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	495390	A. BUILDING _____ B. WING _____	C 03/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRMINGHAM GREEN	8605 CENTREVILLE ROAD MANASSAS, VA 20110

(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 2/27/18 through 3/6/18. Significant corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 172 at the time of the survey. The survey sample consisted of 42 resident reviews: 37 current resident reviews and 5 closed record reviews.	E 000		
E 035 SS=B	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide documentation that the communication plan has been shared with families. The findings included: During the Emergency Preparedness Plan	E 035	There were no residents affected by the deficient practice. All residents may be at risk from this deficient practice. A letter containing Birmingham Green□s Emergency Preparedness	4/20/18

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

Electronically Signed | 03/23/2018

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E 035	Continued From page 1 review, the facility staff were not able to provide documentation that the Emergency Preparedness Plan had been shared with families. During an interview on 3/2/18 at 10:15 A.M. with the Administrator and Assistant Administrator, it was confirmed that the Emergency Preparedness Plan had not been shared with resident families.	E 035	Communication Plan was sent to family members and resident representatives on 3/23/18. A letter will be mailed to family members and resident representatives annually. Annual communication plan sharing with family members and resident representatives will be reviewed as a part of annual emergency preparedness review and update.	
E 037 SS=B	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at	E 037		4/20/18

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E 037	Continued From page 2	E 037		

least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least annually.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

*[For PACE at §460.84(d):] (1) The PACE

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E 037	Continued From page 3	E 037		

organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection,

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E 037	Continued From page 4 and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide documentation that all staff had received Emergency Preparedness training. The findings included: During the Emergency Preparedness Plan review, the facility staff were not able to provide documentation that Emergency Preparedness Plan training had been provided to all staff.	E 037	There were no residents affected. All residents may be at risk from this deficient practice. Two employees identified during survey were educated on Emergency Preparedness Plan on 3/2/18. All staff members are to be educated on Emergency Preparedness Plan by Staff Development and/or designee.	

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E 037	Continued From page 5 During an interview on 3/2/18 at 10:15 A.M. with the Administrator and Assistant Administrator, it was stated all staff had received Emergency Preparedness Training. A list of three personnel records were requested from Human Resources for verification of Emergency Preparedness Training. Two of the three personnel records reviewed did not contain evidence that all staff had received Emergency Preparedness Training.	E 037	Staff Development Manager or designee will audit the compliance of Emergency Preparedness training through monthly audits of 20 personnel records for 6 months. Summary of findings will be reviewed and submitted to quarterly QAPI Committee by Staff Development Manager and/or designee for review and recommendations.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard and Emergency Preparedness survey was conducted 2/27/18 through 3/6/18. One complaint was investigated. Significant Corrections are required for compliance with the following Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 172 at the time of the survey. The survey sample consisted of 42 resident reviews: 37 current resident reviews and 5 closed record reviews.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but	F 583		4/20/18

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F 583	Continued From page 6 this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to ensure privacy of healthcare information for one unit (Unit Garden Hill) of three Units. The findings included: During Garden Hill Unit's Medication Pass Task on 2/28/18 at approximately 11:20 AM, Licensed Practical Nurse (LPN) #2 walked away from the medication cart C, leaving her daily assignment sheet face up on top of the medication cart. The daily assignment sheet included resident names	F 583	There were no residents affected by deficient practice. All residents may be at risk of disclosure of protected health information if staff do not properly safeguard resident assignment sheets. Staff members identified were re-educated on privacy, confidentiality and HIPAA on 3/1/18. Staff are to be educated on personal privacy/confidentiality of records and	

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F 583	Continued From page 7	F 583		

and resident diagnoses. During the time the LPN was away from her cart, one facility staff, maintenance staff, and one visitor walked past the medication cart and had the ability to see personal health protected information.

LPN #2 was interviewed on 2/28/18 at approximately 11:30 AM, and asked if she saw anything wrong with walking away from her assignment sheet with Resident protected healthcare information visible to anyone who would walk by. LPN #2 took her assignment sheet and turned it face down so no protected healthcare information was visible to anyone. She stated that she should not have left the healthcare information visible to others. When asked if she felt this was a HIPPA (Health Insurance Portability and Accountability) violation, she stated, "Yes."

On 3/2/18 at approximately 12:15 PM, an observation was made of Garden Hill Unit's Medication Cart B. Resident Protected Healthcare Information was visible to anyone walking past the cart. The Protected Healthcare Information was the assignment sheet of LPN #5. LPN #5 informed the Unit Manager #2, that she had given the assignment sheet to the aide to write in vital signs.

Garden Hill's Unit Manager #2 was asked what the expectation was for Protected Healthcare Information and she stated on 3/2/18 at approximately 12:15 PM, "The information should not be left visible to others."

On 3/5/18 at approximately 12:45 PM, the Acting Director of Nursing #2 was asked what her expectation was for Protected Healthcare

protected health information by Staff Development and/or designee.

Nurse Managers and nursing leadership team will conduct random observation of 6 residents per neighborhood monthly for 6 months to ensure compliance with privacy, confidentiality and HIPAA.

Summary of findings will be reviewed by DON and/or designee through the monthly Clinical Operations Report (COR) process and submitted to quarterly QAPI Committee for review and recommendations.

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Information. The Acting Director of Nursing #2 stated, "Healthcare information should not be visible."

The Facility provided education on the topic, "Best Practice Tips for Med Pass" on 3/1/18. LPN #2 and LPN #5's signature was included on the sign in log. The topics of this education included but were not limited to:

HIPPA - information/privacy

The Facility Policy and Procedure titled "Reporting Unauthorized Access, Use and Disclosure of Protected Health Information (PHI) dated 5/2012 documented the following:

Policy Statement

The protection of resident and facility information is the responsibility of all facility personnel, including business associates. Unauthorized access, use, and/or disclosure of protected information must be reported.

Incidents include, but are not limited to, the unauthorized access, use, or disclosure of the following information:

Resident personal and medical information
Resident names or other identifying information
Any other resident or facility information that has not been publicly disclosed or has been de-identified according to established facility policy

The facility administration was informed of the findings during a pre-exit briefing on 3/5/18 at approximately 3:50 PM and again during the

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F 583	Continued From page 9 3/6/18 exit briefing at approximately 1:45 PM. The facility did not present any further information about the findings.	F 583		
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 observations, staff interview, and clinical record review, the facility staff failed to ensure 2 out of 42 residents (Resident #68 and #16) in the survey sample who were unable to independently carry out activities of daily (ADL), received necessary services to maintain grooming. 1. The facility staff failed to ensure Resident #68 was provided ADL care to include removal of excessive facial chin hair. 2. The facility staff failed to ensure Resident #16 was provided ADL care to include removal of excessive facial chin hair. Findings include: 1. Resident #68 was admitted to the facility on 12/14/17. Diagnosis for Resident #68 included but are not limited to dementia with behavioral disturbance. Resident #68 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/21/2017 coded Resident #68 with a 03 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating	F 677	Resident #68 was assisted by staff with removal of facial chin hair on 3/1/18. Resident #16 refused to have her facial chin hair removed despite multiple attempts during the survey. Resident #16 did not agree to have her facial chin hair removed until 3/6/18 and staff assisted her with the removal of facial chin hair. Occasional ADL refusals were care planned for both residents. All residents may be at risk for presence of unwanted facial hair. 100% audit of all female residents was conducted on 3/1/18 when the concern was brought to the facility's attention by the surveyors. Facial hair removal was provided if necessary in accordance with resident choice. 100% audit of all residents will be conducted for presence of undesired facial hair. Observation of facial hair was added to the weekly skin assessment. Care plans will be updated to reflect individualized care needs including	4/20/18

