STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VLY WESTMINSTER-CANTERBURY	300 WESTMINSTER CANTERBURY DR WINCHESTER, VA 22603

(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 12/04/18 through 12/06/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency	E 026	Corrective Action: The 1135 Waiver Policy will be modified to reflect the role of the RNHCI under a	1/10/19

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

Electronically Signed | 12/21/2018

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

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E 026	Continued From page 1 preparedness plan. The facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. The findings include: On 12/06/18 at approximately 9:00 a.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administrative staff member) # 1, administrator and OSM (other staff member) # 7, director of environmental services. Review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. ASM # 1 and OSM # 7 stated that the facility did not have it. On 12/06/18 at approximately 10:00 a.m. ASM (administrative staff member) # 1, was made aware of the findings. No further information was obtained prior to exit.	E 026	waiver declared by the Secretary in accordance with section 1135, in the provision of care at an alternate care site identified by the emergency management officials. Other Potential Residents: All residents have the potential to be impacted during an emergency event. System Change: The Emergency Manual and associated policies therein are reviewed annually. The Director of Environmental Services and Administrator will educate the Safety Committee and Management team of the 1135 waiver parameters ensuring that any proposed changes for the 1135 waiver requirements/statutes be addressed and updated immediately upon notification. Monitoring: The Emergency Manual and associated policies therein will be reviewed annually. Our process utilizes software called "Policy Stat" that notifies the responsible manager/director when a policy is due for review and/or revision. The Safety Committee and Management team will also review the policies and Emergency Manual. All updates and/or modifications will be reported to the QAPI committee. Date of Correction: Corrective action will be completed not later than 1/10/19	
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 2 An unannounced Medicare/Medicaid standard survey was conducted 12/4/18 through 12/6/18. 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 51 certified bed facility was 45 at the time of the survey. The survey sample consisted of 22 current Resident reviews and five 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 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.	F 583		1/14/19

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F 583	Continued From page 3 (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, facility document review and clinical record review, it was determined that the facility staff failed to maintain confidentiality of the electronic clinical record for one of 27 residents in the survey sample, Resident #21. The facility staff failed to maintain confidentiality of Resident #21's eMAR (electronic medication administration record). LPN (Licensed practical nurse) #1 left Resident #21's eMAR open and unattended in the hall while obtaining a cup of juice in another room. The findings include: Resident #21 was admitted to the facility on 7/24/18. Resident #21's diagnoses included but were not limited to pain, high blood pressure and muscle weakness. Resident #21's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/27/18, coded the resident's cognition as severely impaired. Resident #21's comprehensive care plan dated 7/24/18 failed to document information regarding confidentiality of the electronic clinical record.	F 583	1. Corrective Action Nurse (LPN) #1 was counseled on HIPPA compliance and the policy and procedure regarding confidentiality when utilizing the electronic medical record on 12/14/18. 2. Other Potential Residents All residents where the electronic medical record is used are potentially affected. 3. Systems Change All Licensed Professional Nurses will be re-educated on HIPPA compliance and the policy and procedure regarding confidentiality when utilizing the electronic medical record. There will be return demonstration of the proper securement of the electronic medical record. 4. Monitoring All Licensed Professional Nurses (100%) will demonstrate the proper securement of the electronic medical record by 1/14/19. The Nurse Educator and/or designee will conduct a random audit of 50% of licensed professionals will be observed to insure proper securement of the electronic medical record every month for	

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F 583	Continued From page 4 On 12/5/18 at 8:09 a.m., LPN #1 was observed preparing Resident #21's medications at the medication cart in the hall. LPN #1 left Resident #21's eMAR open and unattended in the hall on the medication cart while she obtained a cup of juice in another room. At this time, other staff and contracted vendors were observed walking past the unattended eMAR. One contracted vendor was observed looking in the direction of the eMAR. On 12/5/18 at 8:45 a.m., an interview was conducted with LPN #1. LPN #1 was asked what should be done before leaving a medication cart unattended. LPN #1 stated, "Lock your cart." When asked what should be done with the eMAR, LPN #1 stated the eMAR should be closed so nobody can read it. LPN #1 was made aware of, and confirmed this surveyor's above observation. On 12/5/18 at 12:28 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked what should be done before leaving a medication cart unattended. RN #1 stated, "You should lock the cart and keyboard. Close out the MAR and also if you have any paperwork on top you should turn it over so it's not visible." When asked why, RN #1 stated, "Because you don't want anybody- family, staff members, and visitors to see because it shows all their information." On 12/5/18 at 5:24 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of health services) were made aware of the above concern. The facility policy titled, "Medical Records, Electronic" documented, "All staff utilizing the	F 583	three months, then a random audit of 50% of licensed professionals will be observed to insure proper securement of the electronic medical record quarterly for one year. All findings will be reported to the QAPI committee. 5. Date Corrective action will be completed by 1/14/19.	

