STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	C 12/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH & REHAB CENTER	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(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 12/11/18 through 12/13/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/11/18 through 12/13/18. Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. The census in this 180 certified bed facility was 135 at the time of the survey. The survey sample consisted of 31 current Resident reviews and 4 closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		1/14/19

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

Electronically Signed | 12/28/2018

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

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure a dignified dining experience on one of three living units. On the third floor dementia unit, multiple residents waited/watched for at least 30 minutes for meal service while four residents ate their dinner. Table seating was not available for all residents and residents ate dinner on a folding, plastic top table. The findings include: On 12/11/18 from 4:45 p.m. until 5:35 p.m., a	F 550	1. Delivery times of meals and the dining experience have been adjusted on the third floor to better accommodate the needs of all residents on the unit and to provide a homelike dignified dining experience. 2. All current residents have the potential to be affected. There were no other issues identified with meals during the survey. 3. DON/ADON will educate the nursing staff on homelike/dignified dining services by 12/24/18. Newly hired nursing staff will	

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F 550	Continued From page 2 dinner observation was conducted on the third floor dementia unit. The room had one 6-foot plastic top folding table positioned in the center of the room and an additional folding table next to the wall near the windows. On 12/11/18 at 4:50 p.m., four residents were seated at the center folding table. One resident was initially served at the table and in several minutes, the other three residents were served their meal. These four residents ate their meal at the table while eight other residents were seated in the room without a meal. These other residents were seated side by side along the wall in the room. On 12/11/18 at 5:00 p.m., a resident walked to the center table from the hallway and looked at the residents eating. One resident told her to go away and the resident walked back down the hallway. On 12/11/18 at 5:04 p.m., one resident at the table finished her meal and left the area. The eight residents were still seated along the wall with no dinner service. On 12/11/18 at 5:16 p.m., the residents at the center table finished eating. The eight residents seated along the wall had not been served. On 12/11/18 at 5:20 p.m., another resident was served at the center table while the other residents watched/waited, seated along the wall. There were no residents seated/served at the plastic table against the wall during the entire dinner observation. On 12/11/18 at 5:21 p.m., the certified nurses' aide (CNA #3) assisting with meal service was interviewed. CNA #3 stated trays for the "feeders" were usually sent to the unit first. CNA #3 stated the "feeders" were usually assisted first and then the trays for the independent eating residents were served. When asked about the eight residents seated around the wall, CNA #3 stated five of the eight residents had already	F 550	be educated on the dining process during orientation. A change in the dining experience was made for the third floor to promote more of a homelike environment including table cloths, center pieces, and a change of meal delivery times. Activities have been initiated during mealtimes for the third floor. 4. ADON and Unit Managers will conduct audits of the dining room area to ensure that all residents in the third floor dining room are receiving appropriate dining services. This audit will be conducted 5 times per week for 4 weeks then weekly x 1. All findings will be reviewed and brought to QAPI monthly for any follow up.	

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F 550	Continued From page 3 eaten in the downstairs main dining room but three of the residents were still waiting for their meal. CNA #3 stated the meal tray tickets must have been mixed up. As of 12/11/18 at 5:35 p.m., the three residents seated against the wall identified by CNA #3 as not having dinner had not yet been served. On 12/12/18 at 2:15 p.m., the licensed practical nurse (LPN #2) unit manager was interviewed about residents watching/waiting for dinner service on 12/11/18. LPN #2 stated the trays for dinner on 12/11/18 must have been mixed up. LPN #2 stated the trays for residents requiring assistance usually came up first and then the independent eating residents were served. LPN #2 stated they usually had three tables in the dining area and she did not know where the other table was located. These findings were reviewed with the administrator and director of nursing during a meeting on 12/13/18 at 10:00 a.m.	F 550		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to provide nail care for two of 35 residents in the survey sample. Residents #29 and #535, dependent upon staff for personal	F 677	1. Nail care was performed for residents #535 and #29 on 12/12/18. Both residents tolerated having nails trimmed and groomed without issue. No skin issues were noted.	1/14/19

