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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/6/17 through 2/8/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 124 certified bed facility was 119 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents #1 through #21) and 3 closed record reviews (Residents #22 through #24).	F 000	**Ftag – 225 Investigative/Report Allegations/Individuals**	
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or	F 225	1. Certification verification for CNA-Employee #2 has been obtained and is in the personnel file. The criminal background check for Employee #1 has been obtained and is in the personnel file. There have been no substantiated allegations of abuse regarding either employee. 2. Employee personnel records will be audited to assess compliance with the Policy and Procedure for certification/license verification and criminal background checks. Certification/license verification and criminal background checks will be obtained where applicable. 3. The Administrator or designee will educate the Human Resource Generalist on the Policy and Procedure for obtaining certification/license verification and criminal background checks for newly hired employees.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: ADMINISTRATOR (X6) DATE: 2-24-17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate

4. Personnel records for newly hired employees will be reviewed weekly x 4 weeks then monthly x 2 months to ensure compliance with the Policy and Procedure on obtaining certification/license verification and criminal background checks for newly hired employees. The Administrator or designee will review findings and report to the QAPI Committee for any further recommendations monthly x 3 months.
5. Date of compliance 3-1-2017.

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corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation review and employee record review, the facility staff failed to ensure 1 of 2 certified nursing assistant's (CNA-Employee #2) certification verification was obtained through the Department of Health Professions, prior to hire; and failed to ensure a criminal background check was obtained within 30 days of hire for 1 of 5 employees (Employee #1).

1. Employee #2, a CNA hired 11/29/16, did not have CNA certification verification obtained until 11/30/16.
2. Employee #1, a CNA hired 11/15/16, did not have a criminal background check verified until 1/13/17.

The findings included:

1. On 2/7/17 at 11:00 a.m. an employee record review was conducted. The review revealed Employee #2, a CNA hired 11/29/16, had a "Licensure Lookup" from the Department of Health Professions was dated 11/30/16 which was 1 day after hire.

On 2/7/17 at 2:10 p.m. an interview was conducted with Human Resource employee (Admin-C). The above information was reviewed with Admin-C who stated she'd look into it.

On 2/7/17 at 3:05 p.m. Admin-C confirmed Employee #2's certification check was not done until 11/29/16. She stated she was not working at the facility at that time. When asked when she normally checks the certification, Admin-C stated

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"Every time I get an application, I pull the licensure check and attach it to the application before an interview is done."

On 2/7/17 at 4:40 p.m. the Administrator and Director of Nursing were informed of the findings. No further information was provided by the facility staff.

A review of facility policy titled "ABUSE PREVENTION" included:
"PROCEDURE:
I. Screening...
B. State licensure and certification agencies, and applicable registries will be contacted to ensure current licensure or certification and to determine if the potential associate has been subject to disciplinary action against his professional license as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property..."

2. The employee record review also revealed, Employee #1, a CNA hired 11/15/16, did not have a criminal background check verified until 1/13/17 which was 59 days after hire.

On 2/7/17 at approximately 2:10 p.m. an interview was conducted with Human Resources employee (Admin-C). When Employee #1's criminal background check was discussed, Admin-C stated the "Criminal check was run 10/28/16 but was not placed in the file." Although the criminal background check document had a "received date" of 10/28/16, there was no date of verification of when the facility retrieved the background check results from the State computer system. The received date is the date

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that the request was put into the State computer system to run the background check.

A review of facility policy titled "ABUSE PREVENTION" included:
"PROCEDURE:
I. Screening...
C. Potential associates will be subject to a criminal background check and will not be employed if any conviction of abuse, neglect, exploitation, misappropriation of property or mistreatment is found..."

On 2/7/17 at 4:40 p.m. the Administrator and Director of Nursing were informed of the findings. No further information was provided by the facility staff.

F 241 SS=D 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY

(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation and clinical record review, the facility staff failed to provide a dignified living experience for one Resident (Resident #5) in a survey sample of 24 Residents.

