STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	836 GLENDALE RD PO BOX 229 GALAX, VA 24333

(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 09/11/18 through 09/13/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. The census in this 120 certified bed facility was 98 at the time of the survey. The survey sample consisted of 25 current Resident reviews and 4 closed record reviews.	E 000	**Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable State and Federal regulatory requirements.** **F 557(D):** **1. Re-education was provided on 9/27/2018 to the hospitality aide and the maintenance assistant by the Administrator regarding residents' rights and ensuring that there are no interruptions during Resident Council Committee Meetings.**	10/12/2018
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 09/11/18 through 09/13/18. Three complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 98 at the time of the survey. The survey sample consisted of 25 current Resident reviews and 4 closed record reviews.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced	F 557		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: mmonbell — TITLE: Administrator — (X6) DATE: 10-2-18

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

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F 557	Continued From page 1	F 557		

by:
Based on observation and staff interviews, the facility staff failed to provide privacy in a manner that maintained or enhanced the dignity of the residents during a resident council meeting on 9/12/18.

The findings included:

During a resident council meeting held on 9/12/18 beginning at 10:00 a.m., the facility staff failed to respect the resident's dignity, privacy, and individuality. The facility staff entered the area where the resident council meeting was held numerous times disturbing the resident council meeting each time a staff member entered or exited the room.

The group meeting was held in the facility's dining room and was attended by seven residents of the facility.

Soon after the resident council meeting began, the surveyor and group observed a hospitality aide come in the dining room through the door at the back of the dining room carrying a tray and placed the tray in the kitchen window. The hospitality aide then left the dining room.

The same hospitality aide came through the door at the back of the dining room carrying a second tray a second time. She left the tray and then exited the room.

The hospitality aide came in a third time, looked around the corner at the back of the dining room and then exited

The maintenance assistant entered the dining

2. A larger sign stating that Resident Council Committee meeting is Progress and Please Do Not Enter will be posted on the front and the back entrances of the dining room during Resident Council Committee Meetings.

3. Current employees will be re-educated by 10/11/18 by the Administrator/Designee regarding residents' rights and ensuring that Resident Council Committee is not interrupted to maintain residents' rights, privacy, and dignity. Observations will be conducted by the Administrator/Designee monthly at the Resident Council Committee for three (3) months to ensure that there are no interruptions during the meeting.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 557	Continued From page 2	F 557		

room from the back entrance, strolled through the dining room, and exited through the front door entrance.

The surveyor and resident council observed a family member enter through the front entrance of the dining room and push a resident in a Geri-chair to the back of the dining room. Several other family members followed.

There was a sign posted on the front door entrance to the dining room that a meeting was being held.

The surveyor informed the administrator and the director of nursing (DON) of the numerous interruptions during the resident council meeting during the end of the day meeting on 9/12/18.

The surveyor interviewed the activity director on 9/13/18 at 7:40 AM about the numerous interruptions during the resident council meeting. She apologized for all the interruptions. She stated she was not here at the time of the meeting that she was on a transport and the other activity person was having a small group with several residents at the entrance to the building. The activity director stated a sign had been placed on the entrance to the dining room from the front but not one at the back.

The surveyor interviewed the maintenance director on 9/13/18 at 7:47 AM. He stated he had educated his assistant. He stated there was a sign on the front entrance to the dining room to "Do Not Disturb" but not one on the back entrance door. The maintenance director stated when his assistant saw the group meeting, he should have turned around and left. The

4. The results of the observations will be discussed by the Administrator/Designee monthly for three (3) months at the QAPI Committee Meeting. The interdisciplinary team/committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.

5. Date of Compliance: 10/12/18

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F 557	Continued From page 3 maintenance director stated there was not a sign on the back door. No further information was provided prior to the exit conference on 9/13/18.	F 557		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to follow physician orders for medication administration for 1 of 28 residents (Resident #53). The findings included: The facility staff failed to follow physician orders for the administration of insulin. The licensed practical nurse (LPN #1) administered Humalog insulin after Resident #53 had eaten breakfast. The clinical record of Resident #53 was reviewed 9/11/18 through 9/13/18. Resident #53 was admitted to the facility 5/31/16 and readmitted 12/9/17 with diagnoses that included but not limited to diabetes mellitus with diabetic neuropathy, gross hematuria, chronic pain, bipolar disorder with hallucinations, Vitamin D	F 684	**F 684 (D):** **1. For Resident #53, the physician and the responsible party have been notified regarding the insulin administered after breakfast on 9/12/2018. There were no adverse effects to the resident #53 related to the variance.** **LPN #1 was re-educated on 10/1/18 by the DON/Designee related to ensuring that insulin is administered as ordered.** **2. Current Residents' medication administration records were reviewed by the DON/Designee for the previous thirty (30) days to ensure that insulin has been administered as ordered by the physician.**	