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F 677	Continued From page 4 care/hygiene, had long and/or dirty fingernails. The findings include: 1. Resident #29 had long, dirty fingernails with one nail pressing against the palm of his hand. Resident #29 was admitted to the facility on 12/19/15 with diagnoses that included high blood pressure, anxiety, dementia, insomnia, gastroesophageal reflux disease, hyperactivity disorder and osteoporosis. The minimum data set (MDS) dated 9/21/18 assessed Resident #29 as cognitively intact and as requiring extensive assistance of one person for daily hygiene. On 12/12/18 at 9:45 a.m., Resident #29 was observed in bed. The fourth and fifth fingers on Resident #29's right hand were contracted with the fingertips resting against the resident's palm. The nails on the fourth and fifth fingers were long, extending beyond the ends of his fingers. The fourth fingernail had a dark gray substance under the nail and the nail pressed against the palm, indented into the skin. Resident #29 stated he could not move the fourth and fifth fingers on his right hand. When asked about the long fingernails, the resident stated the nails were long and he would like them cut. Resident #29's plan of care (revised 11/1/18) listed the resident required assistance for activities of daily living including hygiene and personal care. Included among interventions to maintain proper hygiene was, "Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse..." On 12/12/18 at 9:48 a.m., the certified nurse's	F 677	2. The ADON and Unit Managers conducted an audit of all residents nails to determine whether nail care was needed on 12/12/18. Residents that required attention to their nails had nails trimmed and filed as needed. 3. DON/ADON will educate nursing staff regarding the policy of nail care and if a resident refused nail care to report to the nurse immediately by 12/21/18. 4. ADON/Unit Managers will perform audits of 5 residents per unit twice weekly x 4 weeks then weekly x 4 weeks then monthly x 1. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed.	

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F 677	Continued From page 5 aide (CNA #2) caring for Resident #29 was interviewed about the long dirty nails on the right hand. CNA #2 stated she did not realize the nails were long. CNA #2 stated nails were usually cut during the day shift. CNA #2 stated she did not routinely care for Resident #29 as she usually worked the evening shift. On 12/12/18 at 9:52 a.m., accompanied by the licensed practical nurse (LPN #1) caring for Resident #29, the long, dirty fingernails were observed. LPN #1 stated the nails were long and needed cutting. LPN #1 stated the aides were responsible for cutting Resident #29's fingernails and were to let the charge nurse know if they were unable to cut the nails. These findings were reviewed with the administrator and director of nursing during a meeting on 12/13/18 at 10:00 a.m. 2. Resident #535, dependent upon staff for assistance with personal hygiene, had long extending fingernails. Resident #535 was admitted to the facility on 11/27/18. Diagnoses for Resident #535 included multiple sclerosis, muscle weakness, muscle spasms, nutritional deficiency, adult failure to thrive, contracture of unspecified joint, anxiety disorder, major depressive disorder, and bio-mechanical lesion of the lumbar region. The most recent MDS (minimum data set) dated 12/4/18 assessed Resident #535 with a cognitive score of 13, indicating the resident was cognitively intact for daily decision making. The	F 677		

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F 677	Continued From page 6 MDS documented the resident had limited functional range of motion of upper and lower extremities on both sides and required extensive assistance of one person for personal hygiene and bathing. On 12/11/18 at 2:30 p.m., Resident #535 was observed in bed in his room. The resident had contracted fingers on her left hand with his fingertips resting on his palms. The resident's fingernails on both hands were long, extending beyond the ends of his fingers. The skin on his hands were noted as dry and scaly. Resident #535 was interviewed at this time about his long nails. The resident stated his nails had not been cut or trimmed since he had been at the facility. Resident #535 stated his left hand had been contracture for months and his right hand was losing functioning because of his MS (multiple sclerosis) diagnosis. Resident #535 stated he could not cut his own nails because of his hand weakness. Resident #535 stated the CNA (certified nursing assistant) only lotion his legs from his knees down to his ankles and didn't touch his hands or feet. On 12/11/18 at 2:45 p.m., the licensed practical nurse (LPN #5) working on Resident #535's living unit was interviewed about nail care. LPN #5 stated Resident #535 had only been on the unit for approximately two weeks and often would refuse care and ADL (activities of daily living) assistance. LPN #5 stated nail care was assessed during skin assessments and/or when the CNA was providing ADL care. On 12/12/18 at 9:00 a.m., a review of Resident #535's clinical record was completed. Resident #535's care plan (date initiated 11/28/18)	F 677		