For Resident #5, the wound care nurse wrote on the dressing after it was applied to the resident.

The findings included:

Ftag – 241 Dignity & Respect of Individuality

1. Resident #5 was discharged from the center February 15, 2017.
2. Any resident has the potential to be affected if center staff fail to provide wound care to residents in a manner that enhances their quality of life.
3. The Director of Nursing or Designee will educate the licensed nurses on the proper technique for dating a wound dressing.
4. Dressing change observations will be completed weekly x 4 weeks then monthly x 2 months to ensure compliance with the proper technique for dating a wound dressing. The DON or designee will review findings and report to the QAPI committee for any further recommendations monthly x 3 months.
5. Date of compliance 3-1-2017.

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Resident #5, was admitted to the facility 1/2/17. Diagnoses included, but not limited to, metabolic encephalopathy, stroke with dysphagia, diabetes, atrial fibrillation, dementia with behavioral disturbance and chronic obstructive pulmonary disease (COPD).

Resident #5's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/27/17 was coded as an admission assessment. Resident #5 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #5 was coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living. The resident was fed by way of a gastrostomy tube (tube inserted into the stomach).

On 2/17/17 at 1:35 PM, a wound care observation was conducted with LPN (licensed practical nurse) B. The resident's wound was cleansed and ointment applied. The cover dressing was applied to the wound. LPN (B) then wrote the date and time, with her initials, on the dressing that had been applied.

On 2/8/17 at 8:10 AM, an interview was conducted with LPN (B). When asked when she initialed and dated the dressing, LPN (B) replied: "I wrote on the dressing after placing the dressing on the resident."

Review of the facility policy and procedure for "Clean Dressing Technique" did not address dating and initialing the dressing.

On 2/8/17 at approximately 11:30 AM, the DON

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(director of nursing) and Administrator were notified of above findings. The DON was asked if it was appropriate to write on residents; the DON stated, "No."

F 281 SS=D 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS | F 281

(b)(3) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to follow professional standards of nursing for medication administration for one Resident (Resident #18) in a survey sample of 24 Residents.

For Resident #18, Eliquis was administered at 4:15 p.m. instead of 6 p.m., per physician's order; and

The findings included:

1. For Resident #18, Eliquis was administered at 4:15 p.m. instead of 6 p.m., per physician's order.

Resident #18, a female, was initially admitted to the facility 9/10/10 and readmitted after a hospitalization 9/18/15. His diagnoses included generalized arthropathy, idiopathic autonomic neuropathy, adult personality disorder, urinary

Ftag – 281 Services Provided Meet Professional Standards

1. Resident #18's physician and responsible party have been notified that resident received Eliquis outside physician prescribed time. Resident #18 has been assessed and there were no adverse effects from receiving Eliquis prior to the administration time.
2. Any resident has the potential to be affected if nurse fails to follow the center's medication pass time schedule.
3. The Director of Nursing or Designee will educate licensed nurses on the center's Policy and Procedure for Medication Administration and the process to follow if a resident wishes to exercise their right to take medications outside scheduled time.

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retention, dementia, diverticulitis, congestive heart failure, major depressive disorder, gastroesophageal reflux disease, hypothyroidism, chronic obstructive pulmonary disease, hypercholesterolemia, chronic obstructive pulmonary disease, hypertension, type II diabetes mellitus, insomnia, macular degeneration, and cataract.

Resident #18's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/6/16 was coded as a quarterly assessment. Resident #18 was coded as having no memory deficits and was able to make her own daily life decisions. Resident #18 was coded as needing standby assistance of two staff members to perform all of her activities of daily living with the exception of bathing. For bathing she was coded as needing total assistance of one staff member.

