provided prior to exiting the facility as to why the facility staff failed to complete a Significant Change MDS assessment after the initiation of Hospice Services on 1/4/18.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		7/27/18

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F 641	Continued From page 6 Based on staff interview and clinical record review it was determined that the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) assessment for 1 of 34 Residents in the sample survey, Resident #32. The Findings Included: For Resident #32 the facility staff incorrectly coded that Resident #32 had Pneumonia in Section I. Health Conditions. Resident #32 was a 68 year old male who was admitted on 4/30/17. Admitting diagnoses included, but were not limited to: peripheral vascular disease, diabetes mellitus, anxiety and depression. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/28/18. The facility staff coded that Resident #32 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #32 required extensive assistance (3/2) with Activities of Daily Living (ALD's). In Section I. Health Conditions., the facility staff coded that Resident #32 had had Pneumonia. On June 13, 2018 at 10:00 a.m., the surveyor reviewed Resident #32's clinical record. Review of the clinical record failed to produce any testing or treatment for pneumonia. The surveyor was unable to locate symptoms of pneumonia, a physician's order to obtain a chest X-Ray, the results of a Chest X-Ray, treatment for pneumonia or a physician diagnoses of pneumonia.	F 641	1. Resident #32 had no adverse effects. A modification to the quarterly assessment 3-28-18 was submitted and accepted. 2. The facility will conduct a house wide audit to identify residents with active diagnosis inaccuracies. Immediate corrective actions will be taken. 3. The facility will initiate a daily quality assurance process that involves daily monitoring of all acute condition changes and order review. The MDS staff will attend the daily quality assurance meeting and will be re-educated on the accurate completion of section I of the MDS, active diseases. 4. In order to ensure ongoing compliance, the facility will conduct random audits of 5 residents weekly x 4 weeks, then monthly x 4 months. All findings will be submitted to the QAA for review and recommendations. 5. The corrective action will be completed by July 27, 2018	

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F 641	Continued From page 7 On June 13, 2018 at 10:52 a.m., the surveyor notified the Assistant Director of Nursing (ADON) that Resident #32's Quarterly MDS with the ARD of 3/28/18 was incorrect. The surveyor notified the ADON that the facility staff had coded that Resident #32 had a diagnosis of Pneumonia. The surveyor notified the ADON that the surveyor was unable to locate any testing, treatment or physician diagnoses for pneumonia. The surveyor reviewed the clinical record with the ADON. The surveyor then reviewed the Quarterly MDS with the ADON. The ADON was unable to locate any documentation that documented that Resident #32 had Pneumonia. On June 13, 2018 at 3:30 p.m., the survey team met with the Administrator (Adm), Director of Nursing (DON) and the ADON. The surveyor notified the Administrative Team (AT) that Resident #32's Quarterly MDS with the ARD of 3/28/18 was incorrect. The surveyor notified the AT that the facility staff had coded that Resident #32 had had Pneumonia. The surveyor notified the AT that the surveyor and ADON were unable to locate any testing, treatment or diagnoses of Pneumonia in the clinical record. No additional information was provided prior to exiting the facility as to why the facility staff failed to complete and accurate MDS assessment for Resident #32.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F 645		7/27/18

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F 645	Continued From page 8 §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission	F 645		

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F 645	Continued From page 9 to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility staff failed to ensure a PASRR (preadmission assessment and Resident review) was completed on 2 of 34 Residents, #66 and #92. The findings included: 1. For Resident #66 the facility staff failed to ensure a PASRR was completed. Resident #66 was admitted to the facility on 02/09/15. Diagnoses included but not limited to congestive heart failure, hypertension, neurogenic bladder, dementia, anxiety, depression, Tourette's	F 645	1. Resident #66 and #92 had no adverse effects. A quarterly assessment and review of mental disorder and intellectual disability was completed for both resident #66 and #92. 2. The facility will conduct a house wide audit to identify residents with incomplete or missing PASARR screening for MD and ID. Immediate corrective actions will be taken. 3. The facility will initiate an ongoing admission audit tool to capture accuracy, completion, and availability of the PASARR screening tool for all new admissions. Upon identification of an	

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F 645	Continued From page 10 syndrome, psychotic disorder, asthma, atrial fibrillation and gastroesophageal reflux disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/11/18 coded the Resident as 15 out of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #66's clinical record was reviewed on 06/12/18. The surveyor could not locate a PASRR in the clinical record. The administrative team was informed of the missing PASRR on 06/13/18 at approximately 1530. On 06/14/18 at approximately 1045 the HIM (health information management) director provided the surveyor with a copy of a PASRR, which had not been signed or dated. The concern of the incomplete PASRR was discussed with the administrative team during a meeting on 06/14/18 at approximately 1720. No further information was provided prior to exit. 2. For Resident #92 the facility staff failed to obtain a PASRR prior to admission. Resident #92 was admitted to the facility on 04/22/17. Diagnoses included but not limited to anxiety, depression and Bipolar disorder. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/02/18 coded the Resident as 15 of 15 in section C, cognitive patterns. This is an annual MDS. Resident #92's clinical record was reviewed on	F 645	inaccurate, incomplete, or missing PASARR, the Social Services department will complete a new PASARR screening tool to identify MD and ID. A plan of care will be immediately implemented upon completion and identification of MD and ID. 4. In order to ensure ongoing compliance, the facility will conduct random audits of 5 residents weekly x 4 weeks, then monthly x 4 months. All findings will be submitted to the QAA for review and recommendations. 5. The corrective action will be completed by July 27, 2018	

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F 645	Continued From page 11 06/12/18. The surveyor could not locate a PASRR in the clinical record. The surveyor spoke with the ADON on 06/12/18 at approximately 1445 regarding the missing PASRR. On 06/12/18 at approximately 1445 the ADON told the surveyor that since Resident #92 had came from an ALF (assisted living facility), she did not need a PASRR. The concern of the missing PASRR was discussed with the administrative team during a meeting on 06/14/18 at approximately 1720. No further information was provided prior to exit.	F 645		
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to follow physician orders for 1 of 34 Residents in the sample survey, Resident #27. The Findings Included: For Resident #27 the facility staff failed to ensure that physician ordered TED hose were applied.	F 675	1. Resident #27 had no adverse effects. The ted hose were immediately re-applied. 2. The facility will conduct a house wide audit to identify residents with active ted hose orders. Immediate corrective actions will be taken. 3. The facility will re-educate all direct care nursing staff and CNA□s on ted	7/27/18