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F 684	Continued From page 4	F 684		

deficiency, major depressive disorder, post-traumatic stress disorder, dementia with behavioral disturbances, hypercholesterolemia, hypertension, atrial fibrillation, diastolic heart failure, chronic obstructive pulmonary disease, and chronic kidney disease.

Resident #53's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 6/22/18 assessed the resident with a BIMS (brief interview for mental status) as 14 out of 15.

Resident #53's current comprehensive care plan had a focus area initiated 6/30/17 for alteration in blood glucose due to insulin dependent diabetes mellitus. Interventions: Administer medications as ordered.

The surveyor observed Resident #53 on 9/12/18 at 8:29 AM. The resident was observed sitting up in bed. Breakfast tray with ticket reading CCD (consistent carbohydrate diet) was on the over the bed table. She had scrambled eggs, raisin toast with jelly, oatmeal, bacon, OJ, coffee and milk. Resident #53 had just finished the glass of orange juice. The resident stated this was the first thing solid she had to eat in a few days. Stated she was feeling so much better.

The surveyor returned to interview Resident #53 on 9/12/18 at 9:04 a.m. Resident #53's breakfast tray had been removed and she stated she had eaten well. During the interview, L.P.N. #1 entered the room and asked if she was ready for her insulin. Resident #53 stated yes and L.P.N. #1 administered Humalog 8 units into the left side of the resident's abdomen at 9:12 a.m.

The surveyor reviewed the physician's orders for

3. Re-education will be completed by 10/11/18 by the DON/Designee with current Licensed Nurses regarding the six (6) rights of medication administration. The education also includes ensuring that medications including insulin are administered per the physician's order. Medication administration observations will be conducted by the DON/Designee with four (4) Licensed Nurses per week for three (3) months to ensure that the six rights of medication administration are followed, medications are administered per the physician's order including insulin.

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F 684	Continued From page 5 September 2018. The order read "Humalog KwikPen Solution Pen-injector 100 unit/ml (milliliter) (Insulin Lispro) If 131-180=4 units; 181-240=8 units; 241-300=10 units; 301-350=12 units; 351-400=16 units; 401+ =20 units, call MD (medical doctor) subcutaneously before meals and at bedtime related to Type 2 Diabetes mellitus with Diabetic Nephropathy." Resident #53's 7:00 a.m. blood sugar was recorded as 182. The September 2018 medication administration record had recorded 8 units of Humalog insulin was administered at 7:30 a.m. However, the surveyor observed L.P.N. #1 administer the Humalog insulin at 9:12 a.m. after Resident #53 had eaten=not before. L.P.N. #1 was not available at the facility on 9/13/18 to interview. The surveyor informed the director of nursing and the administrator of the above concern on 9/13/18 at 2:00 p.m. No further information was provided prior to the exit conference on 9/13/18.	F 684	**4. The results of the medication administration observations will be discussed by the Administrator/Designee at the monthly for three (3) months QAPI committee meeting at the. The interdisciplinary team/committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.** **5. Date of Compliance: 10/12/2018**	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692	**F 692 (D):** **1. Resident #43 was interviewed regarding preferences during the survey process by the Dietician. New orders were obtained to discontinue the magic cup. There were no adverse effects to the resident.**	10/12/2018