Resident #18 was observed beginning 2/6/17 at 4:05 p.m., during medication pour and pass observation. LPN C reviewed the eMAR (electronic medication administration record) and prepared the following medications into a medication cup: Docusate 100 mg (milligram) one capsule (constipation), Famotidine 20 mg once tablet (gastroesophageal reflux disease), Eliquis 2.5 mg one tablet (thrombosis and stroke prevention), and Quetiapine 25 mg 1/2 tablet (adult personality disorder). LPN C picked up the medication cup and entered Resident #18's bedroom. LPN C handed the medication cup to Resident #18 and Resident #18 took the medications at 4:16 p.m.

Upon reconciliation of the medications that were observed as having been administered, a physician's order was noted, "Eliquis 2.5 mg by

F 281

4. Medication Pass Observations will be completed with 2 licensed nurses on random shifts weekly x 4 weeks then monthly x 2 months to ensure compliance with medication administration during the prescribed administration time. The DON or designee will review findings and report to the QAPI committee for any further recommendations monthly x 3 months.
5. Date of compliance 3-1-2017.

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mouth twice daily. The order for Eliquis was on the most recently signed "Order Summary Report" signed by the physician 1/17/16. Review of the eMAR revealed Eliquis 2.5 mg was ordered to be administered at 10 a.m. and 6 p.m.

When interviewed 2/7/16 at 2:30 p.m., regarding administering Eliquis 1 hour and 45 minutes too early, LPN C stated he always administered the medication at around that time. LPN C stated Resident #18 wanted to take all her afternoon medications at the same time. LPN C stated he "guessed the physician should be contacted to have the time of the medication changed."

Review of the facility's policy entitled "Med Pass Procedure" included:

"3. Verify that the following information on the Med Pass bag matches the information on the MAR:
  a. Resident's name
  b. Room number
  c. Administration date
  d. Administration time

4. Read all of the orders from the MAR for that resident to identify which medications are to be administered during the current Med Pass time."

Guidance for nursing standards for the administration of medication was provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many

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medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:

1. The right medication
2. The right dose
3. The right client
4. The right route
5. The right time
6. The right documentation."

Guidance for the administration of Eliquis was provided at www.eliquis.com:

"How should I take ELIQUIS?

· Take ELIQUIS exactly as prescribed by your doctor.

· Take ELIQUIS twice every day with or without food.

· Do not change your dose or stop taking ELIQUIS unless your doctor tells you to."

The administrator, DON (director of nursing), corporate consultants and ADON (assistant DON) were informed of the failure of LPN C to administer Eliquis at the physician ordered time, 2/7/17 at 4:44 p.m.

F 431 SS=D 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS F 431

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

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(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(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.

(h) Storage of Drugs and Biologicals.
(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.

(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 431

Ftag – 431 Drug Records, Label/Store Drugs & Biological

1. Improperly stored and expired insulin have been discarded and reordered.
2. Medication Carts and Medication Rooms will be audited to ensure insulins are properly stored and dated.
3. The Director of Nursing or Designee will educate the licensed nurses on the Policy and Procedure for Insulin storage and dating.
4. Medication Carts and Medication Rooms will be audited weekly x 4 weeks then monthly x 2 months to ensure insulin is properly stored and labeled. The DON or designee will review findings and report to the QAPI committee for further recommendations monthly x 3 months.
5. Date of compliance 3-1-2017.

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abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility documentation review, the facility staff failed to ensure insulin was stored per manufacturer's instructions and failed to ensure out of date insulin was not available for administration on one of two units (Outlook).

1. Three vials of insulin were available for administration greater than 28 days after being opened and accessed and one vial of Novolog insulin was stored in medication cart 2 that was not opened or accessed. The vial of Novolog insulin had been in the medication cart since 1/25/17; and

2. Two vials of insulin were available for administration greater than 28 days after being opened and accessed on the medication cart 1.

The findings included:

1. Three vials of insulin were available for administration greater than 28 days after being opened and accessed and one vial of Novolog insulin was stored in the medication cart 2 that was not opened or accessed. The vial of Novolog insulin had been in the medication cart since 1/25/17.