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F 677	Continued From page 10 severe cognitive impairment. In addition, the MDS coded Resident #68 requiring extensive assistance of one with dressing, personal hygiene and bathing. Section, E (Behavior) was not coded for rejection of care for ADL assistance. The comprehensive care plan documented Resident #68 with requiring assist with Activities of Daily Living (ADL) to include but not limited to dressing and grooming. The goal: the resident will participate in therapy and return to prior level of function. The intervention/approaches to manage goal included, require the assistance of one person with ADL's and PT (physical therapy) to evaluation and treat as indicated for unsteady gait. During the initial tour on 02/27/18 at approximately 12:45 p.m., Resident #68 was sitting in the common area on the secure unit. Resident #68 was observed with an excessive amount of chin hair. On 02/27/18 at approximately 5:10 p.m., during the medication pass and pour observation, Resident #68 remained with an excessive amount of chin hair. On 2/28/18 at approximately 9:40 a.m., Resident #68 was ambulating in the hallway, remained with an excessive amount of chair hair. An interview was conducted with CNA #1 on 02/28/18 at approximately 2:45 p.m., who stated, "The resident refused her bath today and refused to be shaved." On 02/28/18 at approximaltey 2:55 p.m., an interview was conduced with the Unit Manager	F 677	resident preference and/or pattern or refusal. CNAs & licensed nurses will be educated on the need to observe/assess facial hair growth as part of daily care by Staff Development and/or designee. Nurse Managers and nursing leadership team will conduct observation of facial hair and skin assessment audit for 6 residents per neighborhood weekly for 6 months to ensure compliance. Summary of findings will be reviewed by DON and/or designee through the monthly Clinical Operations Report (COR) process and submitted to quarterly QAPI Committee for review and recommendations.	

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F 677	Continued From page 11	F 677		

(UM) who stated, "They were not aware of Resident #68 refusal to be shaved." The surveyor requested Resident #68's refusal care plan. On the same day at 3:20 p.m., the UM stated, "We do not have a refusal care plan for ADL's to include shaving."

Review of residents medical record did not reveal refusal of care for bathing or grooming.

On 3/1/18 at approximately 2:00 p.m., Resident #68 was observed without facial hair to her chin.

An interview was conducted with the Assistant Director of Nursing (ADON) on 3/5/18 at approximatley 1:10 p.m., who stated, "Resdient #68 not being shaved is not acceptable; this is a dignity issue." The ADON proceeded to say, "Not being shaved is the same as having dirty hands. If a resident refuses care, it should be clearly documented and care planned."

The facility administration was informed of the finding during a briefing on 3/05/18 at approximately 3:50 p.m. The facility did not present any further information about the findings.
2. Resident # 16 was admitted to the facility on 5/18/17. Diagnoses included but not limited to: dementia with behavioral disturbances, hypotension, hypothyroidism, and major depressive disorder. The most recent quarterly MDS (minimum data set) assessment had an ARD (assessment reference date) of 11/24/17. Section C of the MDS assessed cognitive patterns and in Section C0500, Resident # 16 had a BIMS (brief interview for mental status) score of 3/15, which indicated severe cognitive impairment. Section G assessed functional status. In Section G0110 for J. Personal hygiene,

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the facility staff coded Resident #16 as 3/2, which indicated that Resident # 16 required extensive assistance with the assistance of one person for personal hygiene.

According to the most recent plan of care for Resident # 16 which was reviewed and revised on 12/5/17, the facility had documented as a problem area, "Resident needs limited assistance with ADL's to remain clean, neat, and free of body odors r/t (related to) cognitive deficits." Interventions included but were not limited to: "PT/OT (physical therapy/occupational therapy) prn (as needed) and tx (treatment) as ordered for assist with ADLs (activities of daily living)/hygiene, transfers," and "showers/ whirlpool 2 times every week to include nail care and shampoo, bed bath prn."

On 2/27/18 at 2:15 pm, the surveyor observed Resident # 16 in her room sitting in her recliner watching TV. The surveyor observed long strands of grey and white hair on Resident # 16's chin.

On 3/1/18 at 2:42 pm, the surveyor observed Resident # 16 sitting in the day room during activities. The surveyor observed several long grey and white chin hairs on Resident # 16's chin at that time. The surveyor asked Resident # 16 if she preferred to have chin hairs. Resident # 16 stated, "No my son usually takes care of that...Do you have a razor?" The surveyor responded, "No but I am sure someone here has one and we will get it taken care of for you." Resident # 16 stated, "I am going to become the bearded lady in the circus." Resident # 16 then asked the activity director on the unit if she had a razor and the activity director stated, "No." Resident # 16 stated," I am going to become the bearded lady in

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the circus, it's disgusting."

On 3/1/18 at 3:00 pm, the surveyor asked CNA (certified nursing assistant) #1 who was responsible for providing care for Resident # 16 and CNA #1 responded, "I am." The surveyor asked CNA #1 if she could shave Resident #16. CNA #1 told the surveyor that it would have to wait until the person from 3-11 shift came on because it was 3:00. The surveyor asked CNA #1 who assisted Resident # 16 in getting dressed today and the CNA #1 stated, "I did." The surveyor asked CNA #1 why she did not shave Resident #16 when she got her dressed for the day. CNA #1 stated, "Honestly I am scared that I am going to cut them so I don't do it." CNA #1 stated that she would report off to the next CNA on 3-11 shift that Resident # 16 needed to be shaved.

On 3/1/18 at 3:10 pm, the surveyor reported to the unit manager about the incident as stated above. The unit manager stated that CNA #1 was one of their newer employees and that she would speak with the employee and send her to staff development to receive more training.

According to the facility policy and procedure for "Shaving the Resident," the purpose is to promote cleanliness and provide skin care. According to the facility policy for "Shaving the Resident" "The following documentation should be recorded in the resident's medical record:
1. The date and time that the procedure was performed.
2. The name and title of the individual(s) who performed the procedure.
3. If and how the resident participated in the procedure or any changes in the resident's ability

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F 677	Continued From page 14 to participate in the procedure. 4. Any problems or complaints made by the resident related to the procedure. 5. If the resident refused treatment, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data." According to the facility "Nursing assistant/certified nursing assistant orientation checklist," the "Skills Evaluated" included but were not limited to "Shaving-men & women/POC" No further information regarding this issue was presented to the survey team prior to the exit conference.	F 677		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility staff failed to provide the necessary preventative measures to prevent	F 686	The resident #156 identified during the survey was immediately assessed by nursing. Orders, treatments, and	4/20/18

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F 686	Continued From page 15 multiple acquired pressure ulcers for one resident (#156) in the survey sample of 42 residents. The facility failed to continue previous physician orders for skillcare boots/heel manager for Resident #156 upon readmission from the hospital to the facility. Subsequently the resident developed a stage II pressure ulcer to his heel. The facility further failed to implement measures to prevent multiple toe pressure ulcers. The findings included: Resident #156 was admitted on 9/27/06 and re-admitted to the facility on 12/14/17. Resident #156 was admitted to the facility with the following diagnoses which included type 2 diabetes mellitus, dysphagia, cataract, protein-calorie malnutrition, anorexia, hyperglyceridemia, hypertension, anemia, chronic ischemic heart disease, gastro-exophageal reflux disease, hyperlipdemia, heart failure, overactive bladder, hypothroidism, intellectual disabilities, traumatic brain injury, dementia without behavioral disturbance, epilepsy, osteoporosis, and major depression. A Quarterly Minimum Data Set (MDS) dated 11/21/17 indicated the following: In the area of hearing, speech and vision this resident was assessed as having moderate difficulty hearing, rarely makes self understood, rarely understands others, has moderately impaired vision. In the area of Brief Interview for Mental Status (BIMS) this resident was unable to answer questions. In the area of cognitive patterns this resident was coded as having long and short term memory problems. In the area of activities of daily living	F 686	interventions were reviewed and updated. The majority of pressure ulcers are healed with remaining pressure ulcers continuing to heal. All residents may be at risk for the development of pressure ulcers if staff do not properly assess, identify alterations in skin integrity, and initiate preventative measures or treatment orders in a timely manner. Skin assessments of all current residents were completed on 03/23/2018. All identified skin needs were addressed with appropriate interventions. Existing policies were reviewed and revised as needed. Facility developed and implemented a new protocol for evaluating footwear prior to use for residents at high risk for skin/pressure injury. Licensed nurses will be educated on 1) admission/readmission order entry, reconciliation and verification, 2) 24 hour chart check process, 3) readmission process to include review of all previous and admitting orders with the admitting physician, 4) proper skin assessment, documentation, and initiation of appropriate interventions as needed, and 5) New footwear protocol by Staff Development or designee. CNAs will be educated on footwear protocol and the need for appropriate footwear when found by Staff Development and podiatrist.	