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F 583	Continued From page 5 electronic medical record has a duty to protect confidentiality of resident communications and information and is trained accordingly..." No further information was presented prior to exit.	F 583		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and employee record review, it was determined that the facility staff failed to implement the facility abuse policy for two of 25 employee record reviews. The facility staff failed to evidence reference verifications were completed when OSM (other staff member) #11 (a contracted occupational therapy employee) was hired on 5/24/18 and failed to evidence a license verification was completed when OSM #12 (a contracted physical therapy employee) was hired on 6/28/18. The findings include:	F 607	1. Corrective action: License verification for OSM#12 was conducted on 12/6/2018 with no additional public information. A favorable reference check for OSM#11 was conducted on 12/14/2018. 2. Other potential residents: An audit was performed effective 10/1/18 of all contractors (OSM's). The audit revealed no new licensed contractors deficient with our Abuse and Neglect policies. 3. System Change: SVWC's policy "Certification and	1/2/19

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F 607	Continued From page 6 Review of OSM #11's employee record failed to reveal evidence of reference verifications and review of OSM #12's employee record failed to reveal evidence of a license verification. On 12/6/18 at 9:20 a.m., an interview was conducted with OSM #8 (the human resources generalist) regarding the facility process for obtaining license and reference verifications. OSM #8 stated she reviews applications when they are received then forwards the applications to department heads to determine if there is interest in holding an interview. OSM #8 stated the department heads return the applications with a yes or no determination for hiring the individual. OSM #8 stated she begins reference checks after the department heads decide an individual will be hired. OSM #8 stated she completes license verifications before the offer for hire is made. OSM #8 stated license and reference verifications are kept in the employee records. At this time, OSM #8 was asked to provide reference verifications for OSM #11 and a license verification for OSM #12. On 12/6/18 at 10:08 a.m., an interview was conducted with OSM #8 and OSM #10 (the clinic assistant for independent living). OSM #8 stated OSM #10 completes the credentialing for contracted employees. In regards to OSM #11's reference verifications, OSM #8 stated she probably attempted a reference verification, wrote it on a note and forgot to transfer the note to the employee record. OSM #8 confirmed she could not provide evidence of any reference verifications for OSM #11. In regards to OSM #12's license verification, OSM #8 stated she thought OSM #10 completed the verification and OSM #10 stated she thought OSM #8 completed	F 607	Licensure" has been updated to include independent contractors. SVWC's Human Resources Generalist has developed a checklist that includes license verification and completion of at least two references before starting work. 4. Monitoring: The Human Resources Director will audit all contractor files prior to the individuals starting orientation/work. Contractors will not begin work until the orientation process is completed. Monthly result of audits will be shared with Administrator and the QAPI committee. 5. Date: Corrective action completed 1/2/2019.	

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F 607	Continued From page 7 the verification. OSM #8 stated she could not provide evidence of OSM #12's license verification. On 12/6/18 at 10:29 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of health services) were made aware of the above concern. The facility abuse policy documented, "A. EMPLOYEE SCREENING AND TRAINING- 1. Before new employees are permitted to work with residents, references provided by the prospective employee will be verified as well as appropriate board registrations and certifications regarding the prospective employee's background..." No further information was presented prior to exit.	F 607		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered;	F 622		1/14/19

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F 622	Continued From page 8	F 622		

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this

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F 622	Continued From page 9 section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to meet the appropriate transfer requirements for one of 27 residents in the survey sample, Resident #32. The facility staff failed to ensure the physician documented why a facility-initiated transfer was necessary for Resident #32 when the resident was transferred to the hospital on 10/24/18.	F 622	1. Corrective Action Resident #32 returned from acute care hospital on 10/26/18. The primary care provider assessed resident on 12/3/18. 2. Other Potential Residents All residents whom have had a transfer or discharge are potentially affected. 3. Systems Change	