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F 692	Continued From page 6 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review it was determined the facility staff failed to provide 1 of 25 residents (Resident #43) with a diet as ordered by the physician. Findings: Facility staff failed to provide Resident #43 with a diet as ordered by the physician. The resident's clinical record was reviewed on 9/12/18 at 9:00 AM. The resident was admitted to the facility on 7/26/18. Her diagnoses included dementia, heart failure and hypertension. The latest MDS (minimum data set) dated 7/27/18 coded the resident with slightly impaired cognitive ability. The resident was coded to eat meals independently with staff oversite. The resident's CCP (comprehensive care plan) documented the resident with involuntary weight loss. The staff interventions included, "Magic cup supplement daily".	F 692	**2. Current Residents with physician's orders for dietary supplements/magic cups will be reviewed by the DON/Designee by 10/11/18. Observations will be conducted by the DON/Designee comparing the physician's order for diet, the tray ticket, and the items provided on the meal tray to ensure that the current residents' physician diet orders are provided and available on the meal tray as ordered by the physician including dietary supplements /magic cups.**	

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F 692	Continued From page 7	F 692		

The resident's physician's orders, signed and dated on 10/17/17, included the resident's dietary supplements for weight loss. The physician ordered a Magic cup one time each day at lunch for weight loss.

The registered dietician notes were reviewed and on 11/27/17 this note was documented: "....She enjoys getting soup with lunch and supper and yogurt and routinely consumes them....."

On 9/11/18 and 9/12/18 the resident was observed eating the lunch meal. Several discrepancies were noted on the tray ticket vs the food served to the resident.
1. 9/11/18 - The tray ticket contained "yogurt 6 oz" which was not set-up on the tray left by the CNA serving the meal.
2. 9/12/18 - The tray ticket contained "yogurt 6 oz and Mechanical Soft Magic Cup - 4 oz." These items were missing from the meal set-up by the CNA setting up the tray and were not obtained from the kitchen prior to the removal of the tray from the room.

On 9/12/18 at 4:00 PM the DON and administrator were informed of the surveyor's observations and asked about the items which were missing from the tray. The administrator said they should check the card with the food on the tray when setting the meal up. "They're supposed to make sure everything is there."

On 9/13/18 at 9:30 AM the RD (registered dietician) was interviewed. She stated, "If it's on the card, it should be on the tray when served."

On 9/13/18 the administrator reported they had an inservice on the meal service that morning.

3. Re-education will be completed by 10/11/18 by the DON/Designee with current nursing /dietary staff regarding ensuring that diet orders including supplements/magic cups are provided on the meal tray are consistent with the tray ticket/physician's order. Observations will be conducted by the DON/Designee three (3) times per week for three (3) months to compare the tray ticket to the items on the meal tray to ensure that items listed on the tray ticket including supplements/ magic cups and other items are provided per the physician's ordered diet.

4. The results of the observations/comparison will be discussed by the Administrator/Designee at the QAPI committee meeting monthly for three (3) months.

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F 692	Continued From page 8 She provided the sign-in sheet and the topic which was "Tray accuracy". The RD was the named as the presenter. Seven staff members were inserviced and the objective was documented, "Resident will be served meals that provide for identified preferences and requests, diet orders and identified needs." No additional information was provided prior to the survey team exit.	F 692	**The interdisciplinary team/committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.** **5. Date of Compliance: 10/12/2018**	
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,	F 758	**F 758 (D):** **1. For Resident #24, the physician reviewed the resident's medications and clarified the physician's order on 9/22/18 for the as needed Xanax to be utilized for no longer than fourteen (14) days and then reviewed by the physician for continued utilization. There were no adverse effects to the resident.** **2. Current Residents' with physician's orders for as needed psycho-active medications have been reviewed by the**	10/12/2018

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F 758	Continued From page 9 §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 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 25 residents in the survey sample was free of unnecessary psychotropic medication (Resident #24). The findings included: The facility staff failed to discontinue or re-evaluate the use of a "prn" (as needed), Xanax, for Resident #24. Resident #24 was admitted to the facility on 7/9/18 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, End Stage Renal Disease, stroke and	F 758	**DON/Designee to ensure that the physician's order is written not to exceed fourteen (14) days, then reviewed by the physician for continued utilization.** **3. Re-education will be completed by 10/11/18 by the DON/Designee with current Licensed Nurses and physicians regarding the regulation for as needed psychoactive medication usage to include as needed psycho-active medication will be ordered not to exceed fourteen (14) days before being reviewed by the physician for continued use of the medication. A review will be conducted by the DON/Designee for three (3) residents with physician's orders for as needed psycho-active medications per week for three (3) months. The review will include that the physician's order for the as needed psycho-active medication is not to exceed**	