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F 686	Continued From page 16 (ADL'S) this resident was assessed being total dependent in the areas of bed mobility, transfer, dressing, eating, toilet use and personal hygiene. In the area of bladder and bowel this resident was assessed as always incontinent. In the area of nutritional status this resident assessed as having a mechanically altered diet and receives a therapeutic diet. In the area of skin assessment this resident was assessed as having no risk for pressure ulcer. In the area of current number of unhealed pressure ulcers at each stage was un-assessed. In the area of healed pressure ulcers on the prior assessment this area was un-assessed. In the area of skin and ulcer treatments this resident was assessed for pressure reducing device for chair, pressure reducing device for bed and applications of ointments/medications other than feet. A revised care plan dated 10/23/17 indicated: "Focus- Resident #156 is at risk for skin breakdown due to IDDM (insulin dependent diabetes mellitus), lower extremity, edema, venous stasis, history of basal cell carcinoma (removed) to left forearm impaired mobility incontinence use of Aspirin Daily. Goal: - Resident #156 risk for skin integrity impairments will be minimized this review period. Interventions- Supplements per MD orders -see MAR (medication administration record) date initiated 12/05/16. APM (alternating pressure mattress) mattress to bed date started 10/23/17. Apply lotions/creams as ordered-see TAR (treatment administration record) date initiated 12/05/16. Diabetic Management as ordered (See TAR/MAR) date initiated 12/05/16. Encourage/Assist resident to consume all fluids	F 686	Nurse Managers or nursing leadership team will 1) conduct a review for all new admissions and readmissions to the community for accuracy of treatment order entry for 6 months and 2) audit 6 residents on each neighborhood for condition of feet and use of proper footwear monthly for 6 months. Summary of findings will be reviewed by DON and/or designee through the monthly Clinical Operations Report (COR) process and submitted to quarterly QAPI Committee for review and recommendations.	

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and meals offered on trays document meal intake daily. Float heels using skill care heel boots date initiated 12/05/16. Monitor feet daily when assisting with removing shoes for proper fit. Notify family if new shoes are needed date initiated 12/05/16. Monitor for increased s/sx (signs and symptoms) of edema, encourage to elevate lower extremities, notify MD of changes. Monitor skin daily with AM/PM incontinence Care for breach in skin integrity. Notify nursing/MD of abnormals, date initiated 12/05/16. Treatments per orders and wound nurse eval (evaluate) as needed date initiated 12/15/17. Head to toe Skin assessment weekly date initiated 12/05/16. Float heels using skillcare heel boots, date initiated 12/05/16.

Focus: Alteration in Comfort: requires pain monitoring due to inability to make his pain needs known to staff. Goal - will maintain adequate level of comfort - no verbal or non verbal s/sx of pain for discomfort. Interventions-monitor for non verbal s/sx of pain guarding, tearfulness, restlessness, moaning, agitation, frowning."

A physician's order dated 12/15/17 following a hospital re-admit on 12/14/17 indicated: Turn and reposition resident every 2 hours and as needed. Pressure reduction mattress to bed every shift. Weekly head to toe skin assessment. Document in progress notes and skin assessment every evening shift every thur document findings in skin assessment.

A review of the orders after re-admission (12/14/17) did not include previous orders to float heels using skill care heel boots or heel manager while in bed or geri chiar/wheelchair with assistance every shift.

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During an interview on 3/4/18 at 10:06 A.M. with the Wound Nurse and Unit Manager, both acknowledged that the order was not continued after the resident was readmitted on 12/14/17.

The Treatment order for December indicated: Float heels using skill care heel boots or heel manager while in bed or geri chair/wheelchair with assistance every shift, discontinue date 12/14/17.

Review of a Wound Evaluation Flow Sheet identified a new pressure area as follows: "Right medial heel found 1/30/18, Measurements (CM) centimeters L =3- W=3.5, Exuade -none, Wound Bed - Pain (no), Tissue type, intact fluid filled blister, Periwound - closed, surrounding tissue intact."

A Guide for Wound Evaluation and Documentation form identified Pressure Ulcer-Definitions and Stages: "Stage II Clinical- partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Further description: Presents as a shiny or dry shallow ulcer without slough or bruising. *This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. *Bruising indicates suspected deep tissue injury."

The January 2018 treatment order indicated: Weekly head to toe skin assessment. Document in progress notes and skin assessment every evening shift every Thur (Thursday) document findings in skin assessment. Pressure reduction mattress to bed. Remove and replace skillcare

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boots Q (every) shift to monitor skin integrity every shift, start date 01/30/2018. Skillcare heel Protector boots on while resident is in bed. Use with foam anti-rotation devices to elevate heels and for positioning monitor placement Q shift every shift, start date 1/30/18.

A 12/19/17 Wound Progress Note signed by the Wound Nurse indicated: "Feet are clear, heels are reddened but blanch, resident tends to press his heels together. Has heel manager to float heels and has had good results."

A 1/29/18 Physician's Telephone order indicated: "Cleanse intact blister to (R) right heel with NS (normal saline) pat dry with gauze, apply skin prep over blister surface and treat surrounding skin. Apply transparent film over area. Change Q 7 days and PRN."

A 1/30/18 Physician's Telephone order indicated: "Skill care heel protector boots on while resident in bed. Use with Foam anti-rotation devices to elevate heel and positioning monitor placement Q shift. Remove inplace Q shift to monitor skin integrity."

A Braden Scale for predicting Pressure Sore Risk was completed on the following dates, all assessing the resident for being moderately at risk for pressure sores:
12/14/17
12/21/17
12/28/17
01/04/18
2/25/18

Facility Weekly Skin Checks indicated the following:

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12/01/17 - Skin intact.
12/08/17 - Skin intact, localized scattered redness to left hip, monitoring in progress.
12/21/17 - Open area to R antecubital and L anterior shoulder.
12/28/17 - No new areas
01/04/18 - No new areas
01/12/18 - Scars to R antecubital and l shoulder
01/19/18 - Scars visible to Rt. antecubital and Lt. shoulder
01/26/18 - No new findings on the skin

A review of the Facilities Shower and Bed Bath Schedule and monitoring from 12/14/17 through 02/28/18 did not indicate Resident #156 was found with pressure areas.

A Pressure Ulcer Investigation dated 1/30/18 indicated:
"Resident name, Diagnoses and Current Pressure Ulcer Status. Location- Right med (medial) heel - Stage II. Was Risk Assessment completed prior to development of pressure ulcer? (Yes- 1/4/18).

Were treatment and interventions implemented based on identified risk factors? (Yes)
Does the record contain physician documentation regarding the presence of and/or change in the pressure ulcer? (this area was blank)

Resident has been identified at risk for pressure ulcers related to the following factors/conditions: Urinary incontinence, poor nutrition (Dx (diagnosis) of partial malnutrition), impaired mobility, extensive assistance bed mobility and/or transfers, Has current ulcer - contracture- feet, unable to change position or shift weight in chair, Thyroid disease, diabetes, spasms, tremors,

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involuntary movements, Others Pulls feet together.

