STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

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F 000	INITIAL COMMENTS An unannounced Abbreviated Medicare and Medicaid survey was conducted 1/3/18 through 1/4/18. Two complaints were investigated during the survey. Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 118 at the time of the survey. The survey sample consisted of 3 current Resident reviews (Resident #1, Resident #2 and Resident #5) and 2 closed record reviews (Resident #3 through Resident #4).	F 000		
F 760 SS=D	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, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure that 1 of 5 residents in the survey sample was free of significant medication errors, Resident # 3. The findings included: The facility staff made significant medication errors when they administered Resident # 3 her roommate's medication. The State Agency received a complaint on 12/28/17 alleging that Resident #3 received her roommate's medications on 12/7/17. The complaint alleged that after Resident #3 received	F 760	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F760	2/5/18

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

Electronically Signed | 01/29/2018

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 760	Continued From page 1 her roommate's medications her blood pressure dropped very low. The complaint also alleged that Resident #3 required IV fluids to "flush the medications these wrong medicines out of her system." Resident # 3 was an 82 year old female who was originally admitted to the facility on 12/2/17. Diagnoses included but not limited to: traumatic subdural hemorrhage, muscle weakness, difficulty in walking, hypertension, hyperlipidemia, asthma, and osteoarthritis. The most recent MDS (minimum data set) assessment was a 14-day assessment with an ARD (assessment reference date) of 12/15/17. Resident # 3 had a BIMS (brief interview for mental status) score of 15 which indicated that she was cognitively intact. The clinical record for Resident # 3 was reviewed on 1/3/18 at 10:35 am. While reviewing the facility progress notes the surveyor observed a note dated 12/7/2017 08:30 which documented "0840 # 22 iv (intravenous) started to rt (right) ac (antecubital) and ns (normal saline) infusing at 100 hr (hour)." (sic) On 12/7/17 a progress note documented that Resident #3's "b/p 80/64 resp 18 02 97%. Pt alert x 3 no s/s (signs or symptoms) distress noted." (sic) On 12/7/17 12:59 documentation in the clinical record stated "at 0810 am wrong meds given in era (error). pt (patient) is alert x 3 and denies pain or discomfort. b/p (blood pressure) 100/60 resp (respirations) 18 sats (oxygen saturation) 98% on ra (room air) pulse 57. Dr (physician's name withheld) notified n.o. (new order) to monitor b/p and start nc (normal saline) at 80/hr (hour). Pt husband notified." A note dated 12/7/17 at 13:02	F 760	Resident # 3 is no longer in the facility. Audits were done for current residents to assure that residents had an arm bracelet in place and a picture done on admission to identify residents for med pass. License staff were educated on the process to identify residents for medication pass and on the 5 R of medication pass by the DON by 2/2/18. Residents having arm bracelets in place is being monitored on daily rounds at least 5 times per week by Administration/ designee. Any non-compliance will be reported to QI committee for tracking, trending, and progressive disciplinary action.	

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stated "at 11am b/p 68/54 p 57 resp 18 O2 98% pt alert x 3 and denies pain and discomfort." (sic) A note in the clinical record dated 12/7/17 14:21 stated "pt alert x 3 and no s/s of distress noted. b/p 82/49 p 58 r 18 96% on 2 lpn (liters per minute) nc. Will cont (continue) to monitor." (sic)

Blood Pressure readings are as follows:

12/2/17 18:46	105/66
12/3/17 05:58	105/66
12/3/17 10:08	129/75
12/3/17 15:32	133/84
12/3/17 22:31	139/80
12/4/17 09:39	120/75
12/4/17 21:31	166/79
12/5/17 05:55	119/69
12/5/17 12:23	105/62
12/5/17 15:54	111/61
12/6/17 04:00	139/80
12/6/17 11:08	144/83
12/6/17 15:26	138/72
12/7/17 06:12	105/61
12/7/17 11:59	139/80
12/7/17 15:35	76/43
12/8/17 03:53	101/59
12/8/17 11:33	104/63
12/8/17 16:27	90/56
12/9/17 06:59	106/65
12/9/17 12:05	95/60
12/9/17 16:35	107/67
12/10/17 00:17	106/64
12/10/17 11:50	113/70
12/10/17 20:26	109/73
12/11/17 04:42	109/73
12/11/17 11:33	110/66
12/11/17 15:23	115/64
12/12/17 05:50	120/69
12/12/17 10:07	113/73