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F 622	Continued From page 10 The findings include: Resident #32 was admitted to the facility on 8/6/14. Resident #32's diagnoses included but were not limited to diabetes, obesity and heart failure. Resident #32's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/10/18, coded the resident as being cognitively intact. Review of Resident #32's clinical record revealed a nurse's note dated 10/24/18 that documented the resident was transferred to the hospital because the resident vomited a large amount of dark emesis with a foul odor. Further review of Resident #32's clinical record failed to reveal documentation by the physician to explain the basis and necessity for Resident #32's transfer to the hospital. On 12/5/18 at 12:28 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked if the physicians document why the transfer is necessary when a resident is transferred to the hospital. RN #1 stated, "Not that I'm aware of." On 12/5/18 at 4:18 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of health services). ASM #2 was asked if the physicians document why the transfer is necessary when a resident is transferred to the hospital. ASM #2 stated the physicians may sign the discharge paperwork from the hospital when the resident returns to the facility but the physicians do not document information regarding the transfer and why it was necessary.	F 622	A checklist will be implemented to insure the notification of the primary care provider to document the basis or reason for transfer or discharge in the electronic medical record. 4. Monitoring The medical record assistant will do monthly audits for all transfer and discharges residents to insure documentation and assessment for reason for transfer and discharge. Report of all findings will be submitted to the QAPI committee. 5. Date The corrective action will be completed by 1/14/19.	

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F 622	Continued From page 11 Further review of Resident #32's clinical record revealed discharge instructions from the hospital that were dated 10/26/18. The physician initialed the instructions on 10/28/18. However, the instructions did not contain documentation by the physician to explain the basis and necessity for the transfer. On 12/5/18 at 5:24 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. The facility policy titled, "Transfer and Discharge" documented, "Upon transfer or discharge of a resident, the following documentation will be made in the resident's electronic medical record. 1. The physician will document the needs which can not be met at (name of facility) or when the resident has improved sufficiently and no longer needs the services at (name of facility), or when the resident's actions endanger the health and safety of himself/herself or others..." No further information was presented prior to exit.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		1/11/19

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(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights,

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including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the

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F 623	Continued From page 14 State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written notification to the resident and/or the resident's representative and the ombudsman for facility initiated transfers, for three of 27 residents in the survey sample, Residents #6, #32 and #29. 1. Resident #6 was transferred to the hospital on 11/6/18. The facility staff failed to provide written notification of the facility-initiated transfer to Resident #6 and the ombudsman. 2. Resident #32 was transferred to the hospital on 10/24/18. The facility staff failed to provide written notification of the facility-initiated transfer to Resident #32 and the ombudsman. 3. The facility staff failed to provide Resident # 29 or the resident's representative and the ombudsman written notification when the resident was transferred to the hospital on 11/14/18. The findings include: 1. Resident #6 was transferred to the hospital on 11/6/18. The facility staff failed to provide written notification of the facility-initiated transfer to Resident #6 and the ombudsman. Resident #6 was admitted to the facility on 11/7/17. Resident #6's diagnoses included but	F 623	1. Corrective Action Resident's records noted during the survey to be out of compliance have had letters of "Notice of Transfer" presented to them. They have been signed by the resident and faxed to the Long Term Care Ombudsman. A note was placed in their respective electronic medical record (EMR) stating the reason the letters were generated and signed post transfer. 2. Other Potential Residents A review of transfers from September 1, 2018 through December 12, 2018 has been conducted. Those resident records found to be out of compliance have had letters of "Notice of Transfer" presented to them. They have been signed by resident or resident representative and faxed to LTC ombudsman. A note was placed in their respective EMR stating the reason the letters were generated and signed post transfer. 3. System Change SVWC's policy "Transfer and Discharge" has been updated by the Nursing Educator to reflect the appropriate terminology and the proper sequencing for the letters to be distributed related to transfer/discharge, the fax number for the LTC ombudsman and the updated	

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F 623	Continued From page 15 were not limited to acute kidney failure, low back pain and high blood pressure. Resident #6's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 12/1/18, coded the resident as being cognitively intact. Review of Resident #6's clinical record revealed a nurse's note dated 11/6/18 that documented the resident was transferred to the hospital due to acute kidney failure. Further review of Resident #6's clinical record failed to reveal written notification of the transfer was provided to the resident and the ombudsman. On 12/5/18 at 12:28 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked if nurses provide residents, residents' representatives or the ombudsman written notification of hospital transfers, RN #1 stated, "We always call the rep [representative]." When asked if written notification is provided to the residents, residents' representatives or the ombudsman, RN #1 stated nurses did not provide written notification but maybe the social worker did. On 12/5/18 at 2:44 p.m., an interview was conducted with OSM (other staff member) #4 (the social worker). OSM #4 was asked if she provides residents, residents' representatives or the ombudsman written notification of hospital transfers. OSM #4 stated she does not and was not aware that anyone in the facility was doing so. On 12/5/18 at 3:24 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of health services). ASM #2 stated residents' representatives are	F 623	resident status change form that includes ED visits. 4. Monitoring The Director of Resident Services has implemented a checklist to include: the distribution date of the transfer/discharge letters; when letters and the resident status change form are faxed to the LTC ombudsman. The Director of Resident Services or designee will do a random audit of 25% of the transfers/discharges monthly for three months, then 25% per quarter for a year with all information being reviewed at QAPI. 5. Date Corrective action completed on 1/11/2019.	