Current Treatment and Interventions include: assist with turning/positioning, peri-care as needed, administer medications as ordered, administer nutritional supplements, encourage/provide good nutrition, encourage/provide good hydration, use of pillows or other cushioning devices, pressure relieving device in bed, weekly skin or body audits, float heels, elbow/heel protectors.

Probable Causative Reasons for Development -Immobility, friction/pressure- Resident crosses clamps legs together.

Recommendations: Skill care boots while in bed with anti rotator devices to further elevate heels and position legs and feet."

During an interview on 3/5/18 at 3:15 P.M. with the Wound Nurse and Administrator they were asked what interventions were in place to prevent Resident #156 from rubbing his heels together. The Wound Nurse and the Administrator both stated, heel boots and a pillow to go between his legs. When asked for supporting treatment records none was presented to the survey team prior to 1/30/18.

A 1/30/18 Progress note signed by the wound nurse indicated: "Assessed (R) medial heel after report of blister observed on resident. Raised, intact, clear fluid filled blister measures approx. 3 X 3.5 cm, Transparent film in place. No indication of pain. Resident's feet were floated, however has been observed to clamp his feet together, pillows used to separate his legs. Placed feet in Skilcare

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boots to protect heels, also placed anti-rotation for positioning purposes. Primary nurse present."

Further review of Facility Weekly Skin Checks indicated:
02/02/18 - No new issues scars to Rt. antecubital and Lt shoulder remain visible
02/09/18 - No new findings
02/16/18 - No new findings
02/23/18 (at 19:18 or 7:18 P.M.) - Reddened areas on toes and feet
02/23/18 (at 20:13 or 8:13 P.M.) - Reddened area on resident feet. Toes and in between toe. Especially on the right foot

A wound evaluation sheet dated 2/22/18 documented:
Right great toe tip - measurements - L = 0.6 - W = 0.3, Exuade - none, Wound Bed - pain (no), Tissue type (blank), Periwound - closed, surrounding tissue intact.

Right 2nd toe top -measurements - L = 0.3 - W = 0.3, Exuade - none, Wound Bed - pain (no), Tissue type (blank), Periwound - closed, surrounding tissue intact.

Right 3rd toe top-measurements - L = 0.2 - W = 0.4, Exuade - none, Wound bed - pain (no), Tissue type (blank), periwound -closed, surrounding tissue intact.

Right inner aspect 2nd toe - measurements - L = 0.5 - W = 0.3, Exudate - none, Wound bed - pain (no), Tissue type (blank), periwound -closed, surrounding tissue intact.

Right 3rd toe inner aspect - measurements - L = 0.2 - W = 0.2, Exudate - none, Wound bed - pain

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(no), Tissue type (blank), periwound - closed, surrounding tissue intact.

Right 4th toe inner aspect, measurements - L = 0.5 - W = 0.2 -D = 4, Exudate - none, Wound bed - pain (no), Tissue type (blank), periwound - closed, surrounding tissue intact.

Right 5th metatrsal head plantar, measurements - L = 2 - W = 1.5 -, Exudate - none, Wound bed - pain (no), Tissue type deep red with pale, soft center, not open. periwound - closed, surrounding tissue intact.

Left great toe tip, measurements - L = 0.5 - W = 0.7, Exudate - none, Wound bed pain (no), Tissue type (blank), periwound - closed surrounding tissue intact.

Left 5th metatarsal head plantar surface - L = 1.5 - W = 0.6, Exudate - none, Wound bed pain (no), Tissue type (blank), periwound - closed surrounding tissue in tact."

A Pressure Ulcer Investigation Report dated 2/22/18 indicated: "Resident name, Diagnoses, Current pressure ulcer status: Location: (R) great toe tip, (R) 2nd and 3rd toe tips, inter toes 2nd, 3rd and 4th, (R) 5th planter (met) head, (L) 5th met head. Was Risk Assessment completed prior to development of pressure ulcer? This area was (blank).

Resident has been identified at risk for pressure ulcers related to the following factors/conditions: Urinary incontinence, poor nutrition (Dx of partial malnutrition), impaired mobility, extensive assistance bed mobility and/or transfers, Has current ulcer - contracture- feet, unable to change

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position or shift weight in chair, Thyroid disease, impaired immune system, spasms, tremors: Other increased CRP, protein metabolism, heart disease, anemia.

Current Treatment and interventions include: assist with turning/positioning, peri-care as needed. administer medications as ordered, referral to PT (physical therapy) date 2/23 (eval position), administer treatment as ordered, administer nutritional supplements (mal absorbed), encourage/provide good hydration, pressure relieving device in chair, apply protective barrier cream. ensure appropriate fitting shoes. use of pillows or other cushioning's devices, pressure relieving device in bed (on extended bed), weekly skin or body audits, float heels (heel magr.(manager) skillcare boots), assist with transfers, weekly wound assessment, monitor labs, encourage rest periods to break sitting for long periods of time.

Probable causative reasons for development: Change in medical condition, immobility, disease process, poor tissue, friction/pressure, poor protein malnutrition, acute illness."

The Wound Nurse was asked during an interview on 3/5/18 at 3:15 P.M. what caused Resident #156 wounds on his toes and inner toe areas? The Wound Nurse stated, he had some new tennis shoes that staff put on him. The Wound Nurse was asked if Resident #156 had been assessed for proper fitting of the tennis shoes prior to staff placing the tennis shoes on Resident #156? The Wound Nurse stated, No.

A Progress Note dated 2/22/18 indicated: "Resident slides down in the bed and frequently

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has to be repositioned up in the bed. Extension is on bed but resident still slides down at times. Maintenance in to make adjustments and add to padding. Brackets on the APM (mattress) motor are hard and fold over footboard of bed- toes may have come in contact with the brackets as well as feet on the foot board. PT consulted to evaluate position in the wheelchair, including foot position. Resident repositioned using soft pillows."

The Wound Nurse was asked during an interview on 3/5/18 at 3:50 P.M. how long would it take for the blisters and deep tissue injuries (DTI) to develop? The Wound Nurse stated, "about one hour" given his compromised state of health.

A deep tissue injury is defined by the National Pressure Ulcer Staging System (NPUAP) as "purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear."

Resident #156 was observed for wound care on 3/1/18 at 9:12 A.M. Physician orders included: Avoid tennis shoes and tight socks. May wear his soft slippers or large non-skid socks when OOB. Padded foot board. Cleanse intact blister to right heel with NSS, pat dry with gauze, apply skin prep over blister surface and to surrounding skin. Apply transparent film dressing. Change every 7 days and PRN if loose. Skin care heel protector boots on while resident is in bed. Use with foam anti-rotation devices to elevate heels and for position monitor placement Q shift. Observed wound care. Nurse assessed bilateral feet and toes. Transparent film intact to R heel. Pressure areas on toes and feet are stable. Sensitivity with cleaning feet and toes. Cleaned and dried,

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applied skin prep feet and lower legs moisturized. Boots reapplied with anti-rotation foams, resident positioned in bed for breakfast. APM functioning, padding on the footboard intact. Bed low.