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F 675	Continued From page 12 TED hose are compression hose used to treat/prevent thromboembolism (blood clots). Resident #27 was an 88 year old female who was admitted on 11/30/17. Admitting diagnoses included, but were not limited to: Escherichia coli, chronic embolism and thrombosis of the deep veins, dysphagia, hemiplegia and hemiparesis following cerebrovascular disease affecting the right dominate side, insomnia, major depression anemia and legally blind. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Significant Change MDS assessment with an Assessment Reference Date (ARD) of 3/19/18. The facility staff coded that Resident #27 had a Cognitive Summary Score of 0. The facility staff also coded that Resident #27 required extensive assistance (3/3) with Activities of Daily Living (ADL's). On June 12, 2018 at 11:06 a.m., the surveyor observed Resident #27 in the day room sitting in a reclining geri-chair (RGC). Resident #27's Daughter was sitting in a chair beside her mother. The surveyor interviewed Resident #27's Daughter. Resident #27's Daughter drew the surveyors' attention to Resident #27's legs and stated that Resident #27 had on her bilateral lower leg boots. Resident #27's Daughter reached down and picked up the edge of the sheet that has covering Resident #27's legs and feet. The surveyor observed that Resident #27 had on white cotton socks and blue boots that were used to alleviate pressure on the heels. The surveyor did not observe TED hose on Resident #27's bilateral extremities.	F 675	hose application policy and procedure, and appropriate documentation if the ted hose are removed after application. 4. In order to ensure ongoing compliance, the facility will conduct random audits of 5 residents weekly x 4 weeks, then monthly x 4 months. All findings will be submitted to the QAA for review and recommendations. 5. The corrective action will be completed by July 27, 2018	

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F 675	Continued From page 13	F 675		

On June 12, 2018 at 1:30 p.m., the surveyor reviewed Resident #27's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "TED Hose: Knee High Ted Hose 1 application miscellaneous every day shift for BLE (bilateral lower extremities) On in Am length is 30 cm and the circumference of calf is 28 cm." (sic)

On June 12, 2018 at 1:35 p.m., the surveyor asked the Assistant Director of Nursing (ADON) to help the surveyor understand the physician orders on the clinical record. The surveyor and ADON reviewed Resident #27's physician orders. The surveyor pointed out that Resident #27 had physician orders for TED hose. The surveyor informed the ADON that Resident #27 did not have on the physician ordered TED hose on. The surveyor asked the ADON to accompany the surveyor down to Resident #27's location. The surveyor and ADON went to Resident #27's room and observed Resident #27 sitting in her room and in her RGC. The ADON stepped into Resident #27's room as the surveyor stood in the doorway The surveyor observed a Certified Nursing Assistant (C.N.A.) was standing on the right hand side of Resident #27's RGC and Resident #27's Daughter was standing on the left hand side of the RGC. The ADON asked if Resident #27 had on her TED hose and lifted the sheet that was covering Resident #27's lower extremities. The C.N.A. shook her head side to side, indicating "No." The ADON exited the room and the surveyor asked if Resident #27 had on the physician ordered TED hose and the DBHS replied, "No."

On June 13, 2018 at the survey team met with the Administrator (Adm), Director of Nursing

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F 675	Continued From page 14 (DON) and ADON. The surveyor notified the Administrative Team (AT) that Resident #27 had a physician order to be applied in the a.m. The surveyor notified the AT that Resident #27 did not have the physician ordered TED hose on on June 12, 2018. No additional information was provided prior to exiting the facility as to why the facility staff failed to apply the physician ordered TED hose to Resident #27.	F 675		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to ensure that a dependent resident received necessary care and assistance with nail care for 1 of 34 Residents in the sample survey, Resident #139. The Findings Included: For Resident #139 the facility staff failed to provide necessary care and assistance for nail care. Resident #139 was an 80 year old male who was admitted on 2/27/18. Admitting diagnoses included, but were not limited to: retention of urine, benign prostatic hyperplasia with lower urinary tract symptoms, unspecified dementia without behaviors and atrial fibrillation.	F 677	1. Resident #139 had no adverse effects. The resident received immediate nail care and has ongoing. 2. The facility will conduct a house wide audit of all resident□s nails. Immediate corrective actions will be taken. 3. The facility will re-educate all direct care nursing staff and CNA□s on daily nail care policy and procedure, and appropriate documentation in case of resident refusal. 4. In order to ensure ongoing compliance, the facility will conduct random audits of 5 residents weekly x 4 weeks, then monthly x 4 months. All findings will be submitted to the QAA for review and recommendations. 5. The corrective action will be	7/27/18

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F 677	Continued From page 15 The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 5/4/18. The facility staff coded that Resident #139 had a Cognitive Summary Score of 6. The facility staff coded that Resident #139 required extensive assistance (3/3) with Activities of Daily Living (ADL's). The facility staff also coded that Resident #139 required extensive assistance of one person (3/2) with personal hygiene. On June 12 2018 at 10:37 a.m., the surveyor observed Resident #139 lying in bed. Resident #139 had his hands lying on top of the covers. The surveyor observed that the fingernails on Resident #139's right hand were soiled with a brown debris around the cuticle and under the free edge of the fingernail. On June 13, 2018 at 08:27 a.m., the surveyor observed Resident #139 sitting in a wheelchair in dining room. Resident #139 was waiting for the delivery of his breakfast tray. The surveyor observed Resident #139's hands and noted that the fingernails on both hands had a brown debris under the free edge of the fingernail and along the cuticles. On June 13, 2018 at 8:37 a.m., the surveyor reviewed Resident #139's clinical record. Review of the clinical record produced the Comprehensive Care Plan (CCP). The CCP identified the following problem for Resident #139: ""The resident has an ADL self-care performance deficit r/t (related to) Dementia." (sic)	F 677	completed by July 27, 2018 F684 □ SS = E: Quality of Care	

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F 677	Continued From page 16 On June 13, 2018 at 3:30 p.m., the survey team met with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON). The surveyor notified the Administrative Team (AT) that Resident #139 had dirty fingernails. The surveyor notified the AT that Resident #139 had a brown debris around his cuticles and under the free edges of the fingernails on 6/12/18 and on 6/13/18. No additional information was provided as to why the facility staff failed to provide necessary nail care to a dependent Resident, Resident #139. Resident #139's fingernails had a brown debris around the cuticles and under the free edges of the fingernails.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow professional standards of practice for 1 of 34 residents in the survey sample. (Resident #152) The findings included: The facility staff failed to follow professional	F 684	1. Resident #152 had no adverse effects. A review of the resident□s medical record and daily blood glucose monitoring records does not reflect adverse effects nor evidence of a medication error. Resident was provided accurate insulin supply, Humalog, from the automated pharmacy dispensing	7/27/18