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F 760	Continued From page 3 12/12/17 15:30 110/69 A review of the MAR for Resident # 3 did display a photograph of Resident # 3 that could be used for identification purposes. Also the MAR has penicillin listed as an allergy for Resident # 3. Resident # 3 received cephalosporin which according to Davis's Drug Guide for Nurses is a cephalosporin and is contraindicated in patients that have hypersensitivity to penicillin. Hopfer-Deglin, J., Hazard-Vallerand, A., & Sanoski, C. (2011). Davis's Drug Guide for Nurses. Philadelphia: F A Davis. On 1/3/18 at 3:00 pm, the survey team met with the nurse consultant, Director of Nursing (DON), assistant administrator (AssistAdm), and administrator (Adm) and discussed the incident as stated above. The surveyor asked the DON did the incident happen. The DON stated "yes." The DON informed the survey team that the employee did not usually work on that unit, but had worked on the unit on 12/7/17 to help another staff member. The DON stated that the employee had gone in and asked Resident #3 if she was (Resident #3's roommate's name withheld) and stated that Resident #3 stated that she was. The DON stated that the Resident #3 had removed her ID bracelet two times. The nurse administered the medication to Resident # 3, and when therapy brought the resident in A bed back from therapy the nurse realized that an error had been made and immediately reported the error to the ADON (assistant director of nursing). The survey team asked if the facility had done a plan of correction? The DON stated "no." The DON stated that they had done counseling with the employee and had done med pass audits in the	F 760		

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facility. The consultant nurse stated that they notified Resident #3's MD and the physician came into the facility to see the Resident # 3 and started the IV's to keep Resident # 3 from going back to the hospital.

Review of the clinical record had not produced a physician progress note indicating that he had come in to assess Resident # 3 following the incident. Also the surveyor had not located any documentation in the facility progress notes that indicated that the physician had come in to see Resident # 3 following the medication error. The survey team asked the facility to provide them with any documentation they could of the physician visit. The survey team notified the Administration Team that the medication errors required the medical intervention of IV fluids to ensure that Resident #3's blood pressure did not drop.

On 1/4/18 at 11:32 am, the facility provided the surveyor with the following written statements:

A written statement from the DON stated "At 830am on 17/7/17 (employee name withheld) LPN (licensed practical nurse) came to my office. He reported that he had made a med (medication) error. We walked to the unit to discuss. (employee name withheld) stated that to help one of the other nurses he had taken a different assignment and was unfamiliar with the patients. He had gathered the meds for 202A (resident name withheld) and entered the room. The patient sitting at A bed did not have a bracelet but he asked "Are you (resident name withheld)?" to which she replied yes. He proceeded to give the medications. Very shortly after therapy brought (resident name withheld)

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back to the room moved Resident # 3 over to the B bed and he realized he had made a mistake. He immediately notified the ADON on the unit and the MD (medical doctor) who ordered IV fluids as a precaution as she had received BP medication and who ordered for her BP to be monitored. At this time the ADON came to the desk at the nurses station to let (employee name withheld) know that she had started the IV He left to hang the IV fluids The ADON reported to me that the pt was asymptomatic. (Employee name withheld) returned and we discussed the incident. We looked together at the pictures in the MAR (medication administration record) to educate him to the back up way to identify patients. There were several nurses in and out of the nurses station and I educated them on identifying patients when passing meds. Pts (patient's) BP was monitored throughout the day while it did drop she remained asymptomatic. Dr. (physician's name withheld) was in the building and went to visit pt and felt she was stable."

A written statement from the Administrator stated "I, (employee name withheld), spoke with (employee name) LPN, on 1/3/18 to clarify the events of 12/7/17. He stated that he spoke to Dr. (physician's name withheld) on the phone that day to notify him of the medication error. Dr. (physician's name withheld) asked him to give the IV fluids if the blood pressure dropped. Dr. (physician's name withheld) happened to be in the building shortly thereafter checking on patients and he swung by to look at Resident #3. After looking at her, he spoke with (employee name withheld) and indicated that he could go ahead and give the IV fluids to be on the safe side."