A facility Timeline for Resident #156 Pressure Sores indicated the following:

12/11/17: Went to hospital for further evaluation and treatment due to altered mental status.
12/14/17: Returned to the facility with antibiotic for sepsis/acute cystitis without hematuria. He also came with blister on his right antecubital, left hand/left thigh bruise, and reddened spotted areas on his stomach.
1/30/18: observed with stage 2 right heel (blister)
Interventions:
Skilcare boots with anti-rotation device for positioning
Remove and replace skilcare boots Q shift to monitor skin integrity
Apply skin prep with transparent film dressing and change every 7 days and PRN
Continuation of protein supplement
Continuation of APM mattress
Continuation of extended bed
2/22/18: Observed with several areas of discoloration on toes and forefeet
2/23/18: Right great toe, 2nd toe, 3rd toe, 4th toe, with DTI not open
Interventions:
Continue Skilcare boots with anti-rotation device for positioning
Avoid tennis shoes and tight socks. May wear his soft slippers or large non-skid socks
when OOB (out of bed) every shift
Monitor toes and feet Q shift
Padded foot board
Place foot cradle to foot of bed to protect toe tips

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F 686	Continued From page 27 from weight of linens (discontinued 2/26/18) Continuation of protein supplement Continuation of APM mattress Continuation of extended bed. A facility Pressure Sore Prevention Policy no date available indicated: Policy: It is the philosophy of the facility to prevent pressure ulcers. Residents will receive care and services in a manner to promote skin integrity. Residents will receive early identification, prompt evaluation and treatment of pressure ulcers and any other problematic skin conditions. Residents with problematic skin conditions will be provided care to support the healing process and prevent infection. Procedure: 1. Each resident will have a risk assessment (Braden Scale) completed upon admission or readmission by a licensed nurse. 2. A reassessment will be completed with each OBRA MDS assessment 3. Each resident will have a weekly skin assessment completed by a licensed nurse to assure timely identification and treatment of areas. Residents with a Braden Score of 14 (moderate risk) or below (high risk) will receive preventive care. Residents with scores above 14 may have preventive care initiated as warranted by assessment. Identify and promptly institute risk reduction strategies in accordance with protocol and other preventive actions as indicated. Plan #1 Score 15-18 or Moderate risk 13-14 1. Turn and reposition every 2 hours if mobility is impaired 2. float heel intermittently	F 686		

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F 686	Continued From page 28 3. Monitor skin daily during personal care 4. Provide prompt incontinence care if incontinent 5. Apply moisturizer to skin daily 6. Monitor PO intake, Dietary Consult every quarter and PRN 7. Apply pressure reducing mattress and wheelchair pressure reduction cushion 8. Weekly skin assessment. No further information was provided prior to exit.	F 686		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to communicate ongoing assessments of 1 of 42 residents condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. (Resident # 165.) Findings: Facility staff failed to communicate ongoing assessments for Resident #165 who attended out patient dialysis three days per week. The resident's clinical record was reviewed on 2/28/18 at 11:00 AM. Resident #165 was admitted to the facility on	F 698	The use of current dialysis communication form was initiated for the resident #165 identified during the survey. A revised form to ensure two-way communication between Birmingham Green and the certified dialysis facility was developed. All residents receiving dialysis services at a certified dialysis facility may be at risk from this deficient practice. Staff members involved in care of the resident identified were educated on purpose and use of the two-way communication form on 3/1/18. Licensed nurses will be educated on the assessment and use of the two-way	4/20/18

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F 698	Continued From page 29 11/09/17. Her diagnoses included: hypertension, peripheral vascular disease, diabetes, depression, asthma, and end stage renal disease. The latest MDS (minimum data set) assessment, dated 12/15/17, coded the resident with slight cognitive impairment. She required the assistance of nursing staff members to assist her with all the ADLS (activities of daily living) and a set-up only to eat. The resident was coded as receiving outside dialysis services. Resident # 165 CCP (comprehensive care plan), reviewed and revised on 2/7/18, documented the resident with end stage renal disease and dialysis services. The interventions included dialysis service three days a week and to check and record bruit/thrill. Report all changes to MD and dialysis center. Resident # 165's physician orders contained an order, signed and dated on 2/12/18, for outpatient dialysis services three days a week on Monday, Wednesday and Friday. The nursing progress notes contained documentation that the resident's vital signs were obtained on each dialysis day. The thrill and bruit were documented as present and the perma-cath dressing was dry and intact. No information was observed in the clinical record or in the electronic chart that contained any communication to or from the dialysis center. On 2/27/18 at 5:00 PM Resident #165 was interviewed about the facility and her trips to dialysis. The resident was asked if she took any	F 698	communication form by Staff Development and/or designee. Facility administrator and DON will contact each certified dialysis center and review the responsibility of certified dialysis center regarding two-way communication and use of communication form. Nurse Managers and nursing leadership team will conduct documentation review of all dialysis residents weekly for 6 months to ensure compliance with two-way communication. Summary of findings will be reviewed by DON and/or designee through the monthly Clinical Operations Report (COR) process and submitted to quarterly QAPI Committee for review and recommendations.	

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documentation (such as a notebook) over with her from the facility to share with the dialysis clinic or if the dialysis clinic ever sent anything back to the facility staff with her. Resident #165 said she did not have anything to take with her on dialysis days, except for her bagged lunch. She said she, personally, was not transporting anything (as far as documentation) to and from the facility to dialysis and back.

On 2/28/18 at 11:42 AM 02/28/18 11:42 AM, RN I was asked about dialysis communication sheets. She said they don't have/use any. RN I said the dialysis facility communicated any issues, or changes in treatment or medications to facility staff via phone. No wet/dry weights or VS (vital signs) were sent to or from the dialysis clinic to facility. RN I said any unusual changes reported by the dialysis facility would be communicated to the physician and responsible party, but an ongoing exchange of information/communication was not in place.

On 02/28/18, at 1:13 PM, the surveyor spoke to the administrator about these findings. The administrator provided the nursing home dialysis contract and a draft of the latest nursing policy with respect to communication sheets on residents.

The nursing home contract, signed and dated by both parties on 5/23/12, documented the "Center will develop a written protocol governing specific responsibilities, policies and procedures to be used in rendering dialysis services...including but not limited to, the development of a designated resident's care plan relative to the provision of dialysis services. The facility will provide for an interchange of information useful or necessary for

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the care of the designated resident and will inform the center of a contact person at facility..."

The facility's policy and procedure for DIALYSIS included the following protocol for nursing staff members: "...The intent of this policy is that the facility assures that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice including the:
~ Ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility;
~ Ongoing assessment and oversight of the resident before and after dialysis treatments; and
~ Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services....."

The administrator also provided a copy of a blank communication sheet the nursing staff was supposed to be using for ongoing daily assessments for each dialysis visit between the facility and the dialysis clinic. The report included details for the resident's vital signs prior to the dialysis treatment and the pre and post dialysis weights from the center.

The administrator told the surveyor this form had not been used to communicate daily on Resident # 165's dialysis treatment days, but it should have been. The administrator said training had been provided to staff about the ongoing use of the forms.

No other information was provided prior to the survey team exit.

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F 758	Continued From page 32	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		4/20/18

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F 758	Continued From page 33 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that 1 of 42 residents in the final survey sample was free from unnecessary medications, Resident # 94. The facility staff failed to monitor the use of Seroquel according to the physician's orders for Resident # 94. The findings included: Resident # 94 is an 81-year-old female who as originally admitted to the facility on 12/31/2011, with a readmission date of 12/28/2017. Diagnoses included but were not limited to: unspecified dementia with behavioral disturbance, heart failure, hyperlipidemia, and hypertension. The most recent MDS (minimum data set) assessment was a 14-day scheduled assessment with an ARD (assessment reference date) of 1/11/18. Section C of the MDS assess cognitive patterns. In Section C0500, the facility staff coded a BIMS (brief interview for mental status) score of 00/15 for Resident # 94, which indicated severe	F 758	Resident #94 identified during the survey did not have any negative outcome for the deficient practice. EHR medication administration record was revised to require the documentation of the prescribed parameters prior to administration of Seroquel for resident #94. All residents may be at risk of adverse outcomes if staff fail to monitor medication orders with parameters. EHR medication administration record was revised to include the documentation of the required parameters prior to administration of specific medication. Licensed nurses will be educated on medication administration and order entry, to include documentation of and compliance with any prescribed written parameters by Staff Development and/or designee. Nurse Managers and nursing leadership team will conduct medication	