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F 684	Continued From page 17 standards of practice when administering insulin to Resident #152. Resident #152 was readmitted to the facility on 5/14/18 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, renal disease, diabetes, dementia and Parkinson's disease. On the significant change, MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/21/18 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #152 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing. During the Medication and Storage Facility Task, the surveyor noted an insulin injection pen with the manufactory's label, which had the name of the insulin as "Levamir". There was a white label on the other side of this insulin pen in which was written in as "Novalog" and a date of "6/6/18" for the date in which it was opened. The name of Resident #152 was also on the insulin injection pen. This was found by the surveyor on 6/14/18 at 10:25 am on 4 East Unit. The Staff Educator for the facility was with the surveyor at the time of this discovery and was notified of such. The surveyor requested that the staff educator investigate which staff member wrote in on the above documented label that was placed by the facility staff. At 11 am, the surveyor reviewed the clinical record of Resident #152. The surveyor noted the present physician order was the following on the resident's MAR (Medication Administration Record):	F 684	system that has a daily supply of Humalog insulin for new orders. Upon surveyor questioning, the Director of Long Term Care Services accidentally discarded the resident□s supply of Humalog as indicated in the surveyors CMS -2567. The facility immediately provided an additional supply from the automated pharmacy dispensing system without charge. The facility immediately discarded the discontinued Levamir that was not given nor active since 5-31-18. 2. There were no other residents involved in this deficiency; however, the facility will conduct a house wide audit of residents on insulin therapy. A house audit of all medication storage areas will be completed in comparison with the insulin therapy audit. Immediate corrective actions will be taken. 3. The facility will re-educate all direct care nursing staff on medication storage and labeling policy and procedure. A nightly medication storage audit will be initiated and completed on a nightly basis to identify the need for medication waste and/or return to the pharmacy, as well as proper labeling. 4. In order to ensure ongoing compliance, the facility will conduct random audits of 8 medication carts weekly x 4 weeks, then monthly x 4 months. All findings will be submitted to the QAA for review and recommendations. 5. The corrective action will be completed by July 27, 2018	

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F 684	Continued From page 18	F 684		

" "Humalog KwikPen Solution Pen-Injector 100 UNIT/ML (unit per milliliter) (Insulin Lispro) Inject as per sliding scale:
" If 0-60 = 0 units call MD
" 200 - 250 = 2 units
" 251 - 300 = 4 units
" 301 - 350 = 6 units
" 351 - 400 = 8 units
" 401+ = 10 units Call MD,
" Subcutaneously before meals and at bedtime ..."

At 1 pm, the surveyor called and spoke to Pharmacist #1 on the phone. The surveyor reported the above observation made on 6/14/18 at 10:25 am and asked Pharmacist #1 what the pharmacy was sending for Resident #152 to the facility to be administrated by the staff. Pharmacist #1 stated, "We previously had an order for Novalog insulin to be sent but according to our records this was discontinued on 5/10/18. Then we had an order for Levamir insulin to begin on 5/18/18 and that was discontinued on 5/31/18." The surveyor asked Pharmacist #1 if Levamir insulin could be given to the resident four times a day and he stated, "No, not that many times. It is a long acting insulin and only should be given 1 or 2 times daily. You need a short acting insulin to be given four times a day." The surveyor requested the last manifest that contains the date and number of insulin syringes be faxed to the facility for the survey team to review. This request was received by the survey team at 1:30 pm, in which the surveyor noted the following: " ...Delivery Manifest: _____ (name of the facility) - Fourth Floor 4/18/18 3:29:05 AM ... _____ (name of Resident #152) Insulin Novalog FLEXIPEN Quantity 3 Status Delivered

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F 684	Continued From page 19 ..."	F 684		

At 1:25 pm, the director of long term care services came into the conference room and stated to the survey team, "I heard there was a concern about _____ (name of Resident #152) insulin. I discarded both the Levamir and Humalog insulin in the sharps container as soon as I was told about the insulin concern of which insulin the resident was receiving. We are ordering the correct insulin from the pharmacy now."

At 1:30 pm, the director of long term care services returned to the conference room and stated the following to the survey team leader and this surveyor (writer): "I need to correct my statement. Reviewed the error and there were no orders for Levamir. That was d/cd (discontinued) 5/31/18 and Humalog was started on 5/31/18 per sliding scale insulin."

At 3 pm, the director of nursing (DON), assistant director of nursing (ADON) and staff educator came into the conference room to speak to the surveyor and survey team leader. The staff educator was holding 4 boxes of insulin in which she stated, "We spoke to the staff, and they have been giving the resident this insulin." The surveyor noted that these boxes contained insulin in vials and was not the FLEXPEN injector that had been order by the physician. The surveyor asked the staff educator where the FLEXPEN injector was that was ordered. The staff educator stated, "They were giving this because this is what they were able to get out of the Omnicell that we have our extra medications in." The surveyor requested the manifest from the pharmacy that has the physician ordered

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F 684	Continued From page 20	F 684		

Humalog insulin on it that supports the staff obtaining this insulin on 5/31/18. The surveyor reviewed these findings as documented above to the survey team. The surveyor and survey team cannot distinguish which insulin the resident did receive by the facility staff.

At 4:25 pm, LPN (licensed practical nurse) #1 came into the conference room to speak to the survey team. The surveyor asked LPN #1 if she knew who or how the white label on _____ (name of Resident #152's) insulin came to be on the Insulin Pen Injector that had a manufactory's label that stated it was "Levamir" insulin. LPN #1 stated, "_____ (name of resident) had an order for Humalog insulin. I wrote the order and then I called the supervisor and asked her to get this insulin for _____ (name of resident). I put the wrong label on this insulin pen. It should had been for _____ (name of another resident on the unit). The surveyor asked if LPN #1 could remember when she had done this. LPN #1 stated, "I believe it had to be last Tuesday then I was off sick for a week. But I know that I gave _____ (name of Resident #152) the right insulin."

The administrative team were notified of the above documented findings at approximately 4:45 pm in the conference room. The surveyor requested a copy of the facility's policy on the administration of insulin to a resident.

The surveyor received a copy of the facility's policy titled "Insulin Administration" at approximately 5:25 pm, which read in part, " ...The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to ensure that it

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F 684	Continued From page 21 corresponds with the order on the medication sheet and the physician's order ..." The surveyor also received another policy titled "Administrating Medications" which read in part, " ...Insulin pens will be clearly labeled with the resident's name or other identifying information. Prior to administrating insulin with an insulin pen, the Nurse will verify that the correct pen is used for that resident ..." No further information was provided to the surveyor prior to the exit conference on 6/14/18.	F 684		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow professional standards of practice for 1 of 34 residents in the survey sample (Resident #152). The findings included: The facility staff failed to follow professional standards of practice when administering insulin to Resident #152. Resident #152 was readmitted to the facility on 5/14/18 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, renal disease, diabetes, dementia and Parkinson's disease. On the significant change, MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/21/18 coded the resident as having a BIMS (Brief Interview for	F 760	1. Resident #152 had no adverse effects. A review of the resident□s medical record and daily blood glucose monitoring records does not reflect adverse effects nor evidence of a medication error. An interview with the resident□s primary care physician concurs that upon assessment and review of the medical record, there is no evidence nor symptoms of a medication error. The nurses clearly documented in the EMR that Humalog insulin was administered per sliding scale order. The resident was provided an accurate insulin supply, Humalog, from the automated pharmacy dispensing machine, which has a daily supply of Humalog insulin in preparation for new orders. Upon	7/27/18