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F 677	Continued From page 7 documented the resident has having a self-care deficit. The Goal was documented as, "Resident needs will be met." Interventions included, "Assist with activities of daily living, dressing, grooming, toileting, feeding, oral care." A review of Resident #535's December 2018 CNA-ADL tracking form documented under the personal hygiene section the resident's ADL - Self Performance as a "4. Total Dependence - full staff performance." The ADL Support provided for personal hygiene documented Resident #535 has a "2. one person physical assist." On 12/12/18 at 2:30 p.m., the second floor unit manager (LPN #2) where Resident #535 resided was interviewed about nail care. LPN #2 stated nails should be assessed during the weekly skin assessments and any concerns would be documented accordingly. Additionally she stated staff should assess for nail care during the biweekly bath/shower days. LPN #2 stated Resident #535 did refuse services when he was first admitted, however he was slowly adjusting and getting more comfortable with staff. She stated the expectation was for staff to assess and offer ADL care including nail care even if he declined or refused. On 12/12/18 at 3:00 p.m., accompanied by the second floor unit manager (LPN #2) to Resident #535's room. Resident #535 was interviewed again about his nail care. Resident #535 said his hands were sore and nails needed cutting. Resident #535 held up his left hand showing long fingernails pressed on his palm and dry, scaly skin. Resident #535 said he couldn't open his left hand fully and that his nails needed cutting. Resident #535 then provided a view of his right	F 677		

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F 677	Continued From page 8 hand which also needed cutting and with dry skin. LPN #2 offered to cut and trim the nails for Resident #535. Upon exiting the room, LPN #2 stated "there are multiple assessments and shifts of people taking care of the residents and staff should have noticed he needed nail care." LPN #2 stated she would need to give an in-service on nail care to the staff. On 12/13/18 at 8:00 a.m., a policy on nail care was presented and reviewed. The policy documented "nursing staff shall administer nail care in order to provide cleanliness and prevent infection." These findings were reviewed with the administrator, director of nursing and regional consultant during a meeting on 12/13/18 at 9:56 a.m.	F 677		
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 one of 35 residents in the survey sample. A medication for Resident #36 was not administered with a meal as ordered by	F 684	1. The physician was notified that Resident # 36 received Lasix without a meal on 12/11/18. Lasix does not need to be taken with a meal. Order changed per physician to reflect this on 12/14/18. No	1/14/19

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F 684	Continued From page 9 the physician. The findings include: Resident #36 was admitted to the facility on 6/20/18 with diagnoses that included mood disorder, intellectual disability, diabetes, depression, heart failure, high blood pressure and atherosclerotic heart disease. The minimum data set (MDS) dated 9/27/18 assessed Resident #36 with severely impaired cognitive skills. On 12/11/18 at 4:35 p.m., a medication pass observation was conducted with registered nurse (RN) #2 administering medications to Resident #36. Included in medications administered at this time was Lasix 10 mg (milligrams). This medication was not served with a meal or food. An hour after the Lasix administration on 12/11/18 at 5:35 p.m., Resident #36 had not been served her evening meal. Resident #36's clinical record documented a physician's order dated 6/20/18 for Lasix 10 mg to be given with meals for the treatment of heart failure. On 12/11/18 at 5:30 p.m., RN #2 was interviewed about the resident's Lasix administered without a meal. RN #2 stated Resident #36 usually got her meal on the second tray cart sent to the unit. RN #2 stated, "We can never predict when meal trays are coming." RN #2 stated she was not sure when to give the Lasix because the meal times were not consistent. This finding was reviewed with the administrator and director of nursing during a meeting on 12/13/18 at 10:00 a.m.	F 684	negative outcomes were noted to the resident. The RN who failed to follow physician's orders received education regarding following physician's orders. 2. ADON completed an order review to determine which residents have physician's orders to receive medications with meals. ADON/Unit Managers will conduct medication pass observation with the nurse failing to follow physician's orders. 3. DON/ADON will provide Licensed Nurses education regarding following physician's orders by 12/21/18. Newly hired Licensed Nurses will be educated on the same during orientation. 4. ADON/Unit Managers will perform a random medication pass observation on each unit 2 x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 1 to ensure physician's orders are followed during medication administration. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed.	