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F 758	Continued From page 34 cognitive impairment. The most recent plan of care for Resident # 94 was reviewed and revised on 1/17/18. In the problem area, "Resident is at risk for compromised quality of life and impaired cognition secondary to diagnosis of dementia and the disease progression." Interventions included but were not limited to "Administer medications for cognition per MD (medical doctor) orders." The clinical record for Resident # 94 was reviewed on 2/27/18 at 3:54 pm. A physician's order was written on 1/24/18 for "Seroquel 25 mg (milligrams) ½ tab (12.5 mg) po (by mouth) BID (twice a day) Hold for SBP (systolic blood pressure) < 100 and DBP (diastolic blood pressure) <60." On 2/28/18 at 9:15 am, the surveyor reviewed the MAR (medication administration record) for February 2018 for Resident # 94. Upon review of the MAR for February 2018, and the vital signs documented in the clinical record, the surveyor could not locate any documentation to support that the facility was monitoring the blood pressures to ensure that the Seroquel was being administered to Resident # 94 as ordered by the physician. On 2/28/18 9:39 am, the surveyor spoke with LPN #1 (licensed practical nurse) about the blood pressure parameters associated with the use of Seroquel for Resident #94. The surveyor asked LPN #1 if she assessed the blood pressure for Resident #94 prior to administering the Seroquel. LPN #1 stated "Yes" and showed the surveyor a piece of paper with blood pressures on it 137/86. The surveyor asked LPN #1 if she had any way	F 758	administration audits on 6 residents per neighborhood monthly for 6 months. Summary of findings will be reviewed by DON and/or designee through the monthly Clinical Operations Report (COR) process and submitted to quarterly QAPI Committee for review and recommendations.	

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F 758	Continued From page 35 to verify that the blood pressure readings were being checked daily prior to administering the medication. LPN #1 reviewed the MAR and stated "No." LPN #1 stated that she would go in and update the MAR so that the documentation of the blood pressures are recorded on the MAR along with the nurses' signature. On 2/28/18 at 2:54 pm, the unit manager was made aware of the findings as stated above. No further information was provided to the survey team regarding this issue prior to the exit conference.	F 758		
F 761 SS=D	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 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	F 761		4/20/18

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F 761	Continued From page 36 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 interviews and facility documentation review the facility staff failed to ensure medications were stored in a secured location, accessible to designated staff only on 1 of 3 units (Unit 3 - secure unit). The facility staff left medications unsecured on top of the medication cart and the cart unlocked, when not in direct sight of the nurse. The findings include: On 02/27/18 at approximately 5:10 p.m., during the medication pass and pour observation, License Practical Nurse (LPN) #6 pulled the following blister cards of medications from her medication cart; Metaformin, Zantac, Lisiniprol and Divalproex then popped one (1) pill off each card into a clear medication cup. The LPN and surveyor walked to room (number) where the LPN administered the medication to Resident #68. The LPN and surveyor returned back to the medication cart at 5:30 p.m., and noted four (4) blister cards of medication on the top of the cart; the medications were *Metformin, *Zantac, *Lisinopril and *Divalproex. Ambulating in front of the medication were 2 residents. The LPN stated, "I should have put the medication back inside the cart after I pulled them for Resident #68." *Metformin is used alone or with other medications, including insulin, to treat type 2 diabetes (condition in which the body does not	F 761	The nurse involved in the deficient practice was educated on 3/1/18 regarding secure storage and handling of drugs and biologicals. All residents may be at risk for harm if medications are not securely stored in medication carts. Licensed nurses will be educated on medication administration including secure storage of drugs and biologicals by Staff Development and/or designee. Nurse Managers and nursing leadership will conduct random observations for secure storage of medications in medication carts and locking medication carts weekly on all three neighborhoods for 6 months. Summary of findings will be reviewed by DON and/or designee through the monthly Clinical Operations Report (COR) process and submitted to quarterly QAPI Committee for review and recommendations.	

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use insulin normally and, therefore, cannot control the amount of sugar in the blood) (https://medlineplus.gov/ency/article/007365.htm).

*Zantac is used to treat ulcers; it decreases the amount of acid made in the stomach (https://medlineplus.gov/ency/article/007365.htm).

*Lisinopril is used alone or in combination with other medications to treat high blood pressure (https://medlineplus.gov/ency/article/007365.htm).

*Divalproex is used alone or with other medications to treat certain types of seizures. Divalpoex is also used to treat mania (episodes of frenzied, abnormally excited mood) in people with bipolar disorder (manic-depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods) (https://medlineplus.gov/ency/article/007365.htm).

An interview was conducted with the Unit Manager (UM) on 3/01/18 at approximately 9:50 a.m., who stated, "The nurse should have ensured the medications were secure before she left her medication cart."

On 3/5/18 at approximately 1:10 p.m., an interview was conducted with the Assistant Director of Nursing (ADON) who stated, "That is not how the nurses are educated. The medication are to be put back in the medication cart after they are pulled and the cart locked."

The facility administration was informed of the finding during a briefing on 3/05/18 at approximately 3:50 p.m. The facility did not present any further information about the findings.

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F 761	Continued From page 38 The facility's policy: Medications - 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles (Last revision Date: 01/01/13). -Applicability: This Policy 5.3 sets for the procedures relating to the storage and expiration dates of medications, biologicals, syringes and needles. -General Storage Procedures: 3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.	F 761		
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	F 880		4/20/18

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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 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

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F 880	Continued From page 40 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, resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to provde a sanitary environment to help prevent the development and transmission of communicable disease and infection. 1. The facility staff failed to ensure the glucometer was sanitized prior and after use for (Resident #79) of 42 Residents in the survey sample. 2. The facility staff failed to ensure a fish bowl was cleaned in a designated "dirty" area to reduce the potential for cross contamination. 3. The facility staff failed to clean and disinfect glucometer after use and implement appropriate hand hygiene after performing a blood sugar check on Resident #68. The findings included: 1. Resident #79 was admitted to the facility on 5/5/09. Diagnoses for Resident #79 included but are not limited to Type 2 Diabetes Mellitus. Resident #79's Quarterly Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 10/3/17 coded Resident #79 as scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) indicating no	F 880	The residents #79 and #68 identified during the survey did not present any signs or symptoms of infection caused by the deficient practice upon assessment. All residents may be at risk for infection from this deficient practice. The nurses involved in failure to clean glucometers were educated on proper hand hygiene and glucometer cleaning on 3/3/18. The Nurse Manager and a nurse involved in fish bowl cleaning were re-educated on proper cleaning and designated “dirty” area on 3/23/18 by Infection Preventionist. “Blood glucose monitoring” policy was revised on 03/01/18 and included manufacturer’s instructions for cleaning the device. Policy defining clean and dirty storage was revised on 03/05/18. Licensed nurses will be educated on 1) proper hand hygiene and cleaning of glucometers and 2) the revised policy on clean and dirty storage by Staff Development and/or designee. Nurse Managers and nursing leadership team will conduct medication	

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F 880	Continued From page 41 cognitive impairment. Resident #79 was completely dependent on 2 staff for bed mobility, transfers, dressing, toilet use and personal hygiene. The Comprehensive Person Centered Care Plan dated 10/11/16 identified the resident required blood sugar monitoring. The goal was glucose will remain at a level so treatment is not required outside of established parameters. One intervention included: monitor blood glucoses per Medical Doctor Orders. The Physician order dated 8/31/17 included: Novolog Flexpen 100 ml (milliliters) Unit inject as per sliding scale: if 300 to 350 inject 2 units if 351 to 400 inject 4 units 400 plus inject 6 units in addition to regular dose subcutaneously before meals and at bedtime. The Physician order dated 12/12/17 included: Novolog PenFill Solution Cartridge 100 unit/ml Inject 32 units subcutaneously with meals for diabetes give 32 units of Novolog flexpen with meals On 2/28/18 During Medication Pass at approximately 11:20 AM, Licensed Practical Nurse (LPN) #2 was observed leaving the medication cart of Garden Hill to obtain the glucometer caddy. Upon return to the resident's room she proceeded to obtain Resident #79's glucometer with a glucometer intended for shared use. Upon completion the LPN returned the glucometer to the glucometer caddy. The Glucometer was not cleaned or sanitized prior to	F 880	administration audit on 6 residents per neighborhood monthly for 6 months. Monitoring of clean and dirty storage areas will be conducted as a part of environmental rounds by facility management team at least monthly on all neighborhoods. Summary of findings will be reviewed by DON and/or designee through the monthly Clinical Operations Report (COR) process and submitted to quarterly QAPI Committee for review and recommendations.	