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notified of hospital transfers via phone but residents, residents' representatives, nor the ombudsman were provided written notification.

On 12/5/18 at 5:24 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern.

The facility policy titled, "Transfer and Discharge" documented, "Before a transfer or discharge is made, notice will be given in writing to the resident and if known, a family member or legal representative 30 days before discharge/transfer of the reasons for the discharge/transfer from (name of facility). The above time frame will not be observed in the transfer/discharge of the resident if any of the following conditions exist...4. An immediate discharge/transfer is required by the resident's urgent medical needs. The written notice will contain the following information: 1. The reason for discharge/transfer. 2. The effective date of the discharge/transfer. 3. The location to which the resident is discharged/transferred..."

No further information was presented prior to exit.

2. Resident #32 was transferred to the hospital on 10/24/18. The facility staff failed to provide written notification of the facility-initiated transfer to Resident #32 and the ombudsman.

Resident #32 was admitted to the facility on 8/6/14. Resident #32's diagnoses included but were not limited to diabetes, obesity and heart failure. Resident #32's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/10/18, coded the resident as being cognitively intact.

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Review of Resident #32's clinical record revealed a nurse's note dated 10/24/18 that documented the resident was transferred to the hospital because the resident vomited a large amount of dark emesis with a foul odor. Further review of Resident #32's clinical record failed to reveal written notification of the transfer was provided to the resident and the ombudsman.

On 12/5/18 at 12:28 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked if nurses provide residents, residents' representatives or the ombudsman written notification of hospital transfers, RN #1 stated, "We always call the rep." When asked if written notification is provided to the residents, residents' representatives or the ombudsman, RN #1 stated nurses did not provide written notification but maybe the social worker did.

On 12/5/18 at 2:44 p.m., an interview was conducted with OSM (other staff member) #4 (the social worker). OSM #4 was asked if she provides residents, residents' representatives or the ombudsman written notification of hospital transfers. OSM #4 stated she does not and was not aware that anyone in the facility was doing so.

On 12/5/18 at 3:24 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of health services). ASM #2 stated residents' representatives are notified of hospital transfers via phone but residents, residents' representatives, nor the ombudsman were provided written notification.

On 12/5/18 at 5:24 p.m., ASM #1 (the administrator) and ASM #2 were made aware of

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the above concern.

No further information was presented prior to exit.
3. The facility staff failed to provide Resident # 29 or the resident's representative and the ombudsman written notification when the resident was transferred to the hospital on 11/14/18.

Resident # 29 was admitted to the facility on 11/01/14 and a readmission on 03/21/16 with diagnoses that included but were not limited to urinary tract infection (1), heart failure (2), anemia (3) and epilepsy (4).

Resident # 29's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/10/18, coded Resident # 29 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions.

The nurse's "Progress Notes" for Resident # 29 dated 11/14/2018 documented, "02:23 (2:23 p.m.) Called to resident room by CNA (certified nursing assistant). Resident laying on the floor on her right side in front of her recliner. Resident complaining of severe pain in her right hip area. Unable to move her right leg because of pain. Resident said she was going to the bathroom. Order to send resident to ER (emergency room) for evaluation. Son (Name of Son) notified."

On 12/5/18 at 12:28 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked if nurses provide residents, resident's representative or the ombudsman written notification of hospital transfers, RN #1 stated, "We always call the rep (representative)." When

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asked if written notification is provided to the residents, residents' representative or the ombudsman, RN #1 stated nurses did not provide written notification but maybe the social worker did.

On 12/5/18 at 2:44 p.m., an interview was conducted with OSM (other staff member) #4, social worker. OSM #4 was asked if she provides residents, resident's representative or the ombudsman written notification of hospital transfers. OSM #4 stated she does not and was not aware that anyone in the facility was doing so.

On 12/5/18 at 3:24 p.m., an interview was conducted with ASM (administrative staff member) #2, director of health services. ASM #2 stated the resident's representative is notified of hospital transfers via (by) phone but residents, resident's representative, nor the ombudsman were provided written notification.

On 12/05/18 at approximately 5:20 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of health services, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) An infection in the urinary tract. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm.