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F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review the facility staff failed to ensure a safe smoking environment for residents assessed as independent smokers. The facility did not keep the door to the smoking area locked, and did not ensure supervision for smokers going out to smoke at night or in early morning hours. Findings include: A FRI (facility reported incident) was received in the Office of Licensure and Certification (OLC) 12/5/18 reporting an incident of a former resident who went outside to smoke at approximately 3:00 a.m. 12/3/18. The report documented the resident (identified as Resident # 108) was observed by a staff member smoking in the facility on the first floor at approximately 2:20 a.m. The staff member reported to the nurse on second floor, where the resident resided. The nurse then went down to the first floor to get the resident, but by that time he had gone out the unlocked door to the smoking area and had barricaded the door with a crutch. The resident then proceeded to light papers and slide them under the door in an [apparent] attempt to set fire to the facility. Resident # 108 was coded as	F 689	1. Resident #108 was discharged on 12/3/18 due to noncompliance of facility smoking policy and safe smoking practices. 2. All Independent smokers were reassessed to ensure they still meet requirements for independent smoking. There were no negative findings with new assessments. 3. On 12/13/18 the ADON provided education to all independent smokers about the time changes of the smoking doors being opened. DON/ADON will perform education on the smoking policy to facility staff including the time changes of the smoking doors being locked from 7:30 pm - 9 am and a staff member being assigned to area for the times the doors are open to ensure safety for residents that prefer to smoke by 12/21/18. Newly hired staff will be educated on the smoking policy during orientation. Social Services will education new admissions that prefer to smoke on the smoking policy and have a smoking contract signed. The nursing staff will complete a smoking assessment for new admissions	1/14/19

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F 689	Continued From page 11 cognitively intact with a total summary score of 15 out of 15, but also had behaviors. The police were called, and the resident was removed from the facility without incident and taken to the hospital, where he remains. The resident will not be readmitted to the facility. On 12/12/18 at 8:30 a.m. the administrator, DON (director of nursing) and ADON (assistant director of nursing) were interviewed about the incident. They were asked how the resident was able to leave the second floor in the middle of the night, and how he obtained a lighter. The DON stated "Well, he is able to sign out LOA (leave of absence) and he goes to Burger King and all; we keep the resident's lighters and cigarettes in individual containers and they have to ask the nursing staff for the items. We think while (name of resident) was out, he obtained a lighter and had it on his person without our knowledge. As far as him coming down to smoke off the floor, I mean, he was assessed as an independent smoker and as such was allowed to go out anytime to smoke." The DON further stated that since the incident, the door was now locked and smokers both supervised and unsupervised, would have to ask a staff member to let them in and out of the smoking area. She continued "There's also someone posted at the door during the designated smoking times." The smoking policy was requested and received at that time. The "Smoking Policy" directed the following: "POLICY: The facility has established smoking areas that takes into account non-smoking residents and complies with applicable state, federal, and local laws regarding smoking, smoking area, and smoking safety."	F 689	and update the care plan as indicated. 4. NHA/Designee will perform audits two times weekly to assure the smoking doors are locked per the new facility guidelines for a total of 3 months to ensure resident safety. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed.	

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F 689	Continued From page 12 "PROCEDURE: A). Upon admission to the facility, all residents who smoke will have a 'Safe Smoking Evaluation' completed by the Social Worker/Designee and be asked to sign a 'Smoking Contract'." Items 1-4 of this section had instructions for the evaluation/contract. "B). Residents may only smoke in designated location. 1. For those deemed unsafe to smoke independently, there will be specific times for smoking..... 2. For those deemed safe to smoke independently, they may smoke at any time the resident chooses in the designated smoking area....." "C). Resident smoking materials will be retained and distributed by the facility staff during the designated smoking times and/or when independent smokers chooses to smoke. 1. No resident is permitted to maintain or store smoking materials on their person or in their room." During a meeting with facility staff 12/13/18 beginning at 1:05 p.m. the DON was again asked about rounds on the floors to ensure where residents were, and if a resident went down to smoke during the night/early morning what supervision was provided to ensure resident safety in case of an event that occurred 12/3/18, or if a resident fell, had a medical emergency, etc.? The DON stated "Rounds should be done every 2 hours.....a staff member who came down to get a soda saw (name of Resident # 108) and went back up to report it....no, there is no planned supervision for that time of night.....we have instituted and educated the smoking residents that the door will be locked at 7:30 p.m. and not re-opened until 9:00 a.m. They may continue to smoke any time up to that time. The doors used to be locked at night, but when the new company took over, we switched to that policy which	F 689		

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F 689	Continued From page 13 basically allowed them to smoke whenever they chose." The administrator stated "We recognized this was an issue, and with the incident that occurred 12/3/18, realized we needed to re-visit how we handled smoking. As the DON stated, we are locking the door at 7:30 p.m. after the last designated smoking time and will unlock at 9:00 a.m." The survey team observed staff at the door leading to the smoking area during the survey process. The team did not observe any incidents related to smoking during the survey process. No further information was presented prior to the exit conference.	F 689		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		1/14/19