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returning it to the Glucometer caddy.

The LPN was asked on 2/28/18 at approximately 11:20 AM, if she cleaned and sanitized the glucometer prior to bringing it to the Resident's room. The LPN stated "No, I didn't, I thought I only did that when I finished."

The Acting Director of Nurses was asked on 3/5/18 at approximately 3:50 PM what her expectation was regarding cleaning of the glucometer. The Acting Director of Nurses stated that the glucometer was to be cleaned prior and after each use. The Acting Director of Nurses was asked if there was a difference in cleaning and sanitizing the glucometer. She stated, "Yes, it is to be done per the manufacture's recommendations."

The Facility Policy titled, "Blood Glucose Monitoring" with a revision date of 3/1/18 documented the following:
Consult manufacturer's instructions for the use of the blood glucose meter.

On 3/5/18 at approximately 4:15 PM, the Acting Director of Nurses #2, provided the Glucometer's Manufacturer's Recommendations. The Manufacturer's Recommendations documented the following from the Assure Prism User Instruction Manual dated 11/2015:

Assure Prism

Any disinfectant product with the EPA registration number listed on the table may be used on the device.
A list of Environmental Protection Agency (EPA) registered disinfectants effective against HIV,

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Hepatitis C, and Hepatitis B virus can be found at the following website: http://www.epa.gov/oppad001list_d_hepatitisbhiv.pdf

Cleaning and Disinfecting Procedures:

Note: Two disposable wipes will be needed for each cleaning and disinfecting procedure: one wipe for cleaning and a second wipe for disinfecting.

On 03/05/18 at 01:12 PM the acting DON #2, was interviewed. When asked the expectation for performing a glucometer to avoid the risk of obtaining bloodborne diseases, she stated her expectation is, "The glucometer should be cleaned prior and after use." When asked is there a difference between cleaning and sanitizing, she stated, "Yes." The Acting DON stated the sanitizer used at the facility was PDI Super Sani-Cloth Germicidal Disposable wipe. This wipe was included on the Assure Prism's manufacturer's recommendations.

The Center for Disease Control (CDC) website: https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html documented the following:

"The Centers for Disease Control and Prevention (CDC) has become increasingly concerned about the risks for transmitting hepatitis B virus (HBV) and other infectious diseases during assisted blood glucose (blood sugar) monitoring and insulin administration."

"Blood glucose meters are devices that measure blood glucose levels.
Whenever possible, blood glucose meters should

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be assigned to an individual person and not be shared.
If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared."

"Unsafe Practices during Blood Glucose Monitoring and Insulin Administration"

"An underappreciated risk of blood glucose testing is the opportunity for exposure to bloodborne viruses (HBV, hepatitis C virus, and HIV) through contaminated equipment and supplies if devices used for testing and/or insulin administration (e.g., blood glucose meters, fingerstick devices, insulin pens) are shared."

"Outbreaks of hepatitis B virus (HBV) infection associated with blood glucose monitoring have been identified with increasing regularity, particularly in long-term care settings, such as nursing homes and assisted living facilities, where residents often require assistance with monitoring of blood glucose levels and/or insulin administration. In the last 10 years, alone, there have been at least 15 outbreaks of HBV infection associated with providers failing to follow basic principles of infection control when assisting with blood glucose monitoring. Due to under-reporting and under recognition of acute infection, the number of outbreaks due to unsafe diabetes care practices identified to date are likely an underestimate."

"Although the majority of these outbreaks have

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been reported in long-term care settings, the risk of infection is present in any setting where blood glucose monitoring equipment is shared or those assisting with blood glucose monitoring and/or insulin administration fail to follow basic principles of infection control. For example, at a health fair in New Mexico in 2010, dozens of attendees were potentially exposed to bloodborne viruses when fingerstick devices were inappropriately reused for multiple persons to conduct diabetes screening. Additionally, at a hospital in Texas in 2009, more than 2,000 persons were notified and recommended to undergo testing for bloodborne viruses after individual insulin pens were used for multiple persons."

"Unsafe practices during assisted monitoring of blood glucose and insulin administration that have contributed to transmission of HBV or have put persons at risk for infection include:
Using fingerstick devices for more than one person
Using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses
Using insulin pens for more than one person
Failing to change gloves and perform hand hygiene between fingerstick procedures"

"Best Practices for Assisted Blood Glucose Monitoring and Insulin Administration"

"The following are infection control recommendations that anyone who performs or assists with blood glucose monitoring and /or insulin administration should review to assure they are not placing themselves or persons in their care at risk."

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"These recommendations apply not only to licensed healthcare facilities but also to any setting where fingerstick procedures are performed and/or insulin is administered, including assisted living or residential care facilities, clinics, health fairs, shelters, detention facilities, schools, and camps. Protection from bloodborne viruses and other infections is a basic requirement and expectation anywhere healthcare is provided."

2. On 3/2/18 at approximately 12:45 PM, during the Task of Medication Storage and Labeling on Cardinal Heights Unit's Medication Storage Room, a gallon jug of opened and dated distilled water was observed. LPN #7 stated the gallon jug of distilled water was used for a Resident's humidifier and also used to clean the Unit's fish bowl.

The fish bowl was observed on 3/2/18 at approximately 12:50 PM, sitting on a shelf in the Unit's dayroom area.

On 3/5/18 at approximately 12:45 PM, the Acting Director of Nurses #2 was asked if she saw a problem using a jug of distilled water for a resident's humidifier and to clean the fish tank. The Acting Director of Nurses stated, "Absolutely, there would be a possibility of contamination." A few minutes later, the Acting Director of Nurses #2 brought the Unit Manager LPN #1 to explain how the fish bowl is cleaned. LPN #2 stated that only herself and one other nurse LPN #2 clean the fish bowl. LPN #1 stated the fish bowl is approximately a gallon sized bowl. LPN #1 states that she always obtains a new gallon of distilled water to use when she cleans the fish bowl. LPN #1 states she discards any water that is not used

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as it shouldn't be used for anything other than the fish bowl. LPN #2 stated that she cleans the fish bowl when the Unit Manager LPN #1 is unavailable to do so. LPN #2 stated that she obtains a new jug of distilled water that the Unit Manager LPN #1 leaves for her. LPN #2 stated that she also throws out any unused water after cleaning the fish bowl in the Medication Room of Unit Cardinal Heights. LPN #2 was asked if she cleans up after cleaning the fish bowl and she stated she sanitizes the counter in the Medication Room. The Unit Manager LPN #1 stated she also uses the Medication Room to clean the fish bowl. When asked why the soiled utility room is not used to clean the fish bowl, the Unit Manager LPN #1 stated that there is no counter space in the soiled utility room.