(2) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was

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F 623	Continued From page 20 obtained from the website: https://medlineplus.gov/ency/article/000158.htm. (3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html . (4) A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.	F 623		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		1/14/19

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F 812	Continued From page 21 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined that the facility staff failed to store and serve food in a sanitary manner in the kitchen, satellite kitchen and one of two dining rooms, the Westeria dining room. 1. The facility staff failed to remove 17 quarts of expired buttermilk from the dairy/vegetable walk-in refrigerator. 2. The facility staff failed to date, wrap and store an open four-pound package of ground meat on the bottom shelf of the refrigerator in the 'Satellite Kitchen.' 3. The facility staff failed to maintain a holding temperature of salmon cakes while on the steam table in the satellite kitchen, prior to serving residents in the Westeria dining room. 4. The facility staff failed to change gloves in the satellite kitchen between tasks and keep the serving utensils off the counter between servings for food. The findings include: 1. The facility staff failed to remove 17 quarts of expired buttermilk from the dairy/vegetable walk-in refrigerator. On 12/04/18 at approximately 12:05 p.m., an observation of the facility's main kitchen was conducted with OSM (other staff member) # 1, operations manager and OSM # 2, executive	F 812	1. Corrective Action Appropriate staff were counseled related to the expired milk, improper storage of ground beef, maintaining of food temperatures and use of gloves. The respective individuals referenced above were in-serviced on the Food Safety Policy, Food Storage Policy and Glove Policy on 12/4 & 5/18. Food products around the raw meat were assessed with none coming in contact. 2. Other Potential Residents All residents where retail items (buttermilk) are available for purchase or by request as well as those whose food consumption could have been impacted from raw meat cross-contamination, food served under proper temperatures or from improper infection control protocols. 3. Systems Change All Dining staff will be re-educated on the Food Safety Policy, Food Storage Policy and Glove Policy starting on December 12, 2018. In addition, a review of HAACP guidelines and documentation, along with a demonstration from all dining staff in a capacity of serving food will be conducted. During random audits and through daily observation, staff will demonstrate an understanding of the respective policy(s) and the “First in, First out” inventory practice related to their duties/responsibilities. All staff will be required on a daily basis, to	

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F 812	Continued From page 22 chef. Observation of the walk-in refrigerator containing dairy and vegetables revealed numerous quarts of buttermilk and milk sitting on a shelf in the walk-in refrigerator. Observations of the quarts of buttermilk revealed six, one-quart containers of buttermilk with a "Sell By Date" of 11/22/18, eleven, one quart containers of buttermilk with a "Sell by date" of 11/29/18. On 12/04/18 at approximately 2:15 p.m., and interview was conducted with OSM # 1, operations manager, OSM # 2, executive chef, and OSM # #, director of dinning. When asked about the "Sell By Date" of 11/22/18 and 11/29/18 stamped on the quarts of buttermilk found on the shelf in the dairy and vegetable walk-in refrigerator, OSM # 2 stated, "The 'Sell By Date' is what we go by to discard the product." When asked to describe the process to ensure that only current dated product is available for use, OSM # 3 stated, "We use the first in first out process. When a new product comes in, we inspect the current product and rotate out the old. This was not done for the buttermilk." The facility policy "Food Storage" documented, "Rotate stock so that the older items are used first. Date products to ensure the use of 'First In, First Out' procedures." On 12/05/18 at approximately 5:20 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of health services, were made aware of the findings. No further information was provided prior to exit. 2. The facility staff failed to date, wrap and store an open four-pound package of ground meat on	F 812	demonstrate the Glove Policy. All staff responsible for handling and/or serving food will be required to demonstrate the Food Safety Policy during each meal service period. 4. Monitoring Food Safety Audits by an external firm will increase from annually to quarterly, in addition to random monthly audits conducted by the Registered Dietician or other appropriate designated non-dining personnel. Daily audits of all designated food storage areas in addition to random audits and observation of safe practices, infection control and food handling will be performed by the Dining leadership team. All results will be shared and presented to the Dining Services Director weekly and reported to the QAPI committee 5. Date Corrective action will be completed by 1/14/19.	

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the bottom shelf of the refrigerator in the 'Satellite Kitchen.'

At 12:13 p.m., an observation of the refrigerator in the "Satellite" kitchen was conducted with OSM # 1, operations manager and OSM # 2, executive chef. The observation revealed a five-pound package of ground meat lying on a wire shelf in the bottom portion of the refrigerator. Observation of the opened five-pound package of ground meat revealed the opened end of the package was loosely wrapped with plastic wrap and partially opened, with no open date on the package of meat. Further observation of the plastic wrap revealed raw ground beef juice (blood) dripping from the opened end of the package. Observation of the area underneath the package of ground beef revealed there was no product on the shelf beneath the ground beef and no visible evidence of raw beef juices (blood) on the bottom shelf of the refrigerator. Upon observing the package of ground beef OSM # 2 removed it from the refrigerator.