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F 758	Continued From page 10 dementia. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/16/18 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 3 out of a possible score of 15. Resident #24 was also coded as requiring extensive assistance of 2 staff members for dressing and being totally dependent on 1 staff member for personal hygiene and bathing. The surveyor performed a review of Resident #24's clinical record on 9/13/18. During this review, the surveyor noted a physician order dated for 8/8/18, which stated, "Xanax tablet 0.25 mg (milligram) ...Give 1 tablet by mouth every 8 hours as needed for anxiety/agitation." The surveyor also noted during the clinical record review, there was no stop date for the Xanax and the resident had not been re-evaluated by the physician for the continuing need of the use of the prn Xanax for anxiety/agitation. The surveyor notified the director of nursing (DON) of the above documented findings on 9/13/18 at approximately 1:15 pm. The DON stated, "I understand. There had been discussions with the doctor about this but there is not documentation to support this." No further information was provided to the surveyor prior to the exit conference on 9/13/18.	F 758	**fourteen (14) days before being reviewed by the physician for continued use of the medication.** **4. The results of the reviews will be discussed by the Administrator/Designee at the QAPI committee meeting monthly for three (3) months. The interdisciplinary team/committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.** **5. Date of Compliance: 10/12/2018**	
F 813 SS=D	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.	F 813	**F 813 (D):** **1. The expired milk identified during the survey process was removed from the refrigerators and discarded on 9/13/2018 by the**	10/12/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 813	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, facility staff failed to ensure that milk in personal refrigerators had not expired for 2 of 27 residents in the survey sample (Residents #9 and 79). 1. For Resident #9, facility staff failed to discard expired milk stored in the personal refrigerator in the resident's room. Resident #9 was admitted to the facility on 3/13/12. Diagnoses included alzheimer's disease, urinary tract infection, gastrointestinal hemorrhage, pain, hallucinations, dementia, hypertension, and anxiety. On the Quarterly Minimum Data Set Assessment with assessment reference date 6/26/18, the resident was assessed with short and long term memory impairment and without symptoms of delirium, or psychosis. The resident exhibited physical behavior symptoms toward others 1-3 of the 7 days prior to the assessment. During initial tour on 09/11/18 at 01:19 PM , the surveyor checked the contents of the resident's personal refrigerator. The milk in the refrigerator in the resident's room expired on 9/9/18. The surveyor checked again on 09/13/18 at 11:29 AM. The resident's refrigerator contained milk that expired on 9/9/18. The CNA assigned to the resident's hall reported that staff checked the residents' refrigerators daily and recorded the temperatures on a log sheet. The temperature log sheet on the resident's refrigerator had been completed daily.	F 813	**Administrator for Resident #9 and Resident #79. There were no adverse effects to either resident.** **2. Refrigerator observations have been completed on the refrigerators in the facility by the Administrator/Designee to ensure that there are no expired items including expired milk in the refrigerators.** **3. Re-education will be completed by 10/11/18 by the Administrator/Designee with current employees related to ensuring expired items including expired milk are being discarded from refrigerators as required. Refrigerator observations will be conducted by the Administrator/Designee for three (3) refrigerators per week for three (3) months to ensure that there are no expired items including expired milk in the refrigerator.**	

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	495250	A. BUILDING _____ B. WING _____	C 09/13/2018

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F 813	Continued From page 12 On 9/12/18, the surveyor asked the director of nursing services (DNS) for the policy concerning personal refrigerators. The policy "Food Safe Handling for Foods from Visitors" HSG Policy 031addressed labeling foods with the date they were brought to the facility and directed they be discarded after 7 days. The policy did not address discarding foods that had passed the manufacturer's expiration dates. During a summary meeting on 9/12/18, the administrator and DNS were informed of the concern. 2. For Resident #79, facility staff failed to discard expired milk stored in the personal refrigerator in the resident's room. Resident #79 was admitted to the facility on 6/17/09. Diagnoses included multiple sclerosis, escherichia coli, hypertension, constipation, paraplegia, and anxiety. On the Annual Minimum Data Set assessment with assessment reference date 8/16/18 the resident scored 9/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. During initial tour on 09/11/18 at 01:19 PM , the surveyor checked the contents of the resident's personal refrigerator. The resident's refrigerator had 3 cartons of chocolate milk with expiration dates 8/17/18, 8/27/18, and 9/1/18 Refrigerator temperatures were documented as between 18 and 24 degrees. The milk did not feel as if it were frozen. The surveyor checked again on 09/12/18 at 8:00 AM. There was no milk in the resident's refrigerator. The thermometer in the refrigerator read 30 degrees.	F 813	**4. The results of the observations will be discussed by the Administrator/Designee at the QAPI committee meeting each month for three (3) months. The interdisciplinary team/committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.** **5. Date of Compliance: 10/12/2018**	