On 3/5/18 at approximately 3:50 PM, the Acting Director of Nursing was asked if it would be an expectation to clean a soiled bed pan in the Medication room and she stated, "Absolutely not." Then the Acting Director of Nursing was asked if the fish bowl should be cleaned in the Medication room, and she stated that the fish bowl should be cleaned in a designated dirty area to not potentially cross contaminate the clean items in the medication room from possible splatter that may occur from cleaning the fish bowl. The Acting Director of Nursing also stated, that it would not be the facility's expectation to clean the fish bowl in the medication room even if the counter top was sanitized after use.

On 3/6/18 at approximately 1:30 PM, the Administrator was asked if there was any policy on cleaning a fish bowl. She stated that a fish bowl was acquired when the facility adopted the Eden Way Alternative. She stated the mission of

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the Eden Way Alternative was to improve the well-being of Elders and those who care for them by transforming the communities in which they live and work. The Administrator stated that the Vision of the program was to eliminate loneliness, helplessness, and boredom. The Administrator showed a 2009 Training Manual for the Eden Alternative and it documented the following:

"The training manual documented that opportunities included but are not limited to:

"Other Pets"
"Chicken coop, birdfeeders, fish tank"

The training manual did not include any recommendations for cleaning of fish bowls.

The Center for Disease Control (CDC) website (https://www.cdc.gov/healthypets/pets/fish.html) documented the following:

"Like all animals, fish may carry germs that make people sick. These germs can also contaminate the water in which fish live."

"Cleaning and maintaining your aquarium
Be aware that fish and their aquariums may carry germs. ?Wash your hands before and after cleaning or maintaining the aquarium or aquarium water. Plan to wear gloves when working with rough rocks or spiny fish to avoid injury."

"If you have any cuts or wounds on your hands, wear Pink gloved hands and cleaning brush. gloves or wait until your wounds are fully healed before working with your fish or aquarium water to avoid possible infection."

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"Avoid cleaning fish aquariums in areas where people with weak immune systems may be affected."

"The most common diseases associated with aquarium fish that can cause human illness are:"

"Aeromonas is a type of bacteria that is commonly found in fresh water ponds and aquariums. This germ can cause disease in fish and amphibians. Aeromonas can cause discoloration of the limbs of amphibians and fins of fish. It can also cause internal bleeding in these aquatic animals. People can become infected through open wounds or by drinking contaminated water. Young children and adults with weak immune systems are most commonly affected and may have diarrhea or blood infections."

"Mycobacterium marinum is a type of bacteria that causes disease in fish, reptiles, and amphibians. This germ is found in fresh water ponds and aquariums. It is spread to people and animals through contaminated aquarium water. The most common sign of infection is development of a skin infection. In very rare cases, the bacteria can spread throughout the body systems. Infections progress slowly and may get better on their own. In some instances, antibiotics and surgical wound treatments are required to prevent deep infection."

"Salmonella is a type of bacteria that spreads to people and animals through contaminated food or contact with the stool or habitat of certain animals, including fish. People infected with Salmonella might have diarrhea, vomiting, fever, or abdominal cramps. Infants, elderly persons,

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and those with weakened immune systems are more likely than others to develop severe illness."

"Streptococcus iniae is a type of bacteria that causes serious disease in fish. People, especially those with open skin abrasions or scrapes, could get infected by Streptococcus iniae bacteria while handling fish or cleaning aquariums. Affected people usually develop a skin infection at the site of open cuts or scrapes. Though rare, more serious illness can happen in people with weakened immune systems."

"People can become infected through open wounds or by drinking contaminated water. Young children and adults with weak immune systems are most commonly affected and may have diarrhea or blood infections."

Medline Plus website (https://medlineplus.gov/ency/article/004008.htm) documented the following:

"Your immune system helps protect your body from foreign or harmful substances. Examples are bacteria, viruses, toxins, cancer cells, and blood or tissues from another person. The immune system makes cells and antibodies that destroy these harmful substances."

"AGING CHANGES AND THEIR EFFECTS ON THE IMMUNE SYSTEM"

"As you grow older, your immune system does not work as well. The following immune system changes may occur:
The immune system becomes slower to respond. This increases your risk of getting sick."

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRMINGHAM GREEN	8605 CENTREVILLE ROAD MANASSAS, VA 20110

(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
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The facility administration was informed of the findings during a pre-exit briefing on 3/5/18 at approximately 3:50 PM and again during the 3/6/18 exit briefing at approximately 1:45 PM. The facility did not present any further information about the findings.

3. Resident #68 was admitted to the facility on 12/14/17. Diagnosis for Resident #68 included but are not limited to *Type II Diabetes.

Resident #68 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/21/2017 coded Resident #68 with a 03 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment.

*Diabetes Mellitus Type II is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (https://medlineplus.gov/ency/article/007365.htm).

On 02/27/18 at approximately 5:10 p.m., during the medication pass and pour observation, License Practical Nurse (LPN) #6 removed an alcohol pad, 2 x 2 gauze, a lancet, a test strip and *glucometer from a blue caddy basket containing items to test blood sugars and insulin syringes. The glucometer was wiped down using a *Sani Cloth Wipe prior to using the glucometer. LPN #6 went into Resident #68's room then proceeded to clean resident's finger with an alcohol pad, pricked her finger with the lancet, inserted the test strip into the glucometer to obtain the blood sugar. After obtaining blood for blood sugar, LPN #6 returned to the medication cart, placed the glucometer back into the blue caddy basket without disinfecting the glucometer. The surveyor asked if the glucometer machine should have

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been cleaned after use, the LPN stated, "Yes, I just forgot." The surveyor asked, "Should you have washed your hands before and after doing a blood sugar check the nurse replied, "Yes." The surveyor asked, "What is the purpose of washing your hands and cleaning the glucometer before and after use: the LPN stated, "To prevent the potential spread of infection between residents."

*Glucometer is a device that uses a small drop of blood to measure your blood sugar level. Some glucose meters measure a drop of blood taken from your finger using a special lancet device (https://www.drugs.com/cg/how-to-check-your-blood-sugar-aftercare-instructions.html).

*Sani Cloth Disposable Wipes is a disinfectant for use on hard, non-porous surfaces and patient care equipment (www.medline.com).

On 3/01/18 at approximately 9:50 a.m., an interview was conducted with Unit Manager (UM) who stated, "The glucometer should be cleaned before and after use and the nurse should have washed her hands before and after the blood sugar check on Resident #68."

An interview was conducted with the Assistant Director of Nursing (ADON) on 3/5/18 at approximately 1:10 p.m., who stated, "I expect for the nurses to clean the glucometer before and after the use and to wash their hands before and after any resident care."

The facility administration was informed of the finding during a briefing on 3/05/18 at approximately 3:50 p.m. The facility did not present any further information about the findings.

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The facility's policy: Blood Glucose Monitoring (Last revision date 3/1/18).
-After care induced but not limited to: Cleanse the glucose meter between resident tests.

-Procedure: Clean/disinfect meter after each use.

Hand Hygiene (Last revision date 8/30/17)
-Policy statement: This facility considers hand hygiene the primary means to prevent the spread of infection.

-Purpose of Handwashing/Hand Hygiene: All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.

-When to Wash hands: Employees must actively was their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions; (Hand sanitizer may be used when indicated up to 5 times, the Hand Washing Protocol) to include but not limited to:

*Before and after direct resident contact.
*Before and after performing any invasive procedure (e.g., finger stick, blood sampling).
*After removing gloves or aprons.

-Use of Gloves: The use of gloves does not replace handwashing/hand hygiene.

Policy and Procedure (Standard Precautions) revision date 12/4/17.
Policy statement: Standard Precautions will be used in the care of all residents regardless of

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F 880	Continued From page 54 their diagnosis, or suspected or confirmed infection status. Standard Precautions presume that all blood, bloody fluids, secretions, and excretions (except seat), non-intact skin and mucous membranes may contain transmissible infectious agents.	F 880		