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F 760	Continued From page 22 Mental Status) score of 15 out of a possible score of 15. Resident #152 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing During the Medication and Storage Facility Task, the surveyor noted an insulin injection pen with the manufactory's label, which had the name of the insulin as "Levamir". There was a white label on the other side of this insulin pen in which was written in as "Novalog" and a date of "6/6/18" for the date in which it was opened. The name of Resident #152 was also on the insulin injection pen. This was found by the surveyor on 6/14/18 at 10:25 am on 4 East Unit. The Staff Educator for the facility was with the surveyor at the time of this discovery and was notified of such. The surveyor requested that the staff educator investigate which staff member wrote in on the above documented label that was placed by the facility staff. At 11 am, the surveyor reviewed the clinical record of Resident #152. The surveyor noted the present physician order was the following on the resident's MAR (Medication Administration Record): o "Humalog KwikPen Solution Pen-Injector 100 UNIT/ML (unit per milliliter) (Insulin Lispro) Inject as per sliding scale: o If 0-60 = 0 units call MD o 200 - 250 = 2 units o 251 - 300 = 4 units o 301 - 350 = 6 units o 351 - 400 = 8 units o 401+ = 10 units Call MD, o Subcutaneously before meals and at bedtime ..."	F 760	surveyor questioning, the Director of Long Term Care Services admitted she accidentally discarded the resident□s supply of Humalog as indicated in the surveyors CMS -2567. The sharps discarding system was available for inspection and evidence. The facility immediately provided an additional supply from the automated pharmacy dispensing machine without charge. The facility immediately discarded the discontinued Levamir that was not given nor active since 5-31-18. 2. There were no other resident□s involved in this listed deficiency; however, the facility will conduct a house wide audit of residents on insulin therapy. A house audit of all medication storage areas will be completed in comparison with the insulin therapy audit. Immediate corrective actions will be taken. 3. The facility will re-educate all direct care nursing staff on medication storage and labeling policy and procedure. All supervisors will be educated on the labeling policy and procedure of medications dispensed from the automated pharmacy dispensing machine, and the policy and procedure for medication dispensing from the automated pharmacy dispensing machine. A nightly medication storage audit will be initiated and completed on a nightly basis to identify the need for medication waste and/or return to the pharmacy, as well as proper labeling and storage. 4. In order to ensure ongoing compliance, the facility will conduct	

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F 760	Continued From page 23 At 1 pm, the surveyor called and spoke to Pharmacist #1 on the phone. The surveyor reported the above observation made on 6/14/18 at 10:25 am and asked Pharmacist #1 what the pharmacy was sending for Resident #152 to the facility to be administrated by the staff. Pharmacist #1 stated, "We previously had an order for Novalog insulin to be sent but according to our records this was discontinued on 5/10/18. Then we had an order for Levamir insulin to begin on 5/18/18 and that was discontinued on 5/31/18." The surveyor asked Pharmacist #1 if Levamir insulin could be given to the resident four times a day and he stated, "No, not that many times. It is a long acting insulin and only should be given 1 or 2 times daily. You need a short acting insulin to be given four times a day." The surveyor requested the last manifest that contains the date and number of insulin syringes be faxed to the facility for the survey team to review. This request was received by the survey team at 1:30 pm, in which the surveyor noted the following: " ...Delivery Manifest: _____ (name of the facility) - Fourth Floor 4/18/18 3:29:05 AM ... _____ (name of Resident #152) Insulin Novalog FLEXIPEN Quantity 3 Status Delivered ..." At 1:25 pm, the director of long term care services came into the conference room and stated to the survey team, "I heard there was a concern about _____ (name of Resident #152) insulin. I discarded both the Levamir and Humalog insulin in the sharps container as soon as I was told about the insulin concern of which insulin the resident was receiving. We are ordering the correct insulin from the pharmacy now."	F 760	random audits of 8 medication carts weekly x 4 weeks, then monthly x 4 months. All findings will be submitted to the QAA for review and recommendations. 5. The corrective action will be completed by July 27, 2018	

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F 760	Continued From page 24	F 760		

At 1:30 pm, the director of long term care services returned to the conference room and stated the following to the survey team leader and this surveyor (writer): "I need to correct my statement. Reviewed the error and there were no orders for Levamir. That was d/cd (discontinued) 5/31/18 and Humalog was started on 5/31/18 per sliding scale insulin."
At 3 pm, the director of nursing (DON), assistant director of nursing (ADON) and staff educator came into the conference room to speak to the surveyor and survey team leader. The staff educator was holding 4 boxes of insulin in which she stated, "We spoke to the staff, and they have been giving the resident this insulin." The surveyor noted that these boxes contained insulin in vials and was not the FLEXPEN injector that had been order by the physician. The surveyor asked the staff educator where the FLEXPEN injector was that was ordered. The staff educator stated, "They were giving this because this is what they were able to get out of the Omnicell that we have our extra medications in." The surveyor requested the manifest from the pharmacy that has the physician ordered Humalog insulin on it that supports the staff obtaining this insulin on 5/31/18. The surveyor reviewed these findings as documented above to the survey team. The surveyor and survey team cannot distinguish which insulin the resident did receive by the facility staff.

At 4:25 pm, LPN (licensed practical nurse) #1 came into the conference room to speak to the survey team. The surveyor asked LPN #1 if she knew who or how the white label on _____ (name of Resident #152's) insulin came to be on the Insulin Pen Injector that had a manufactory's label that stated it was "Levamir" insulin. LPN #1

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F 760	Continued From page 25 stated, "_____ (name of resident) had an order for Humalog insulin. I wrote the order and then I called the supervisor and asked her to get this insulin for _____ (name of resident). I put the wrong label on this insulin pen. It should had been for _____ (name of another resident on the unit). The surveyor asked if LPN #1 could remember when she had done this. LPN #1 stated, "I believe it had to be last Tuesday then I was off sick for a week. But I know that I gave _____ (name of Resident #152) the right insulin." The administrative team were notified of the above documented findings at approximately 4:45 pm in the conference room. The surveyor requested a copy of the facility's policy on the administration of insulin to a resident. The surveyor received a copy of the facility's policy titled "Insulin Administration" at approximately 5:25 pm, which read in part, " ...The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to ensure that it corresponds with the order on the medication sheet and the physician's order ..." The surveyor also received another policy titled "Administrating Medications" which read in part, " ...Insulin pens will be clearly labeled with the resident's name or other identifying information. Prior to administrating insulin with an insulin pen, the Nurse will verify that the correct pen is used for that resident ..." No further information was provided to the surveyor prior to the exit conference on 6/14/18.	F 760		
F 761	Label/Store Drugs and Biologicals	F 761		7/27/18