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F 813	Continued From page 13 The CNA assigned to the resident's hall reported that staff checked the residents' refrigerators daily and recorded the temperatures on a log sheet. The temperature log sheet on the resident's refrigerator had been completed daily. On 9/12/18, the surveyor asked the director of nursing services (DNS) for the policy concerning personal refrigerators. The policy "Food: Safe Handling for Foods from Visitors" HSG Policy 031addressed labeling foods with the date they were brought to the facility and directed they be discarded after 7 days. The policy did not address discarding foods that had passed the manufacturer's expiration dates. During a summary meeting on 9/12/18, the administrator and DNS were informed of the concern.	F 813		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and 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,	F 880	**F 880 (D):** **1. The LPN # 1 was re-educated by the DON/Designee on 9/12/2018 related to hand-washing/sanitation during medication administration. There were no adverse effects to Resident #72 and Resident #8.** **2. Medication Administration observations have been conducted by the DON/Designee for current Licensed Nurses to ensure**	10/12/2018

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F 880	Continued From page 14 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards: §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the 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	F 880	**that hands are washed/sanitized during medication administration.** **3. Re-education will be completed by 10/11/18 by the DON/Designee with current Licensed Nurses related to hand-washing/hand sanitation during medication administration. Medication administration observations will be conducted by the DON/Designee for two (2) Licensed Nurses per week for three (3) months to ensure that Licensed Nurses continue to wash/ sanitize their hands during medication administration as required.** **4. The results of the medication administration/hand sanitation observations will be discussed by the Administrator/Designee in the Quality Assurance Performance Improvement (QAPI) committee meeting monthly for three (3) months.**	

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F 880	Continued From page 15 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and during a medication administration observation the facility staff failed to follow established infection control guidelines in regards to hand hygiene on 1 of 2 units (unit A). The findings included: The facility nursing staff failed to complete hand hygiene during a medication administration observation. On 09/12/18 beginning at approximately 7:58 a.m. the surveyor observed LPN (licensed practical nurse) #1 prepare medications for administration. During this time surveyor did not observe LPN#1 wash hands or use hand sanitizer prior to preparing medications. After preparing the medications LPN #1 offered Resident #72 medications as Resident #72 was awaiting by medication cart. Resident #72 refused one of the prepared medications. LPN #1 put bare fingers in administration cup to get refused medication out and once again did not wash hands, use sanitizer or don gloves. LPN #1 continued with administration by donning gloves and administering eye drops to Resident #72. LPN#1	F 880	**The interdisciplinary team/committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.** **5. Date of Compliance: 10/12/2018**	

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F 880	Continued From page 16	F 880		

handed Resident #72 a tissue to wipe eyes, LPN#1 then removed gloves. LPN# 1 took tissue from unsampled Resident #72 with bare hands to discard. LPN #1 then began to document administered medications on EMAR (electronic medication administration record). At 8:11 a.m. LPN #1 proceeded to set up medications for the next Resident (Resident #8) without washing hands, using hand sanitizer or donning gloves.

The DON (director of nursing) was notified of the above issue regarding hand hygiene during collaboration on 09/12/18 11:08 a.m. DON voiced LPN #1 reported to her that she did not use proper hand hygiene during medication administration.

On 09/13/18 at approximately 1:44 p.m. the surveyor interviewed the designated infection control nurse. The infection control nurse verbalized to the surveyor that this was not facility practice and education was being implemented on every shift regarding hand hygiene.

The facility policy/procedure titled "Hand washing technique" read in part "All personnel will wash hands before beginning the treatment/care of a Resident and upon completion of such task, to prevent the spread of nosocomial infections. Wash hands after removal of gloves or other personal protective equipment."

No further information regarding this issue was provided to the survey team prior to the exit conference.