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F 690	Continued From page 14 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, facility document review, and in the coarse of a complaint investigation, the facility failed to provide appropriate and sufficient services for the treatment and care of an indwelling catheter resulting in harm for one of 35 Resident's in the survey sample, Resident #100. Resident #100's catheter was pulled out causing trauma to the penis and he was admitted to the hospital. The Findings Include: Resident #100 was admitted to the facility on 3/14/16 with the most readmission on 10/30/18. The most current MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 11/6/18. Resident #100 was assessed as being cognitively intact with a score of 15 of 15. Section G of the MDS coded Resident #100 as total dependence	F 690	1. Foley catheter was secured to the leg of Resident #100 on 12/14/18. Resident #100 healed without issue from occurrence on 8/10/18. 2. ADON/Unit Managers conducted an audit of residents with catheters and applied stat locks to ensure catheters would remain secure on 12/14/18. Orders for stat locks for residents with Foley catheters were written on 12/17/18 to include checking placement every shift. None of the residents presented with injury or skin issues related to Foley placement and/or stat locks. 3. DON/ADON will provide education to the nursing staff to ensure they are knowledgeable of appropriate Foley care procedures and securement of catheters. Newly hired nursing staff will be educated regarding Foley care and securement of Foley catheters during orientation. All new admissions will be reviewed for	

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F 690	Continued From page 15 with one person assist for bed mobility. Diagnoses for Resident #100 included: Quadriplegia, sepsis, pressure ulcer, muscle weakness, urinary tract infection, and flaccid neuropathic bladder. Resident #100's medical chart was reviewed on 12/12/18. A "Change in Condition Evaluation" dated 8/10/18 by the facility documented that Resident #100 was actively bleeding, had blood in urine and a "Summarized Observation and Evaluation" that read: "Resident foley pulled out during care by CNA [certified nursing assistant], bleeding over 100 cc [cubic centimeters] in urine bag, unable to determine if urine is flowing." Resident #100 was sent out to the hospital. Review of Resident #100's hospital records documented (via a Hospital Discharge Summary, dated 9/4/18) that Resident #100 was admitted to the hospital on 8/10/18 with a diagnoses of "[...] urosepsis related to a traumatic Foley removal." On 12/12/18 10:07 AM Resident #100 was interviewed regarding the incident. Resident #100 verbalized that a CNA had came into the room to turn Resident #100 (as he, Resident #100 is quadriplegic and cannot turn himself). During being turned the CNA did not move the catheter bag from one side of the bed to the other and as a result the Foley catheter tubing was pulled out of the penis with the balloon still inflated. The CNA seen what had happened and went and got the nurse. Resident #100 verbalized that he was unable to feel that the Foley was being pulled due to his paraplegia, but seen a lot of blood. Resident #100 was asked if a catheter anchor (a device used to secure the tubing of the catheter to the leg to prevent the	F 690	catheter usage and orders will be obtained for stat locks for securement of catheters. 4. ADON/Unit Managers will monitor 3 residents with catheters 5 x weekly x 4 weeks to ensure catheter is secured then weekly x 4 weeks, then monthly x 1 to ensure urinary catheters are secured. All findings will be reviewed and brought to QAPI monthly for follow up and review.	

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F 690	Continued From page 16	F 690		

tubing from being pulled from the bladder through the penis) was in place at the time of being turned. Resident #100 verbalized that there was no anchor in place and went onto verbalize that the facility had started putting an anchor in place after coming back from hospital.

A facility incident report was provided for review. A hand written note by the CNA dated 8/10/18 said "while during rounds with [Resident's name] catheter came out of [Resident's name] penis. As soon I notice [SIC] , I reported to charge nurse [signed by CNA] and dated 8/14/18. There was no other information regarding an investigation or other interviews. The CNA and nurse on duty was unable to be interviewed during this investigation. The nurse no longer works at the facility and the CNA was not available.

On 12/12/18 10:49 AM the ADON (assistant director of nursing) was interviewed concerning the finding. The ADON verbalized the incident happened when Resident #100 was being turned and the CNA did not move the Foley bag to the other side of the bed before being turned causing tension on the tubing and pulling out from the penis.

Resident #100's care plan was reviewed along with physician orders, nurses notes, skin assessments, and treatment administration record from a time period of July 1st 2018 through August 10th 2018 (the day Resident #100 was sent to the hospital). There was no evidence that a catheter anchor was ordered, care planned, or placed for Resident #100.