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A written statement from the ADON dated 1/4/18 at 11:22 stated "On 12/7/17 at approximately 0815 I was notified by charge nurse (employee name withheld) of a medication error on Resident # 3. Apparently the resident was at A bed not her assigned B bed and stated she was her roommate when asked. The error wasn't noted by Nurse until therapy came in to place the roommate back in her assigned bed. The nurse immediately notified Dr. (physician's name withheld) who ordered x1 Liter of IV fluids in case of b/p dropping. I assessed the resident myself at the time of the medication error and throughout the day of the error on 12/7/. She remained alert with noted confusion but never symptomatic and stated she was ok and felt fine. Dr. (physician's name withheld) also came in later that day and assessed the resident."

Memo discussion with (employee name withheld) LPN re med error today 12-7 Resident # 3 stated "Today discussed med error with (employee name withheld) LPN He had mistakenly given medication to the wrong pt. I educated him on the alternate way to identify a pt who did not have an arm bracelet. We reviewed at MAR and the pictures of residents which is our back up identifier. He verbalized understanding of the education given to him"

A written statement from the physician dated 1/4/18 that stated "Resident # 3 had a medication error on 12/7/17. She was sitting in the A bed of her room instead of her normal B bed and identified herself as the A bed patient when asked. She received aspirin, ceftin, clonidine, Tylenol, coreg, donepezil, amlodipine, lasix, and alprazolam. I instructed the nurse to start her on normal saline in case her blood pressure

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dropped. She experienced no adverse reactions from the medication error. Her blood pressure remained stable. She was alert and oriented throughout the day. I did instruct the nurses to hold her pm blood pressure medications that day. I have included her blood pressure readings from her nursing home stay."

According to the facility "Medication Observation Non-Sterile Treatment Technique " form under "Administers meds correctly:"

"Right Patient
-Calls patient by name
-Verifies photo or ID band"

On 11/4/17 at 11:43 am, the survey team met with the consultant nurse, the DON, administrator, and the assistant administrator. The surveyor discussed the resident blood pressure readings following the medication error on 12/7/17 and notations documented in the physical and occupational therapy progress reports. Documentation from the "Physical Therapy Progress Report" stated under Patient Response "Progress & Response to Tx (treatment): Patient had a major setback midway through this rehab period with a medical decline but has since recovered from it and is back on track with making progress." (sic) The rehab period was from 12/3/17 - 12/14/17. Documentation in the "Occupational Therapy Progress Report" stated under Patient Response "Progress & Response to Tx: "Patient was doing extremely well but had a minor setback due to medication creating a negative reaction such as joint stiffness and discomfort making functional mobility difficult." (sic) The consultant nurse verbally told the survey team that Resident # 3 had a problem with

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"Statins." Consultant Nurse stated that Resident # 3 had been switched to Lipitor had continued to experience pain and verbally told the survey team that the Lipitor had been discontinued on 12/8/17, and that the setback was due to the discomfort from the Lipitor not from the medication error. Consultant nurse also stated that Resident # 3 always had blood pressure fluctuations even while in the hospital prior to admission to the facility on 12/2/17. This surveyor discussed with the consultant nurse, DON, administrator, and assistant administrator that after reviewing the blood pressure readings for Resident # 3 there were no documented blood pressures with a systolic reading below 100 or diastolic reading below 60 until after the medication error on 12/7/17. Following the medication error on 12/7/17, there were 12 documented blood pressures in the clinical record for Resident # 3 that had a reading of systolic below 100 or diastolic below 60.

On 1/4/18 at 12:00 pm, the Administrative Team and the therapy manager spoke with the survey team. The therapy manager stated to the survey team that Resident # 3 had received speech therapy on 12/7/17, but had not received physical therapy or occupational therapy due to Resident # 3 being "sleepy" and was getting IV's. Therapy manager also stated that Resident # 3 received half of her treatment time in physical therapy and occupational therapy on 12/8/17 due to Resident # 3 being "sleepy."