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F 761 SS=E	Continued From page 26 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to record the open date on medications stored in the medication carts and failed to discard insulin after the expiration dates had occurred in the medication storage areas of the facility (The medication storage areas of the facility included: Main South Medication Cart, 1st Floor Pantry Room, Terrace Red (1 East), 2nd Floor Pantry Room, 2nd South Medication Cart, 4th Floor	F 761	1. No residents were identified in the deficiency. No resident demonstrated any evidence of adverse effects. a. #1: Latanoprost standard labeling from Remedi pharmacy does not generalize discard dates of 42 days. All Latanoprost labels, clearly indicate actual discard dates printed on the pharmacy dispensed label upon pharmacy dispensing. The Latanoprost in question	

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F 761	Continued From page 27 Pantry Room, 4 East Medication Cart and 4th Floor Nursing Office Refrigerator). The findings included: The facility staff failed to record the open dates of medications and failed to discard insulin and glucometer controls after the expiration dates had occurred in the medication storage areas of the facility. These medication storage areas included: Main South Medication Cart, 1st Floor Pantry Room, Terrace Red (1 East), 2nd Floor Pantry Room, 2nd South Medication Cart, 4th Floor Pantry Room, 4 East Medication Cart and 4th Floor Nursing Office Refrigerator. On 6/14/18, the surveyor observed the following areas of concern when reviewing the storage areas of the facility with the staff educator. The areas of concern were identified as: 1. At 8:20 am, on the Main South medication cart, the surveyor observed the following: " Latanoprost Ophthalmic Solution 0.005% was filled by the pharmacy on 6/11/18. The surveyor read the following on the pharmacy label, which read in part, " ...Refrigerate until opened - Discard after 42 days after opening ..." The surveyor did not find an open date on the eye drops. " Another bottle of Lantanoprost Ophthalmic Solution 0.005% for another resident of the unit was labeled with the following by the pharmacy, which read in part, " ...Refrigerate until opened - Discard after 42 days after opening ..." The surveyor did not find an open date on the eye drops. 2. At 8:40 am, on 1st Floor Pantry Room, the	F 761	had a printed pharmacy label that clearly indicated, Discard on 6/11/19 or sooner if otherwise indicated. b. #2: High and Low control for blood sugar glucometer were labeled with an open date of 4-14-18, per the surveyors CMS 2567. According to manufacturer recommendations and guidelines, controls are to be used within 90 days after first opening. The survey was conducted on 6 -14-18 within the 90 days of use. c. #3: Humalog Kwik Pens are automatically labeled from Remedi pharmacy. The pharmacy labeling system does not have the capacity to double label; nor does staff have the ability to print resident labels. A review of the facilities 802 indicates only resident on the listed assignment had an insulin injection. This deficiency was not reviewed with the DON or ADON upon the findings, and Nurse Educator denies this event on Terrace East Hall. d. #3: High and Low control for blood sugar glucometer were labeled on the individual bottles under EXP: date; however staff did not label the exterior box. The labeling regulation does not take mention of specific locations for recording expiration dates. e. #4: Multi use vial of Lorazapem 2mg/ml do not require date opened, as these are single one time use vials. Upon use, remaining doses are discarded. At the time of the survey, all vials were unused, seals and capped as the order in question is PRN seizure activity. f. #4: Novalog insulin with unreadable open date was immediately discarded.	

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F 761	Continued From page 28 surveyor observed the following: " High and Low Controls for the blood sugar glucometer were labeled with an opened date of "4/14/18. 3. At 9:15 am, on Terrace Red (1 East), the surveyor observed the following: " Humalog Kwik Pen opened date of 5/26/18. This pen had 2 labels with 2 different resident's name on it. The staff educator was with the surveyor and the staff educator threw this insulin pen away and notified the medication nurse on the unit to reorder the correct insulin for the 2 residents that had names on this one insulin pen. The staff educator stated, "I'm not sure so I threw those away." " Normal and High controls for the blood sugar glucometer did not have a date of when the controls were opened. On the side of the box, it stated, " ...Discard after 90 days after first opened". 4. At 9:30 am, on the 2nd Floor Pantry room, the surveyor observed the following: " Multiple use vial of Lorazepam 2 mg/ml did not have a date on it when opened. " Novalog insulin 100 units/ml had a date that was unclear of the date of when the insulin was first opened. The date was "__/14/18". The surveyor showed this to the staff educator and she stated, "I don't know what the date is supposed to be." 5. At 9:50 am, on the 2nd Floor medication cart, the surveyor observed the following: " Diphenhydramine liquid vial had an opened date of 3/28/17 on the side of the box. The medication nurse stated to the surveyor, "She's	F 761	g. #5: Diphenhydramine bottled labeled 3-28-17 was immediately discarded. h. #6: Individual albuterol inhalants (nebulization unit doses) are dispensed in a bulk supply in a dispensed box. Individual unit doses are not supplied. i. #7: Humalog □ as described in F760 and F685, was immediately accidentally discarded by the Director of Long term Care Services. A new supply was provided without cost and labeled per protocol. j. #8: Levimir flexpen was immediately discarded k. #9: Tuberculin solution date was noted on the bottle under the Ex section; however, staff did not label the exterior box. The labeling regulation does not take mention of specific locations for recording expiration dates. 2. The facility will conduct a house wide audit of all medication storage areas. Immediate corrective action will be taken. 3. The facility will re-educate all direct care nursing staff on medication storage and labeling policy and procedure. A nightly medication storage audit will be initiated and completed on a nightly basis to identify the need for medication waste and/or return to the pharmacy, as well as proper labeling and storage. 4. In order to ensure ongoing compliance, the facility will conduct random audits of 8 medication carts weekly x 4 weeks, then monthly x 4 months. All findings will be submitted to the QAA for review and recommendations. 5. The corrective action will be	

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F 761	Continued From page 29	F 761	completed by July 27, 2018	

no longer on this and we forgot to take it out of the drawer."

6. At 10:15 am, on the 4th Green Floor, the surveyor observed the following on the medication cart:
" Albuterol Inhalation individual dose packs were lying on top of the box in the last drawer of the medication cart. Three individual packs were not stored in the foil packets that were provided in the box.

7. At 10:25 am, on the 4th Floor Pantry Room, the surveyor observed the following:
" Humalin R insulin vial did not have an opened date of when the staff had opened the vial and began using it for administrations to residents that were ordered this insulin.

8. At 10:35 am, on The 4th East medications cart, the surveyor observed the following: Levamir Flexpen insulin had a manufactory's label that stated the insulin was Levamir. On the side of the pen was a white label on it that stated Resident #152's name with it label with the name of an insulin as "Novalog". The date of the pen was 6/6/18 as to when this insulin had been opened.

9. At 10:50 am, on the 4th Floor Nursing Office, the surveyor observed the following:
" Tuberculin Purified Protein multiple use vial had been opened but not dated.

The surveyor requested and received the facility's policy titled "Storage of Medications" which read in part:
" ...1. Drugs and biologicals shall be stored in the packing, containers or other dispensing systems

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F 761	Continued From page 30 in which they are received. .. 3. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed ..." The administrative team was notified of the above documented findings by the surveyor on 6/14/18 at approximately 4:45 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 6/14/18.	F 761		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet	F 849		7/27/18

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professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice

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representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible

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for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.