On 12/04/18 at approximately 2:15 p.m., and interview was conducted with OSM # 1, operations manager, OSM # 2, executive chef, and OSM # #, director of dinning. When asked about the opened package of ground beef found in the refrigerator of the "Satellite kitchen", OSM #2 stated, "The meat should have been placed in a pan, covered, dated and placed on the bottom shelf of the refrigerator."

The facility policy "Food Storage" documented, "Opened Foods: Cover, label, date in clean container."

On 12/05/18 at approximately 5:20 p.m., ASM

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(administrative staff member) # 1, the administrator and ASM # 2, director of health services, were made aware of the findings.

No further information was provided prior to exit.

3. The facility staff failed to maintain a holding temperature of salmon cakes while on the steam table in the satellite kitchen, prior to serving residents in the Westeria dining room.

On 12/04/18 at 4:27 p.m., food temperatures were obtained in the "Satellite kitchen's" serving area for food service in the Westeria dining room of the health care center. OSM (other staff member) # 5, diet aide was asked to obtain the holding temperatures of the food in the "Satellite kitchen's" steam table. OSM # 5 used a digital thermometer to obtain the holding temperatures of the food on the steam table. When the temperature of the salmon cakes was obtained OSM # 5 was observed to place the thermometer through several salmon cakes on the right side of the pan obtaining a temperature of one-hundred twenty-six degrees. When asked what the temperature should be, OSM # 5 stated, "One-hundred thirty degrees." OSM # 5 then placed the thermometer through a few salmon cakes on the left side of the pan an obtained a temperature reading of one-hundred twenty-seven degrees." OSM # 5 then placed the thermometer through a few salmon cakes back on the right side of the pan obtaining a temperature of one-hundred twenty-seven degrees. OSM # 5 then proceeded to obtain the temperatures of the remainder of the food on the steam table. Continuous observation of the "Satellite kitchen's" serving area for food service in the Westeria dining room of the health care

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center revealed the following observation of OSM # 5 and OSM # 6 plating and serving food:

At 5:02 p.m., OSM # 5 was observed removing two salmon cakes from right side of pan using a large serving fork, placed the salmon cakes on a dinner plate. Further observation revealed no further temperatures were taken of the salmon cakes before serving them to a resident.

At 5:04 p.m., OSM # 6 was observed removing one salmon cakes from the middle of pan using a large serving fork, placed the salmon cake on a dinner plate. Further observation revealed no further temperatures were taken of the salmon cakes before serving them to a resident.

At 5:06 p.m., OSM # 6 was observed removing one salmon cakes from the middle of pan using a large serving fork, placed the salmon cake on a dinner plate. Further observation revealed no further temperatures were taken of the salmon cakes before serving them to a resident.

At 5:09 p.m., OSM # 5 was observed removing two salmon cakes from the middle of pan using a large serving fork and placed the salmon cakes on a dinner plate. Further observation revealed no further temperatures were taken of the salmon cakes before serving them to a resident.

At 5:14 p.m., OSM # 5 was observed removing two salmon cakes from the middle of pan using a large serving fork and placed the salmon cakes on a dinner plate. Further observation revealed no further temperatures were taken of the salmon cakes before serving them to a resident.

The facility's "Daily Temperature Log" for the

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'Satellite Kitchen" for 12/5/18 documented, "Product Name, Empl. (Employee) Initials, Holding Temperature. Hot foods 140 [degrees] F [Fahrenheit] (60 degrees C) [Celsius] or above. Cold foods 40 (degrees) F (4 degrees C) or below." Under "Product Name it documented, "Salmon." Under "Empl. (Employee) Initials" it documented, "(OSM # 5's Initials)." Under "Holding Temperature. Hot foods 140 [degrees] F [Fahrenheit] (60 degrees C) [Celsius] or above. Cold foods 40 (degrees) F (4 degrees C) or below" it documented, "144 (one-hundred forty-four degrees)."