According to Davis's Drug Guide for Nurses, the following medications have adverse reactions/side effects are listed but not limited to as follows:
Lipitor arthralgia, arthritis

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F 760	Continued From page 9 Donepezil headache, dizziness, drowsiness, fatigue, syncope, sedation, hypotension, arthritis, and muscle cramps Coreg fatigue, weakness, mental status changes, bradycardia, arthralgia, back pain, muscle cramps Amlodipine headache, fatigue, bradycardia, hypotension Alprazolam dizziness, drowsiness, lethargy, confusion Hopfer-Deglin, J., Hazard-Vallerand, A., & Sanoski, C. (2011). Davis's Drug Guide for Nurses. Philadelphia: F A Davis. On 12/4/17 at 2:45 pm the survey team spoke with the facility administrator, assistant administrator, the DON, and consultant nurse about the findings as stated above. The survey team informed the Administrative Team that Resident #3 received her roommate's medication on 12/7/17 causing Resident #3's blood pressure to drop and requiring the medical intervention of IV fluids. The survey team notified the Administrative Team that the complaint would be substantiated with a deficient practice. No further information was provided to the survey team prior to the exit conference on 1/4/18 as to why the facility failed to ensure that Resident #3 was free of significant medication errors. This is a Complaint Deficiency.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals 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	F 761		2/5/18

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F 761	Continued From page 10 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 a medication pass and pour observation, staff interview and clinical record review, it was determined that the facility staff to ensure that medications were within date for administration for 1 of 5 Residents in the sample survey, Resident #5. The Findings Included: For Resident #5 the facility staff failed to identify that the physician ordered Gabapentin 600 mg was expired. The Gabapentin had been administered for 6 administrations from the expired Gabapentin punch card and was	F 761	F761 Resident # 5 is no longer in the facility. Medication carts were audited by the pharmacy to assure that medications were current and no expired medications present and any that were found were removed and replaced. License staff were educated on the process to check expiration dates prior to giving medications by SDC by 2/2/18. Pharmacy will audit medications carts at least 2 times per month for the next 2 months to monitor for expired medications in the carts.	

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F 761	Continued From page 11 available for administration to Resident #5. Resident #5 was a 60 year old male who was admitted on 12/21/17. Admitting diagnoses included, but were not limited to: cellulitis of the right toe, diabetes mellitus, hypertension, cirrhosis of the liver, hepatitis C and ascites. The clinical record did not contain a Minimum Data Set (MDS) assessment due to Resident #5's recent admission into the facility. On January 4, 2018 at 12:45 p.m. the surveyor was making a Medication Pass and Pour observation with a Licensed Practical Nurse (LPN #1). The surveyor and LPN #1 were standing outside of Resident #5's room and the LPN (#1) obtained Resident #5's medications out of the medication cart. LPN (#1) reviewed the medications to be administered on the computer and reviewed the medication punch cards for the two medications. LPN (#1) reviewed Gabapentin 600mg and Pentoxifylline ER 400 mg. LPN (#1) handed the surveyor the medication cards for review. The surveyor reviewed the Gabapentin medication card and noted that the pharmacy had delivered 90 Gabapentin 600 mg tablets to the facility on Resident #5's day of admission on 12/21/17. The surveyor also noted that the Gabapentin 600 mg tablets had expired on 12/31/17. The surveyor additionally noted that six (6) Gabapentin 600 mg had been punched from the card and administered to Resident #5 by the nursing home staff. LPN (#1) was in the process of popping the Gabapentin out of the punch card to administer the medication to Resident #5. The surveyor stopped the medication pass and pour observation since the Gabapentin was expired and LPN (#1) was in the process of getting ready	F 761	Any non-compliance will be reported to the QI committee for tracking, trending and progressive disciplinary action as needed.	