The medication cart 2 was observed 2/7/17 at 11:10 a.m. Located within the medication cart was a vial of Novolog insulin that was unopened and not accessed. LPN (licensed practical nurse)

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E, the nurse giving medications on that cart, stated 2/7/17 at 11:10 a.m., the vial should have been stored in the refrigerator. LPN E said the vial had been stored in the medication cart, out of refrigeration, since delivered to the facility 1/25/17. LPN E determined when the vial was delivered and stored in the medication cart by reviewing the label on the box of insulin.

Review of the facility guidance, "Medications with Shortened Expiration Dates" included:

"Prior to use refrigerate, Good for 28 days after opening or removing from refrigerator."

Guidance was also provided at www.novolog.com:

"Store NovoLog® in the refrigerator-between 36°F and 46°F (2°C and 8°C)-until first use. Do not freeze. NovoLog® FlexPen® and PenFill® cartridges that are in use must be kept at room temperature-below 86°F (30°C)-for up to 28 days and must not be refrigerated. Vials, once in use, can be kept at either room temperature or in the refrigerator. Do not store NovoLog® in areas of extreme moisture and where there may be very hot or cold temperatures, such as in a freezer or car."

Additionally three vials of opened and accessed insulin were observed within the medication cart and were available for administration. Two vials of Lantus insulin were opened and accessed. The vials were both dated as having been opened and accessed on 1/5/17 (33 days prior). One vial of Novolog insulin was also dated as having been opened and accessed on 1/6/17 (32 days prior). A notation was observed on the

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pharmacy prepared label indicating the insulin was only good for 28 days after being opened and accessed.

Review of the guidance "Medications with Shortened Expiration Dates" included:

"Lantus   Good for 28 days after opening or removing from refrigerator."

2. Two vials of insulin that were opened and accessed greater than 28 days were available for administration on the medication cart 1.

Medication cart 1 was observed 2/7/17 at 11:45 a.m. Located within the medication cart were two vials of insulin, a vial of Humulin R dated as having been opened 1/3/17 (35 days prior) and a vial of Lantus dated as opened 1/8/17 (30 days prior).

LPN D stated the vials were only good for 28 days after being opened and accessed. LPN D referred to the entry on the boxes from the pharmacy indicating the vials were only good for 28 days after being opened and accessed.

Guidance was also provided on the facility policy, "Medications with Shortened Expiration Dates" included:

"Humulin R, Humulin N, Humulin 70/30 Good for 28 days after opening or removing from refrigerator."

Guidance was provided at www.lantus.com:

"Storage Instructions ·   Store unused Lantus® vials in the refrigerator between 36°F to 46°F

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(2°C to 8°C)
- Store in-use (opened) Lantus® vials in a refrigerator or at room temperature below 86°F (30°C)
- Do not freeze Lantus®
- Keep Lantus® out of direct heat and light
- If a vial has been frozen or overheated, throw it away
- The Lantus® vials you are using should be thrown away after 28 days, even if it still has insulin left in it."

Also guidance was provided at https://pi.lilly.com:

"Storage
Not in-use (unopened): Humulin R U-100 bottles not in-use should be stored in a refrigerator (36° to 46°F [2° to 8°C]), but not in the freezer.
In-use (opened): The Humulin R U-100 bottle you are currently using can be kept unrefrigerated as long as it is kept as cool as possible [below 86°F (30°C)] away from heat and light. In-use bottles must be used within 31 days or be thrown out, even if they
still contain Humulin R U-100."

The administrator, DON (director of nursing) ADON (assistant DON), and corporate consultants were advised of vials of insulin opened and accessed available for use after out of date and a vial of unopened insulin being stored, out of refrigeration, on the medication cart, on Outlook wing, 2/8/17 at 11:40 a.m.

F 441 SS=D 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS — F 441

(a) Infection prevention and control program.