On 12/05/18 at 11:25 a.m., an interview was conducted with OSM # 5 in the presence of OSM # 2, executive chef. When asked what the hot holding temperature should be for resident's food, OSM # 5 stated, "It should be one-hundred forty." When asked why it was important to hold temperatures at one-hundred forty, OSM # 5 stated, "I'm not really sure. To ensure residents get a hot meal." When asked to describe the process when the resident's food is not at the proper holding temperature, OSM # 5 stated, "I would reheat the product or get new product from preparation kitchen." When asked if she followed the process in regard to the salmon cakes, OSM # 5 stated, "No." OSM # 5 was asked to read the temperature she recorded on the "Daily Temperature Log" for the salmon cakes on 12/05/18. OSM # 5 stated, "one-hundred forty-four degrees." After reviewing the "Daily Temperature Log" for the 'Satellite Kitchen" for 12/5/18, OSM # 5 was asked if the temperature was accurate based on the observations of the holding temperature on 12/05/18. OSM # 5 stated, "No."

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On 12/05/18 at 11:45 a.m., an interview was conducted with OSM # 2, executive chef. When asked about the holding temperatures for food on the steam table, OSM # 2 stated, "Should be held at one-hundred forty-five or above. The salmon cakes should have been removed and reheated or she should have gotten new product."

The facility's policy "Food Safety" documented, "Hot Foods. Hold at 140 (degrees) (60 degrees C) or above."

On 12/05/18 at approximately 5:20 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of health services, were made aware of the findings.

No further information was provided prior to exit.

4. The facility staff failed to change gloves in the satellite kitchen between tasks and keep the serving utensils off the counter between servings for food.

On 12/04/18 at approximately 4:45 p.m., OSM (other staff member) # 5, diet aide was observed in the "Satellite kitchen" serving area. While wearing plastic gloves OSM # 5 was observed push open the door into the kitchen food preparation area, returned through the door from the kitchen food preparation area pushing a cart that contained four covered prepared meals on plates. OSM # 5 removed the plates from the cart, opened the door to the warmer, and placed them inside the warmer. While wearing the same gloves OSM # 4 opened a loaf of raisin nut bread, place it on a cutting board, sliced the loaf of bread, placed the bread into a linen lined basket and placed the basket on one of the dining room

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tables where two residents were seated. While still wearing the same plastic gloves, OSM # 5 was observed picking up two soup bowls, placing her left gloved thumb on the inside of each bowl, filled them with soup and served them to two residents seated in the dining room. Further observations of OSM # 5 and OSM # 6 on 12/05/18 revealed the following:

At 5:02 p.m., OSM # 5 was observed removing two salmon cakes from right side of pan using a large serving fork, placed the salmon cakes on a dinner plate, and then placed the serving fork directly onto the counter. OSM #5 then picked up a serving spoon, placed a serving of zucchini on the plate, placed the serving spoon directly on the counter, picked up another serving spoon, placed a serving of roasted potatoes on the plate, placed the serving spoon directly on the counter.

At 5:04 p.m., OSM # 6 was observed removing one salmon cakes from the middle of pan using a large serving fork, placed the salmon cake on a dinner plate, placed the serving fork directly onto the counter. OSM #6 then picked up a serving spoon, placed a serving of zucchini on the plate, placed the serving spoon directly on the counter, picked up another serving spoon, placed a serving of roasted potatoes on the plate, placed the serving spoon directly on the counter.

At 5:06 p.m., OSM # 6 was observed removing one salmon cakes from the middle of pan using a large serving fork which she picked up directly off the counter, placed the salmon cake on a dinner plate, placed the serving fork directly onto the counter. OSM #6 then picked up a serving spoon from lying on the counter, placed a serving of zucchini on the plate, placed the serving spoon

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directly on the counter, picked up another serving spoon directly from lying on the counter, placed a serving of roasted potatoes on the plate, placed the serving spoon directly on the counter.

At 5:09 p.m., OSM # 5 was observed removing two salmon cakes from the middle of pan using a large serving fork which she picked up directly off the counter, placed the salmon cakes on a dinner plate, placed the serving fork directly onto the counter. OSM #5 then picked up a serving spoon from lying on the counter, placed a serving of glazed carrots on the plate, placed the serving spoon directly on the counter, picked up another serving spoon directly from lying on the counter, placed a serving of roasted potatoes on the plate, placed the serving spoon directly on the counter.

At 5:14 p.m., OSM # 5 was observed removing one salmon cake from the right side of pan using a large serving fork, which she picked up directly off the counter, placed the salmon cakes on a dinner plate, placed the serving fork directly onto the counter. OSM #5 then picked up a serving spoon from lying on the counter, placed a serving of glazed carrots on the plate, placed the serving spoon directly on the counter, picked up another serving spoon directly from lying on the counter, placed a serving of mashed potatoes on the plate, placed the serving spoon directly on the counter.