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to administer the expired Gabapentin to Resident #5. The surveyor asked for LPN (#1) to have the Director of Nursing (DON) and Corporate Compliance Nurse (CCN) to come speak with the surveyor. LPN (#1) went and called the DON and CCN and asked them to come speak with the surveyor. When LPN (#1) returned to the medication cart the surveyor notified LPN (#1) that the Gabapentin was expired. The surveyor pointed out the expiration date of 12/31/17 on both the front and back of the Gabapentin medication punch card. LPN (#1) stated that she had not seen that the medication was expired. LPN (#1) then obtained another Gabapentin 600mg medication punch card that contained 30 Gabapentin 600 mg tablets from the medication cart. The surveyor and LPN (#1) reviewed the second Gabapentin medication punch card and observed that the second punch card also expired on 12/31/17.

On January 4, 2018 at 12:50 p.m. the DON and CCN approached the surveyor and LPN (#1) at the medication cart. The surveyor notified the DON and CCN that Resident #5's Gabapentin 600 mg was expired. The surveyor also notified the DON and CCN that LPN (#1) had not identified that the medication was expired and was in the process of administering the medication to Resident #5. The surveyor reviewed the initial punch card of Gabapentin with the DON and CCN. The surveyor pointed out that the Gabapentin expired on 12/31/17 and that 6 tablets had been removed from the punch card and administered to Resident #5. The surveyor then reviewed the second Gabapentin punch card with the DON and CCN. The surveyor pointed that the second Gabapentin punch card had expired on 12/31/17 also.

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On January 4, 2018 at 1:15 p.m. the DON approached the surveyor and informed the surveyor that she, the DON, had called the pharmacy and spoke with the pharmacy director. The DON stated that the pharmacy director had told her that medications were reviewed and pulled 60 days prior to expiration dates. The DON stated that the pharmacy director stated he did not know how the expired medications were still available for administration.

On January 4, 2018 at 1:40 p.m. the surveyor reviewed Resident #5's clinical record. Review of the clinical record produced signed physician orders dated 12/21/17. Signed physician orders included, but were not limited to: "Gabapentin Tablet 600 MG Give 1 tablet by mouth three times a day for neuropathic pain." (sic)

On January 4, 2018 at 2:50 p.m. the surveyor notified the Administrator (Adm), Assistant Adm (AAdm), DON and CCN that the Resident #5's Gabapentin had expired on 12/31/17 and had been administered for 6 doses. The surveyor also notified the Administrative Team that Resident #5's second Gabapentin medication punch card had expired on 12/31/17 and was available for administration.

No additional information was provided prior to exiting the facility as to why the facility staff had failed to ensure that Resident #5's medications were in date. Resident #5's Gabapentin 600 mg had expired on 12/31/17. Resident #5 had received 6 doses of the expired Gabapentin. A total of 54 Gabapentin 600 mg tablets that expired on 12/31/17 and were available for administration.

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F 880 SS=E	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 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:	F 880		2/5/18

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F 880	Continued From page 15 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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, and facility document review, it was determined that the facility staff failed to adhere to infection control policies during meal time on 1 of 6 halls. The findings included: The facility staff failed to use infection prevention strategies while handling ice and passing trays during meal times on the 200 hallway.	F 880	F880 Ice scoops was removed at the time of survey and cleaned. Staff were instructed to close doors on food carts when passing trays and on hand washing. New ice scoops were ordered and obtained so that scoop does not sit in water and new ice chest with closing lid was put in place. Education was provided to C NA staff on passing ice, closing doors on the food	