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F 849	Continued From page 34 (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to coordinate Hospice Services for 2 of 34 Residents in the sample survey, Resident #27 and #47. The Findings Included: 1. For Resident #27 the facility staff failed to coordinate a Hospice Care Plan between the facility and the Hospice vendor. Resident #27 was an 88 year old female who was admitted on 11/30/17. Admitting diagnoses included, but were not limited to: Escherichia coli, chronic embolism and thrombosis of the deep veins, dysphagia, hemiplegia and hemiparesis following cerebrovascular disease affecting the right dominate side, insomnia, major depression	F 849	1. Resident #27 had no adverse effects. The facility immediately coordinated with the hospice provider, and a current plan of care was immediately obtained and entered into the medical record. Resident #47 had no adverse effects. The facility immediately coordinated with the hospice provider, and a current plan of care was immediately obtained and entered into the medical record. 2. The facility will conduct a house wide audit of all resident□s under hospice services. Immediate corrective actions will be taken. 3. The facility will initiate a new process for obtaining copies of the admission contract/consent, plan of care, and care plan. The facility will institute a policy and procedure for collaborating with hospice	

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F 849	Continued From page 35 anemia and legally blind. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Significant Change MDS assessment with an Assessment Reference Date (ARD) of 3/19/18. The facility staff coded that Resident #27 had a Cognitive Summary Score of 0. The facility staff also coded that Resident #27 required extensive assistance (3/3) with Activities of Daily Living (ADL's). In Section P. Special Treatments, the facility staff coded that Resident #27 was receiving Hospice Services. On June 12, 2018 at 1:30 p.m., the surveyor reviewed Resident #27's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "HOSPICE: Admit to (name of Hospice Vendor withheld) for senile degeneration of the brain with routine level of care. Call (telephone number for Hospice Vendor withheld) for changes in patient condition or death. LEVEL OF CARE: Hospice." (sic) Further review of the clinical record documented that the Hospice Vendor initiated Hospice Services of 1/4/18. Additional review of the clinical record failed to produce the Hospice Care Plan to coordinate services between the Hospice Agency and the facility staff. On June 12, 2018 at 1:35 p.m., the surveyor asked the Assistant Director of Nursing (ADON) to help the surveyor understand the physician orders on the clinical record. The surveyor and ADON reviewed Resident #27's physician orders. The surveyor pointed out that Resident #27 had a	F 849	to maintain a hospice care plan. The facility will institute a new hospice CNA documentation protocol in the facilities EMR. All routine hospice providers will be re-educated on documentation and EMR policy and procedure. 4. In order to ensure ongoing compliance, the facility will conduct random audits of 5 residents weekly x 4 weeks, then monthly x 4 months. All findings will be submitted to the QAA for review and recommendations. 5. The corrective action will be completed by July 27, 2018	

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physician order for Hospice Services. The surveyor notified the ADON that Hospice Services care plan for Resident #27 could not be located in the clinical record. The surveyor and ADON reviewed Resident #27's clinical record. The ADON was unable to locate a care plan from the Hospice Vendor to coordinate the services between the Hospice Vendor and the facility.

On June 12, 2018 at 2 p.m., the surveyor met with the ADON and Director of Nursing (DON). The ADON and DON stated that Resident #27 was on Hospice at another facility and that Resident #27 was discharged to a local hospital. The ADON and DON stated that when Resident #27 admitted into their facility, Resident #27 was on Medicare for reimbursement. The ADON stated when Medicare was discontinued Resident #27 went on Medicaid Hospice services started again. The DON stated that the Hospice Vendor picked up Resident #27 back up "from where they left off at the other facility." The DON stated that the Hospice Vendor never leaves care plan or contract with that is discussed/signed with the family/resident. The DON stated that the Hospice Vendor uses their own computerized system. The surveyor asked the ADON and DON how the facility staff to know what services the Hospice Vendor was providing and who was responsible for certain care areas for Resident #27.

On June 12, 2018 at 3:30 p.m., the ADON hand delivered a Hospice care plan for Resident #27 from the Hospice vendor. The ADON stated that she had called the Hospice vendor and told them to bring the care plan to the facility.

On June 13, 2018 at 3:30 p.m., the survey team met with the Administrator (Adm), DON and

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ADON. The surveyor notified the Administrative Team (AT) that Resident #27 had a physician order for Hospice services. The surveyor informed the AT that the Hospice Services stated on 1/4/18. The surveyor informed the AT that the Hospice Vendor had not provided the facility with a copy of the Hospice Vendors care plan for Resident #27. The surveyor notified the AT that the facility failed to coordinate Hospice services with the Hospice Vendor.

On June 13, 2018 at 4:25 p.m., the ADON hand delivered a facility policy and procedure titled, "Hospice Program." The policy and procedure read in part ...

"3. When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms as indicated in the physician's orders. The facilities care plan shall be revised and updated as necessary to reflect the resident's current status."

No additional information was provided prior to exiting the facility as to why the facility staff failed to coordinate Hospice Services for Resident #27.
2. Facility staff failed to collaborate with hospice to maintain a hospice care plan for Resident #47. The resident's clinical record was reviewed on 6/12/18 at 10:00 AM.

Resident #47 was admitted on 1/6/16. Her diagnoses included hypertension, hemiplegia, depression, dysphagia, and renal failure.

Resident #47's MDS (minimum data set) dated

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4/3/18 coded the resident with significant cognitive impairment. The resident required staff assistance for all the ADLs (activities of daily living).

The resident's CCP (comprehensive care plan), reviewed and revised on 3/26/18, documented the resident was admitted to hospice with a routine level of care. The CCP did not outline the resident's care that was to be provided by the hospice staff.

Resident #47's physician's orders contained a directive to admit the resident to hospice care. It was signed and dated on 8/23/17.

On 6/12/18 03:23 PM the surveyor asked LPN II where the hospice care plan could be located. He told the surveyor it should be in the computer and said the unit supervisor could locate it.

LPN I (unit supervisor) said Resident #47 did not have a hospice care plan in the clinical record for use by nursing staff. She left the floor and returned with a copy of the hospice care plan that had been obtained from the hospice service earlier in the day.

LPN I said, "We're going to scan them to the computer so the floor nurses will have access to them." The surveyor asked how do the floor nurses know what the what the staff hospice does for the resident? LPN I replied, "That's a good question."

06/12/18 03:37 PM RN I was asked what care the hospice staff provided. She said they (hospice nurses) will see if the patient is comfortable, check for pain, and make them more

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comfortable. They provide end-of-life care. They talk with them, evaluate, and do assessments. They check the medicine list and see if they need anything and order medication for pain. Then we give the medicine. They ask the facility nurses if pain medication helped or not.

RN I said she didn't know what care was provided by the hospice CNAs. "Our CNAs check her every hour to reposition her and do personal hygiene. She is incontinent of bowel and bladder."

LPN I said she just got the hospice care plan today and the nurses haven't had the plan available. The surveyor asked LPN I what service hospice provided.