Resident #100's care plan for indwelling catheter was updated on 10/18/18 to include an

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F 690	Continued From page 17 intervention for an anchor to Resident #100's Foley catheter. Also an order was written on 10/30/18 and read "[...] ensure foley secured to leg [...]" On 12/12/18 02:52 PM Resident #100 physician (other staff, OS #1) was interviewed. OS #1 was asked about information in regards to Foley coming out. OS #1 verbalized he had not read any of the incident report and was unable to answer why the catheter came out. OS #1 verbalized that he doesn't disagree with hospital diagnoses. When asked about a catheter anchor, OS #1 verbalized that an anchor would have helped prevent the tubing being pulled out, but could not say it would be a fail safe. When asked about ordering an anchor for a catheter OS #1 verbalized he doesn't typically order a anchor so if one was ordered, it must have been ordered because a nurse asked for one, verbalizing that an anchor would be more of a nursing intervention and can be done without an order. On 12/13/18 08:01 AM registered nurse (RN #1) MDS coordinator was interviewed concerning the updated care plan to include a Foley anchor. RN #1 verbalized that the care plan was updated to ensure the Foley catheter would be secure in place and prevent the tubing being pulled out. A facility policy and procedure was asked for and received for indwelling catheter placement and care. The policy was titled "Catheterization Competency" and read in part "Tape the catheter or apply a Velcro leg strap. Never leave the room until the catheter is secured. The mechanical irritation caused by catheter movement can cause urethral and meatal tearing, accidental removal, and serious complications. [...] The catheter in	F 690		

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F 690	Continued From page 18 the male is secured to either the upper thigh (with leg strap)or the abdomen (with tape)." On 12/13/18 09:55 AM the above finding was brought to the attention of the director of nursing (DON) and administrator and was asked to provide any evidence to support an anchor being in place at the time of the incident or any evidence that would support the CNA moving the Foley bag prior to turning Resident #100 (as not to cause tension on the Foley tubing). The facility staff did not elaborate. No other information was provided prior to exit conference on 12/13/18. This is a complaint deficiency.	F 690		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, facility staff failed to ensure pain medications were available for administration for one of 35 residents in the survey sample, Resident #63. Resident #63 did not receive Oxycodone 20mg po (oral) on 12/5/18 at 1:00 a.m., and did not receive Oxycodone 5mg po on 12/5/18 at 1:00 a.m. and 5:00 a.m., 12/10/18 at 5:00 p.m. and	F 697	1. The physician was notified that Oxycodone was not given to Resident # 63 on 12/5/18, 12/10/18, and 12/11/18 as the physician had ordered. DON/ADON provided education to the facility nurse who did not pull the medication from the stat box on 12/5/18. The agency nurse failing to pull the mediation from the stat box on 12/10/18 and 12/11/18 will be a "no client return" for the facility.	1/14/19

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F 697	Continued From page 19 9:00 p.m., and 12/11/18 at 1:00 a.m. Findings included: Resident #63 was originally admitted to the facility on 06/13/18 and readmitted on 11/18/18 with diagnoses including, but not limited to: Chronic Pain Syndrome, Osteomyelitis, Peripheral Vascular Disease, Diabetes and bilateral BKA's (below knee amputations). The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 10/15/18. Resident #63 was assessed as cognitively intact with a total cognitive score of 15 out of 15. Resident #63 and his wife were interviewed on 12/11/18 at approximately 2:20 p.m. During this interview both mentioned that there has been several occasions when Resident #63's pain medication has not been available for administration, specifically Oxycodone 5mg. The wife stated, "It is because it hasn't come from the pharmacy." When asked what happens if a medication is not available, Resident #63 stated, "I just don't get it." When asked about his pain level, Resident #63 stated, "I am always in pain." The clinical record for Resident #63 was reviewed on 12/12/18 at approximately 10:00 a.m. The POS (physician order sheet) dated "Active Orders As Of: 12/12/2018" included the following: "...Order Date: 11/18/2018, Start Date: 11/19/18, Oxycodone HCl Tablet 20 MG [milligrams] Give 1 tablet by mouth every 4 hours related to CHRONIC PAIN SYNDROME...give with 5mg tab to equal 25mg. Order Date: 11/18/2018, Start Date: 11/19/2018, Oxycodone HCl Tablet 5 MG	F 697	2. On 12/14/18 the ADON and Unit Managers completed a 100% Med to MAR audit with all medication and treatment carts to ensure medication availability. Medications were available. 3. DON/ADON will provide Licensed Nurses education regarding medication availability procedures and following physicians orders by 12/21/18. Newly hired Licensed nurses will receive education regarding following physician orders and medication availability. 4. ADON/Unit Managers will perform a narcotic availability audit on 5 residents 5 x weekly x 4 weeks, then 3 x weekly x 4 weeks, and weekly x 4. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed.	