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

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

F 441 **Ftag – 441 Infection Control, Prevent Spread, Linens**

1. Resident #18 and #12 have been assessed and have had no adverse effects related to infection control breach during the medication pass observation. LPN C has received an associate counseling related to the breach in infection control practices during the medication pass observation.
2. Any resident has the potential to be affected if a nurse fails to follow effective infection control practices during medication administration.
3. The Director of Nursing or Designee will educate licensed nurses on the Infection Control Policy & Procedure and Policy & Procedure for Medication Administration.
4. Medication Pass Observations will be completed with 2 licensed nurses on random shifts weekly x 4 weeks then monthly x 2 months to ensure compliance with infection control practices. The DON or designee will review findings and report to the QAPI committee for any further recommendations will be discussed during the QA Committee Meeting monthly x 3 months.
5. Date of compliance 3-1-2017.

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circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure the infection control committee implemented an effective infection control program to ensure medications were administered in a manner to prevent the spread of infection for two Residents (Residents' #18 and #12) in a survey sample of 24 Residents.

1. For Resident #18, LPN (licensed practical nurse) C lifted up her mattress, touched her, administered medications including inhaler, and removed gloves without washing nor cleaning his hands;

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2. For Resident #12, LPN C prepared and administered eye drops to Resident #12 without washing or cleaning his hands after administering medications to Resident #18 nor did LPN C clean or wash his hands after removing his gloves; and

The findings included:

1. For Resident #18, LPN C lifted up her mattress, touched her, administered medications including inhaler, and removed gloves without washing nor cleaning his hands.

Resident #18, a female, was initially admitted to the facility 9/10/10 and readmitted after a hospitalization 9/18/15. Her diagnoses included generalized arthropathy, idiopathic autonomic neuropathy, adult personality disorder, urinary retention, dementia, diverticulitis, congestive heart failure, major depressive disorder, gastroesophageal reflux disease, hypothyroidism, chronic obstructive pulmonary disease, hypercholesterolemia, chronic obstructive pulmonary disease, hypertension, type II diabetes mellitus, insomnia, macular degeneration, and cataract.

Resident #18's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/6/16 was coded as a quarterly assessment. Resident #18 was coded as having no memory deficits and was able to make her own daily life decisions. Resident #18 was coded as needing standby assistance of two staff members to perform all of her activities of daily living with the exception of bathing. For bathing she was coded as needing total assistance of one staff member.

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Resident #18 was observed beginning 2/6/17 at 4:05 p.m., during medication pour and pass observation. LPN C entered Resident #18's bedroom to assess her. Resident #18 complained of something being wrong with her bed and LPN C lifted up the entire bottom end of her mattress. LPN C placed his hand on her shoulder prior to leaving the bedroom. LPN C did not clean nor wash his hands prior to leaving the bedroom and after lifting up the mattress and touching Resident #18.

LPN C reviewed the eMAR (electronic medication administration record) and opened the medication cart. LPN C removed the medication packets and prepared the following medications into a medication cup: Docusate 100 mg (milligram) one capsule (constipation), Famotidine 20 mg one tablet (gastroesophageal reflux disease), Eliquis 2.5 mg one tablet (thrombosis and stroke prevention), and Quetiapine 25 mg 1/2 tablet (adult personality disorder). LPN C picked up the medication cup and entered Resident #18's bedroom. LPN C handed the medication cup to Resident #18 and Resident #18 took the medications at 4:16 p.m. LPN C did not wash or clean his hands prior to leaving Resident #18's bedroom. Additionally LPN C administered 2 puffs of Symbicort inhaler to Resident #18.

LPN C returned to the medication cart and removed a box that contained Artificial tears eye drops. He entered Resident #18's bedroom again after donning a pair of gloves. LPN C attempted to administer the eye drops to Resident #18, however she refused the drops. LPN C removed his gloves, discarding them in the trash. LPN C returned to the medication cart, opened the drawer and put the eye drops in the cart. LPN C

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documented within the eMAR that the medications were administered and the eye drops were refused and prepared to administer medications to Resident #12. LPN C failed to clean or wash his hands from the time he lifted up the mattress through the entire administration of medications to Resident #18, nor did he clean or wash his hands prior to preparing to administer medications to the next Resident, Resident #12.