On 12/05/18 at 11:25 a.m., an interview was conducted with OSM # 5. When asked why gloves are worn when serving resident's food, OSM # 5 stated, "Its for the protection of myself and the residents. Keeping my hands clean." After being informed of the observation of cutting up and handling the raisin nut bread for the

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residents and placing her thumb on the inside of the soup bowls, OSM # 5 stated, "I should have changed my gloves and washed my hands before cutting up the bread and serving the soup." When asked how the serving utensils should be stored between food servings, OSM # 5 stated, "I put them on the counter." When asked if the food was served in a sanitary manner, OSM # 5 stated no.

On 12/05/18 at 11:45 a.m., an interview was conducted with OSM # 2, executive chef. When asked why gloves are worn when serving resident's food, OSM # 2 stated, "For sanitation, prevent cross contamination, make sure nothing is transferred from the staff to the resident's food. Gloves should be changes when the tasks changes, such as changing the gloves before cutting the bread." When asked how the serving utensils should be stored between food servings, OSM # 5 stated, "They should be kept in the food that they are being used to serve or a heated bath to keep them clean and sanitized. They should not be kept on the counter."

The facility's policy "Gloves" documented, "PURPOSE: To limit contamination of food from hands. PROCEDURE: All personnel shall wear gloves while preparing all food products (this includes while prepping and ready to eat foods). All personnel shall wash hands each time before gloves are put on."

On 12/05/18 at approximately 5:20 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of health services, were made aware of the findings.

No further information was provided prior to exit.

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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, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		1/14/19

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F 880	Continued From page 32 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain infection control practices for one of 27 residents in the survey sample, Resident #1. The facility staff failed to prepare and administer Resident #1's medication in a sanitary manner. LPN (licensed practical nurse) #1 dropped a pill on top of the medication cart and administered the pill to the resident.	F 880	1. Corrective Action Nurse (LPN) #1 was counseled on the practice of infection control and the spread of infection during medication administration on 12/14/18. No ill effects were noted to Resident # 1. 2. Other Potential Residents All residents who are prescribed medications are potentially affected.	

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F 880	Continued From page 33 The findings include: Resident #1 was admitted to the facility on 5/19/15. Resident #1's diagnoses included but were not limited to major depressive disorder, hearing loss and generalized anxiety disorder. Resident #1's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 9/8/18, coded the resident's cognition as severely impaired. On 12/5/18 at 8:23 a.m., LPN #1 was observed preparing Resident #1's medications at a medication cart in the hall. LPN #1 dropped a tablet of Tylenol (1) on top of the medication cart, scooped the tablet into a medication cup with a spoon and administered the tablet to Resident #1. On 12/5/18 at 8:45 a.m., an interview was conducted with LPN #1. LPN #1 was asked what should be done if a nurse drops a pill on the medication cart. LPN #1 stated, "You can pick it up with your gloves or a spoon. Never pick it up with your fingers." When asked if the medication should be administered after picking it up with a gloved hand or a spoon, LPN #1 stated, "Yeah because your cart is clean. If your cart was dirty I would discard it." When asked how one would know if the cart is clean if it is in the hall and exposed to contaminate in the air, LPN #1 stated, "That's true." LPN #1 was made aware of, and confirmed this surveyor's above observation. On 12/5/18 at 12:28 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked what should be done if a nurse drops a pill on the medication cart. RN #1 stated, "It should be discarded and you should get one from	F 880	3. Systems Change All nurses who administer prescribed medications will be re-educated on medication administration guidelines and infection control practices with particular attention on dropped medication. Nurses who administer medications will sign an acknowledgment form attesting to receiving and comprehending the medication administration guidelines and infection control standards when administering medications. All new licensed nurse employees will have a medication audit completed within 30 days of employment. 4. Monitoring The Nurse Educator and/or designee will perform random observation audits during medication administration monthly for three months, then quarterly for one year. All findings will be reported to the QAPI committee. 5. Date The corrective action will be completed by 1/14/19.	

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backup." When asked why, RN #1 stated, "Because it's a dirty surface. It doesn't matter how much you clean it, it's still dirty you have things that are airborne."

On 12/5/18 at 5:24 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of health services) were made aware of the above concern.

The facility policy titled, "Medication Administration-General Guidelines" documented, "9. If you will be handling the medication gloves are to be worn. Medications should be dispensed into medication cups; if a dispensed medication does not land in the medication cup (i.e. top of a med cart, floor, drawer), the medication will be discarded and a new pill will need to be used..."

No further information was presented prior to exit.

(1) Tylenol is used to relieve pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html