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F 697	Continued From page 20 Give 1 tablet by mouth every 4 hours related to CHRONIC PAIN SYNDROME...give with 20mg to equal 25mg..." The December 2018 MAR (medication administration sheet) was reviewed and included, "...Oxycodone HCl Tablet 20MG Give 1 tablet by mouth every 4 hours..." The 1:00 a.m. dose on 12/5/18 was marked with an "x" indicating medication was not given. All pain levels assessed for the previous 24 hours and prior to 1:00 a.m. on 12/5/18 were documented as a "4." Pain levels assessed post 1:00 a.m. on 12/5/18, for a period of 24 hours, were documented as "0." No corresponding nurse's note was located in the record for explanation of the missed dose. The ADON (assistant director of nursing) was interviewed on 12/13/18 at 8:10 a.m. regarding this missing dose of medication. The ADON stated, "I don't know what happened with this." The December 2018 MAR also included, "...Oxycodone HCl Tablet 5MG Give 1 tablet by mouth every 4 hours..." The 1:00 a.m. dose on 12/5/18 was marked "16" along with initials. Per the "Chart Codes" Legend included on the MAR, "16=Hold/See Nurse Notes." The 5:00 a.m. dose on 12/5/18 was marked with an "x" and "16" along with initials. The 5:00 p.m. dose on 12/10/18 was marked "19" along with initials. Per the "Chart Codes" Legend included on the MAR, "19=Other/See Nurse Notes." The 9:00 p.m. dose on 12/10/18 and the 1:00 a.m. on 12/11/18 were both marked with an "x" and "19" along with initials. No corresponding nurse's notes were located in the record for explanation of the missed doses. During an interview with the ADON on 12/13/18 at 8:10 a.m. regarding missed doses of this medication, the ADON stated, "The	F 697		

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F 697	Continued From page 21 medicine wasn't here from the pharmacy. It is in the stat box. They didn't check the stat box." A list of medications included in the stat box was requested and received by the DON (director of nursing) on 12/12/18 at 5:40 p.m. The list included, "...Oxycodone 5MG Tablet, 7." Seven meaning the number of Oxycodone available in the stat box. The Administrator and DON were informed of the above findings during a meeting with the survey team on 12/13/18 at approximately 10:00 a.m. No further information was received by the survey team prior to the exit conference on 12/13/18.	F 697		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		1/14/19

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F 755	Continued From page 22 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, facility staff failed to ensure pain medications were available for administration for one of 35 residents in the survey sample, Resident #63. Resident #63 did not receive Oxycodone 20mg po (oral) on 12/5/18 at 1:00 a.m., and did not receive Oxycodone 5mg po on 12/5/18 at 1:00 a.m. and 5:00 a.m., 12/10/18 at 5:00 p.m. and 9:00 p.m., and 12/11/18 at 1:00 a.m. Findings included: Resident #63 was originally admitted to the facility on 06/13/18 and readmitted on 11/18/18 with diagnoses including, but not limited to: Chronic Pain Syndrome, Osteomyelitis, Peripheral Vascular Disease, Diabetes and bilateral BKA's (below knee amputations). The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 10/15/18. Resident #63 was assessed as cognitively intact	F 755	1. The physician was notified that Oxycodone was not given to Resident # 63 on 12/5/18, 12/10/18, and 12/11/18 as the physician had ordered. DON/ADON provided education to the facility nurse who did not pull the medication from the stat box on 12/5/18. The agency nurse failing to pull the mediation from the stat box on 12/10/18 and 12/11/18 will be a "no client return" for the facility. 2. On 12/14/18 the ADON and Unit Managers completed a 100% Med to MAR audit with all medication and treatment carts to ensure medication availability. Medications were available. 3. DON/ADON will provide Licensed Nurses education regarding medication availability procedures and following physicians orders by 12/21/18. Newly hired Licensed nurses will receive education regarding following physician orders and medication availability. 4. ADON/Unit Managers will perform a narcotic availability audit on 5 residents 5 x weekly x 4 weeks, then 3 x weekly x 4	