She said the hospice staff visit, support, take her outside and talk with the resident. The CNAs came in and helped with ADL care. "They may help bath her with our CNAs. Sometimes 1 x wk--sometimes 2 x a week."

LPN I also told the surveyor the hospice care plan didn't really define what care was provided by the nursing staff or CNAs. "They keep a schedule of visits which are logged into our computer. The hospice nurse charts hospice visits in the computer under assessments."

None of the facility staff members could really describe the specific duties ascribed to the hospice staff.

The facility had a signed and dated contract for services with the hospice facility. It was signed by the facility and the hospice on 10/26/15. This documented, "Admission of patients, development and initiation of the Hospice Plan of

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F 849	Continued From page 40 Care shall be the responsibility of Hospice. The Hospice Plan of Care shall be the sole responsibility of Hospice." The facility policy for the Hospice Program indicated the hospice agency retained overall management responsibility for directing the implementation of the plan of care related to the terminal illness and related conditions, which included: "a. A designated Hospice Registered Nurse to coordinate the implementation of the plan of care; b. Provision of all core services (e.g. physician, nursing, medical, social work, and counseling services) that must be routinely provided directly by the hospice employees, and cannot be delegated to the facility as outlined in current hospice regulations....; c. Provision of drugs and medical supplies as needed for palliation and management of the terminal illness and related conditions; d. Identification of the specific services the will be provided by each entity and the information that will be communicated in the plan of care; and e. All communication between the hospice and facility when any changes are indicated or made to the plan of care." On 6/13/18 at 12:30 PM the DON was informed of the surveyor's findings. No additional information came in prior to the survey team exit.	F 849		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		7/27/18

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comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(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;

§483.80(a)(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 least restrictive possible for the resident under the

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F 880	Continued From page 42 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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 observation, staff interview, facility document review and clinical record review, the facility staff failed to follow infection control during the wound care observations of 3 of 34 residents in the survey sample. (Resident #15, #222 and #82) The findings included: Resident #15 was admitted to the facility on 5/23/18 with the following diagnoses of, but not limited to anemia, atrial fibrillation, coronary artery disease, heart failure, arthritis and dementia. On the admission MDS (Minimum Data Set) with an ARD (Assessment reference Date) of 5/30/18, coded the resident as having a BIMS (Brief	F 880	1. Resident #15, #82, and #222 had no adverse effects. All residents affected were immediately assessed and dressings reapplied. 2. The facility will conduct a house wide audit of all resident□s with wound care. Immediate corrective actions will be taken. 3. The facility will re-educate the wound nurses regarding wound care policies and procedures, Dressings Soiled/Contaminated policy, as well as infection control policy hand washing policy and procedure. 4. In order to ensure ongoing compliance, the facility will conduct	

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F 880	Continued From page 43 Interview for Mental Status) score of 3 out of a possible score of 15. Resident #15 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent of 1 staff member for bathing. During the wound care observation on 6/13/18 at 8:30 am with LPN (Licensed Practical Nurse) #1, the surveyor observed the following: " LPN #1 donned clean gloves and removed the old dressing from the sacral area of the resident. " With the same gloves, LPN #1 cleaned the wound with normal saline and wiped down the center of the wound bed. The nurse did not use a circular motion from the inner aspect working in an outward direction when cleaning the wound bed. " LPN #1 removed her gloves and applied a pair of clean gloves on but did not wash her hands between changing of the gloves. " Santyl was applied to the wound bed and the nurse placed a clean dressing to cover the wound. " LPN #1 removed her gloves, discarded them into the trashcan, and washed her hands. The surveyor interviewed the following on 6/13/18 at 2:45 pm in the conference room: Infection Control Nurse, LPN (licensed practical nurse) and LPN #1 and #2. The surveyor notified them of the above observations during wound care. The Infection control nurse stated, "We preach wash your hands, wash your hands, and yes they should change their gloves then wash their hands, apply clean gloves and clean the wound." The surveyor requested and received a copy of	F 880	random audits and wound care inspections of 5 residents weekly x 4 weeks, then monthly x 4 months. All findings will be submitted to the QAA for review and recommendations. 5. The corrective action will be completed by July 27, 2018	

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the policy titled "Dressings, Dry/Clean" which read in part: "Under Section 11 Remove a Soiled Dressing"
" ...16. As soon as you have finished removing the soiled dressing and cleansing the wound, remove and discard your gloves ..."
Under Section 13. Cleansing the wound and applying a clean dressing, it read in part as follows:
" ...1). Cleanse the wound ...Clean from the least contaminated area to the most contaminated area (usually, from the center outward).
2. Remove and discard your gloves.
3. Wash your hands or use an alcohol-based hand cleaner ..."17. Wash your hands (and scissors, if used) or use alcohol hand cleaner before applying a clean (or sterile) dressing or leaving the room ..."

No further information was provided to the surveyor prior to the exit conference on 6/14/18.
2. The facility staff failed to ensure appropriate handwashing during wound care.

Resident # 82 is a 74-year-old-female who was admitted to the facility on 4/27/18. Diagnoses included but were not limited to: dementia with behavioral disturbance, pressure ulcer of the sacral region, stage 3, cognitive communication deficit, and major depressive disorder.

The clinical record for Resident # 82 was reviewed on 6/12/18 at 11:10 am. The most recent MDS (minimum data set) assessment was a significant change assessment with an ARD date (assessment reference date) of 4/30/18. Section C assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 82's cognitive status is severely impaired.

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Section M assesses skin conditions. In Section M0210, the facility staff documented that Resident # 82 had at least one or more unhealed pressure ulcer(s) at Stage 1 or higher. In Section M0300, the facility staff documented that Resident # 82 has 1 Stage 3 pressure ulcer.

The plan of care for Resident # 82 was reviewed and revised on 5/14/18. The focus area of "Impaired skin integrity, R/T (related to) admitted with current altered skin integrity, disease process (Alzheimer's disease, Dementia with behavioral disturbance, HX (history) if TIA (transient ischemic attack) and CVA (cerebrovascular accident) History of altered skin integrity (scaring top under breast and right buttock) Impaired mobility (general muscle weakness) Braden score of 12 or less fragile skin, incontinence of bowel and bladder
1. Left heel blanchable redness
2. Right heel blanchable redness
3. Sacrum stage 3"
Interventions include but are not limited to: "Treatment per order" and "Continue at risk for skin breakdown interventions."

The physician signed the physician's orders for Resident # 82 on 6/12/18. Orders include but are not limited to: "Treatment for sacrum as needed for wound care. Cleanse wound to sacrum with normal saline, apply skin prep to peri wound, cover with allevyn life 6x6 and every evening shift for wound care Cleanse wound to sacrum with normal saline, apply skin prep to peri wound, cover with allevyn life 6x6 and every shift monitor dressing placement and monitor and assess for s/s (signs and symptoms) of infection."