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F 880	Continued From page 16 On 1/3/18 at 12:42 pm, CNA (certified nursing assistant) #1 was observed by the surveyor putting ice in cups. The surveyor observed CNA # 1 scooping ice from the ice container that was on top of the meal cart. CNA #1 was observed placing the ice scoop that had been touched with her bare hands in the ice container touching the ice in the container. CNA #1 walked away from the food cart leaving the doors open and the ice container uncovered. The surveyor observed that CNA #1 left the scoop in the ice container. On 1/3/18 at 12:44 pm, the surveyor observed CNA # 2 leave a resident room without washing his hands. CNA # 2 removed the ice scoop from the ice container with his bare hands and scooped ice from the container, and placed ice in a cup. CNA # 2 placed the ice scoop uncovered on a tray that was on top of the food cart that had water, tea, and thickened liquids on it. CNA # 2 filled the cup with tea and placed the cup on a resident tray and took the tray into a resident room. The ice container was left uncovered and the food cart was left open and unattended. On 1/3/18 at 12:47 pm, the surveyor observed CNA # 3 retrieve the ice scoop from the tray with her bare hands and used the scoop to get ice from the uncovered ice container. CNA #3 then received a call on her walkie talkie. CNA #3 replaced the ice scoop back into the uncovered ice container and reached in her left lateral pant pocket retrieved the walkie talkie and replied "we got a couple more trays to pass." CNA # 3 was observed replacing the walkie talkie into her left lateral pant pocket and proceeded to pick up a resident tray and take the tray into the room. The food cart was left open and unattended and the ice container that contained the ice scoop was left	F 880	carts when not at the carts and also on the use of hand sanitizer and handwashing by Dietary Manager by 2/2/18. Administrator/Designee will monitor tray pass at least 5 times per week for next 6 weeks to assure staff are cleansing hands between resident trays, closing doors on the food carts and not touching ice scoops. Any non □compliance will be reported to the QI committee for tracking, trending and progressive disciplinary action as needed.	

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uncovered.

On 1/3/18 at 12:50 pm, the surveyor observed CNA # 3 retrieve the ice scoop from the uncovered ice container and use the scoop to get ice which she placed in a cup and filled with tea. CNA # 3 replaced the ice scoop that she had used with her bare hands in the ice container and ice scoop was observed by the surveyor touching the ice that remained in the container. CNA #3 walked away from the meal cart leaving the ice container which contained the ice scoop uncovered and the meal cart open and unattended and took the cup of tea to a resident's room and gave it to the resident. While in the room with the resident the surveyor observed CNA #3 touching the bedside table and the bed of the resident that was in the room. CNA # 3 exited the room and did not wash her hands.

On 1/3/18 at 12:53 pm, the surveyor interviewed CNA # 3 and asked how often is the staff expected to use hand hygiene while passing trays? CNA # 3 stated "I usually catch hand sanitizer on the way out." Surveyor spoke with CNA # 3 about leaving the room she just exited without washing her hands. CNA # 3 stated "I just took him some sweet tea." The surveyor informed CNA # 3 of observations of her touching the bedside table and the resident's bed and exiting the room without washing her hands. CNA # 3 stated "I guess I didn't think about it." The surveyor asked CNA # 3 if the food cart containing resident meal trays is normally left open and unattended. CNA # 3 stated "normally the food cart is closed." "It's only left open if we go across the hall." The surveyor informed CNA # 3 that she had observed the food cart left open and unattended. The surveyor also asked CNA

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#3 if the ice containers are normally covered? CNA # 3 stated "normally it has a lid or tin foil on it." Surveyor informed CNA #3 of the observation of the ice container being left uncovered and the ice scoop being used and replaced in the container touching the ice.

On 1/3/18 at 3:00 pm the administrator, assistant administrator, the consultant nurse, and the DON (director of nursing) were made aware of the above findings.

On 1/4/18 at 11:32 am the facility provided the survey team with the facility "Infection Prevention & Control Policies and Procedures for Patient Care Equipment" had documentation that stated the following:

"4. Ice machines/Portable Ice Chests, Hydration Carts

a. All ice handlers should be taught the following precautions:
b. Perform hand hygiene frequently.
c. Hold scoop by handle (do not touch bowl surface or inside of the ice chest with hands).
d. Do not handle ice with hands.
e. Discard unused ice.
f. Keep access doors to chest closed except when removing ice.
g. Ice scoops, buckets, portable ice chests, hydration carts or other containers used to transport or store ice need to be sanitized per manufacturer's guidelines."

The facility "Infection Prevention & Control Policies & Procedure for Handwashing" requirements had documentation that stated the following:

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F 880	Continued From page 19 "4. Hand Hygiene 1. The following is a list of some situations that require hand hygiene:" Applicable situations are: "e. Before and after eating or handling food (hand washing with soap and water) f. Before and after assisting a patient with meals (handwashing with soap and water)" No further information was provided to the survey team prior to the exit conference on 1/4/18 as to why the facility failed to implement infection control policies and procedures for passing ice and passing food trays to the residents on the 200 hallway.	F 880		