When interviewed, 2/7/17 at 2:30 p.m., LPN C was unaware that he had not cleaned or washed his hands during the entire medication administration observation 2/6/17 beginning at 4:05 p.m. through 4:20 p.m.

Review of the facility's policy entitled "Hand Washing" included:

"When caring for people, the hands are always touching the resident, or articles and equipment used in the care of residents. As a result, germs from these are transferred to your hands. In turn you transport them to other persons and places, including your own face and mouth...

Constant care must be taken to prevent the spread of disease organisms. Frequent and thorough hand washing is of major importance in preventing the spread of the organisms.

TIMES WHEN HAND WASHING IS VERY IMPORTANT:

C. Before and after resident contact.
D. After handling resident's articles or equipment used in his care."

Guidance was provided in "Fundamentals of

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Nursing 7th Edition, page 652, Use your critical thinking skills to prevent an infection from developing or spreading. Implement procedures to minimize the numbers and kinds of organisms that could be possibly transmitted. Eliminating reservoirs of infection, controlling portals of exit and entry, and avoiding actions that transmit microorganisms prevent bacteria from finding a new site to grow. Proper use of sterile supplies, barrier precautions, standard precautions, transmission -based precautions and proper hand hygiene are examples of methods to control the spread of microorganisms."

Guidance was also provided in "MMWR (Morbidity and Mortality Weekly Report, CDC, March 25, 2002, page 32,

Recommendations
1. Indications for handwashing and hand antisepsis

J. Decontaminate hands after removing gloves."

When interviewed, RN (registered nurse) A, the infection control nurse, stated 2/8/17 at 11 a.m., LPN C should have cleaned or washed his hands during the medication pass observation. RN A stated she has frequent inservices about proper hand washing and she had "no idea what happened." RN A stated "he (LPN C) should have known better."

The administrator, DON (director of nursing), corporate consultants, and ADON (assistant DON) were informed 2/8/17 at 11:40 a.m. of the failure of LPN C to clean or wash his hands after lifting Resident #18's mattress, touching Resident

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#18, prior to preparing and administering medications to Resident #18, and after removing his gloves.

2. For Resident #12, LPN C prepared and administered eye drops to Resident #12 without washing or cleaning his hands after administering medications to Resident #18.

Resident #12, a female, was admitted to the facility 7/30/15. Her diagnoses included bipolar, anxiety, Parkinson's, dementia, congestive heart failure, and hypertension.

Resident #12's most recent MDS with an ARD of 12/21/16 was coded as a quarterly assessment. Resident #12 was coded as needing extensive to total assistance of one to two staff members to perform her activities of daily living.

Resident #12 was observed during the medication pour and pass observation 2/6/17 beginning at 4:20 p.m. LPN C had administered medications to Resident #18 including oral medications and inhaler and returned to the medication cart to prepare medications for Resident #12. LPN C did not wash or clean his hands after interacting with Resident #18.

LPN C reviewed the eMAR and removed a box that was later identified as Ketotifen 0.25% eye drops. LPN C picked up the box and entered Resident #12's bedroom. LPN C donned a pair of gloves, entered Resident #12's bedroom and administered Ketotifen 0.25% eye drops, one drop in each eye at 4:26 p.m. LPN C returned to the medication cart. LPN C cleaned the top of the eye drops and put the top back on the drops. LPN C removed his gloves and documented the

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administration of the medication in the eMAR. At no time did LPN C clean or wash his hands after removing the gloves and prior to entering the medication cart and eMAR computer.

LPN C stated 2/7/17 at 2:30 p.m., he was unaware that he did not clean or wash his hands after administering medications to Resident #18 and prior to preparing and administering medication to Resident #12.

The administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and corporate consultants were advised of the failure of LPN C to clean or wash his hands prior to preparing and administering medications to Resident #12, 2/7/17 at 11:40 a.m.

When interviewed 2/7/17 at 2:06 p.m., LPN D was unaware she should not have the bottom of a medication cup placed on top of prepoured medication.

The administrator, DON, ADON, and corporate consultants were advised of the failure of LPN D to prepare medications in a sanitary manner, 2/8/17 at 11:40 a.m.

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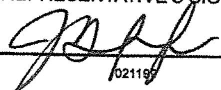
F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 2/6/17 through 2/8/17. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 124 certified bed facility was 119 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents #1 through #21) and 3 closed record reviews (Residents #22 through #24).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12VAC5-371-210 Nurse Staffing 12VAC5-371-210 (F) Based on staff interview, facility documentation review and employee record review, the facility staff failed to ensure certified nursing assistant (CNA) certification verification, was obtained through the Department of Health Professions prior to hire, for one of 12 CNA's (Employee #24). On 2/7/17 at 11:00 a.m. an employee record review was conducted. The review revealed Employee #24, a CNA, was hired 10/18/16	F 001	**12VAC5-371-210 Nurse Staffing** **12VAC5-371-210(F)** 1. Certification verification for CNA-Employee #2 has been obtained and is in the personnel file. There have been no substantiated allegations of abuse regarding the employee. 2. Employee personnel records will be audited to assess compliance with the Policy and Procedure for certification/license verification. Certification/license verification will be obtained where applicable. 3. The Administrator or Designee will educate the Human Resource Generalist on the Policy and Procedure for obtaining certification/license verification for newly hired employees. 4. Personnel records for newly hired employees will be reviewed weekly x 4 weeks then monthly x 2 months to ensure compliance with the Policy and Procedure on obtaining certification/license verification for newly hired employees. The Administrator or designee will report findings to the QAPI committee for further recommendations monthly x 3 months. 5. Date of compliance 3-1-2017.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE ADMINISTRATOR (X6) DATE 2-24-17

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RIVERVIEW ON THE APPOMATTOX HEALTH & REH	201 EPPS STREET HOPEWELL, VA 23860

(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) COMPLETE DATE
F 001	Continued From Page 1 however, the "Licensure Lookup" from the Department of Health Professions was dated 10/24/16 which was 6 days after hire. On 2/7/17 at 2:10 p.m. an interview was conducted with the Human Resource employee (Admin-C). The above information was reviewed with Admin-C. Admin-C stated she'd look into it. On 2/7/17 at 3:05 p.m. Admin-C confirmed Employee #24's certification check was not done until 10/24/16. She stated she was not working at the facility at that time. When asked when she normally checks the certification, Admin-C stated "Every time I get an application, I pull the licensure check and attach it to the application before an interview is done." On 2/7/17 at 4:40 p.m., the Administrator and Director of Nursing were informed of the findings. No further information was provided by the facility staff. The facility was not in compliance with the following cross-referenced regulations: 12VAC5-371-220 Nursing Services 12VAC5-371-220 (D)-Cross Reference to F-241. 12VAC5-371-200 Nursing Director 12VAC5-371-200 (B)-Cross Reference to F-281. 12VAC5-371-300 Pharmaceutical Services 12VAC5-371-300 (B)-Cross Reference to F-431. 12VAC5-371-180 Infection Control 12VAC5-371-180 (A,C)-Cross Reference to F-441.	F 001	12VAC5-371-220 Nursing Services 12VAC5-371-220 (D)-Cross Reference to F-241 See POC F-241 12VAC5-371-200 Nursing Director 12VAC5-371-200 (B)-Cross Reference to F-281 See POC F-281 12VAC5-371-300 Pharmaceutical Services 12VAC5-371-300 (B)-Cross Reference to F-431 See POC F-431 12VAC5-371-180 Infection Control 12VAC5-371-180 (A, C)-Cross Reference to F-441 See POC F-441	