On 6/13/18 at 9:03 am, LPN # 1 (licensed

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practical nurse) and LPN # 2 washed hands appropriately and donned gloves. LPN # 1 and LPN # 2 explained what they were doing, and repositioned Resident # 82 in bed and assisted her to turn toward her right side. LPN # 1 removed the old dressing from Resident # 82's sacral area did not remove gloves or wash her hands. LPN # 1 then opened sterile gauze and applied saline bullet to moisten the gauze. Next LPN # 1 opened the new allevyn package, initialed, and dated the dressing. Next, LPN # 1 opened the skin prep. LPN # 1 then removed her gloves, discarded the gloves in the trash, and did not wash her hands. LPN # 1 applied clean gloves. The surveyor observed a small dime sized crescent shaped area in mid sacrum. LPN #1 cleaned the area with the moistened saline gauze and dried the area with a dry saline gauze. LPN # 1 applied skin prep to the crescent shaped area on Resident # 82's sacrum and covered the area with the allevyn dressing. Resident # 82 tolerated the procedure well.

On 6/13/18 at 2:58 pm, the survey team spoke with director of infection control, LPN # 1, and LPN # 2 about the issues with not removing gloves and washing hands during wound care. LPN # 1 stated that they had been followed by wound care before and was told that they did not have to change gloves. The surveyor recalled the events of the wound care as stated above and asked the director of infection control what the nurses are expected to do. The director of infection control stated, "Everything I have known is handwashing, handwashing, handwashing." The surveyor asked the director of infection control if she would expect the nurses to remove gloves and wash hands after changing a soiled dressing and the director of infection control

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stated "yes."

According to the facility policy on "Handwashing/Hand Hygiene," "Policy Interpretation and Implementation" contains documentation that includes but is not limited to:

"7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for following situations:
g. Before handling clean or soiled dressings, gauze pads, ect,;
k. After handling used dressings, contaminated equipment, ect.;"

According to the facility policy on "Dressings, Dry/Clean," "Steps in the Procedure" contains documentation that includes but is not limited to:

"11. Removing a Soiled Dressing
16) As soon as you have finished removing the soiled dressing and cleansing the wound, remove and discard your gloves.
17) Wash your hands (and scissors, if used) or use alcohol and cleaner before applying a clean (or sterile) dressing or leaving the room."

On 6/13/18 at 3:45 pm, the administrative team was made aware of the findings as stated above.

No further information was provided to the survey team prior to the exit conference on 6/14/18.
3. The facility staff failed to follow infection control guidelines during a wound care observation on Resident #222.

The clinical record of Resident #222 was reviewed 6/12/18 through 6/14/18. Resident

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#222 was admitted to the facility 6/8/18 with diagnoses that included but not limited to pneumonitis due to inhalation of food, muscle weakness, dysphagia, severe-protein malnutrition, gastroesophageal reflux disease, major depressive disorder, hypertensive chronic kidney disease, diaphragmatic hernia without obstruction, osteoarthritis, skin tear to right shin and unstageable pressure ulcer left lateral ankle.

The admission minimum data set (MDS) assessment had not been completed.

The initial care plan for Resident #222 was reviewed. Resident #222 was admitted with current altered skin integrity-sacrum (non-blanchable redness),left heel non-blanchable redness, right heel non-blanchable redness, right medial ankle/foot non blanchable redness, mid back non-blanchable redness, abdominal fold redness, perianal redness, right lower leg skin tear, left lateral ankle (unstageable), left arm/hand multiple bruises, right arm/hand multiple bruises, left lower leg multiple bruises, right lower leg/thigh multiple bruises, and callous right 3rd and 4th toes. Interventions: Consult with wound MD (medical doctor), continue at risk for skin breakdown interventions, treatment per order, and weekly wound team monitoring as needed.

The surveyor observed wound care on 6/13/18 at 10:27 a.m. with licensed practical nurse #1 and licensed practical nurse #2. L.P.N. #2 provided the wound care and L.P.N. #1 was the assistant. L.P.N. #2 informed the resident of the wound care.

The wound care nurses had set up the over the

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bed table with the wound care supplies prior to the surveyor entering the room. L.P.N. #1 was positioned to the right side of Resident #222 and had donned gloves already. The surveyor did not observe L.P.N. #1 wash hands prior to glove application.

L.P.N. #2 washed hands and put gloves on. L.P.N. #2 removed the old dressing from the left outer ankle and discarded dressing into trash can. L.P.N. #2 cleaned the ankle with normal saline on 4 x 4 gauze x 3 times and then dried. L.P.N. #2 removed the soiled gloves and then reapplied a new pair of gloves. No handwashing or hand hygiene was observed. L.P.N. #2 then applied skin prep to the perimeter of the wound. L.P.N. #2 applied Santyl to inner (center) area with a qtip. Allevyn dressing applied to area. Allevyn had been dated and initialed prior to applying. Blue pad removed. Scissors placed in pocket and gloves removed. Hands washed. Scissors not observed to be cleaned prior to L.P.N. #2 placing them in uniform pocket.

The surveyor observed wound care to right shin. Barrier set up. Wound care supplies placed on barrier. Scissors removed from L.P.N. #2's pocket. L.P.N. #2 cut a piece of xeroform gauze and then placed scissors on barrier (scissors not cleaned before use). L.P.N. #2 removed old dressing and discarded. L.P.N. #2 cleaned the right shin area with normal saline and then dried. Removed gloves. L.P.N. #2 donned new gloves. L.P.N. #2 applied skin prep to the area around the skin tear. Xeroform gauze applied to the wound bed and then allevyn gentle dressing-dated and initialed prior to applying. Old gloves off. New gloves on. The surveyor did not observe L.P.N. #2 wash hands after removing

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gloves and applying new ones. Scissors cleaned with alcohol. Barrier and used supplies removed and discarded. Gloves off. Hands washed.

The surveyor requested the facility policy on dressing changes and the facility policy on handwashing from the director of nursing on 6/13/18 at 9:00 a.m.

The facility policy titled "Dressings, Soiled/Contaminated" read in part "11. Removing a Soiled Dressing. 15. Discard the soiled dressing in the plastic bag or trash can, placed at the foot of the bed. 16. As soon as you have finished removing the soiled dressing and cleansing the wound, remove and discard your gloves. 17. Wash your hands (and scissors, if used) or use alcohol hand cleaner before applying a clean (or sterile) dressing or leaving the room." The policy titled "Handwashing/Hand Hygiene" read in part "7. Use an alcohol based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: k. After handling used dressings, contaminated equipment, etc."

Three surveyors met with the wound care team (L.P.N. #1 and L.P.N. #2) and the infection control nurse on 6/13/18 2:45 p.m. and discussed the wound care observations. The infection control nurse stated "You need to wash your hands, wash your hands, wash your hands." The surveyor interviewed L.P.N. #2 about cleaning scissors. L.P.N. #2 stated she should have cleaned the scissors."

The surveyor informed the administrator, the director of nursing and the assistant director of

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