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F 755	Continued From page 23 with a total cognitive score of 15 out of 15. Resident #63 and his wife were interviewed on 12/11/18 at approximately 2:20 p.m. During this interview both mentioned that there has been several occasions when Resident #63's pain medication has not been available for administration, specifically Oxycodone 5mg. The wife stated, "It is because it hasn't come from the pharmacy." When asked what happens if a medication is not available, Resident #63 stated, "I just don't get it." When asked about his pain level, Resident #63 stated, "I am always in pain." The clinical record for Resident #63 was reviewed on 12/12/18 at approximately 10:00 a.m. The POS (physician order sheet) dated "Active Orders As Of: 12/12/2018" included the following: "...Order Date: 11/18/2018, Start Date: 11/19/18, Oxycodone HCl Tablet 20 MG [milligrams] Give 1 tablet by mouth every 4 hours related to CHRONIC PAIN SYNDROME...give with 5mg tab to equal 25mg. Order Date: 11/18/2018, Start Date: 11/19/2018, Oxycodone HCl Tablet 5 MG Give 1 tablet by mouth every 4 hours related to CHRONIC PAIN SYNDROME...give with 20mg to equal 25mg..." The December 2018 MAR (medication administration sheet) was reviewed and included, "...Oxycodone HCl Tablet 20MG Give 1 tablet by mouth every 4 hours..." The 1:00 a.m. dose on 12/5/18 was marked with an "x" indicating medication was not given. All pain levels assessed for the previous 24 hours and prior to 1:00 a.m. on 12/5/18 were documented as a "4." Pain levels assessed post 1:00 a.m. on 12/5/18, for a period of 24 hours, were documented as "0." No corresponding nurse's note was located in the	F 755	weeks, and weekly x 4. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed.	

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F 755	Continued From page 24	F 755		

record for explanation of the missed dose. The ADON (assistant director of nursing) was interviewed on 12/13/18 at 8:10 a.m. regarding this missing dose of medication. The ADON stated, "I don't know what happened with this."

The December 2018 MAR also included, "...Oxycodone HCl Tablet 5MG Give 1 tablet by mouth every 4 hours..." The 1:00 a.m. dose on 12/5/18 was marked "16" along with initials. Per the "Chart Codes" Legend included on the MAR, "16=Hold/See Nurse Notes." The 5:00 a.m. dose on 12/05/18 was marked with an "x" and "16" along with initials. The 5:00 p.m. dose on 12/10/18 was marked "19" along with initials. Per the "Chart Codes" Legend included on the MAR, "19=Other/See Nurse Notes." The 9:00 p.m. dose on 12/10/18 and the 1:00 a.m. on 12/11/18 were both marked with an "x" and "19" along with initials. No corresponding nurse's notes were located in the record for explanation of the missed doses. During an interview with the ADON on 12/13/18 at 8:10 a.m. regarding missed doses of this medication, the ADON stated, "The medicine wasn't here from the pharmacy. It is in the stat box. They didn't check the stat box."

A list of medications included in the stat box was requested and received by the DON (director of nursing) on 12/12/18 at 5:40 p.m. The list included, "...Oxycodone 5MG Tablet, 7." Seven meaning the number of Oxycodone available in the stat box.

The Administrator and DON were informed of the above findings during a meeting with the survey team on 12/13/18 at approximately 10:00 a.m.

No further information was received by the survey

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F 755	Continued From page 25 team prior to the exit conference on 12/13/18.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to ensure Tuberculin PPD (purified protein derivative) solution was disposed of within 30 days of opening per manufacturer's instructions in one of three refrigerators in the facility.	F 761	1. The expired PPD solution was discarded on 12/13/18 by the ADON. 2. The ADON/Unit Managers completed an audit of medication storage areas on 12/14/18 with no negative findings. 3. DON/ADON will educate licensed nursing staff on medication storage by	1/14/19

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F 761	Continued From page 26 One multi-dose vial of PPD solution was observed opened and available for administration on the 200 unit refrigerator. The vial was dated 11/10/2018. Findings were: On 12/13/2018 at approximately 8:30 a.m., the refrigerator on the 200 unit was inspected with LPN (licensed practical nurse) #6 and LPN #3. Observed in the refrigerator was an opened multi-dose vial of Tuberculin PPD solution. The vial was dated 11/10/2018. LPN #6 and LPN #3 was asked when does a bottle of multi-dose vial of Tuberculin PPD solution expire once opened. LPN #6 stated, "I'm not sure, but I will find out right now." LPN #3 stated, "I'm not sure." At approximately 8:40 a.m., LPN #6 approached this surveyor and stated, "It is 30 days. I called the pharmacy." The facility policy for PPD solution was requested from the ADON (assistant director of nursing) on 12/13/18 at 09:15 a.m. A copy of the facility policy, "Storage and Expiration of Medications, Biologicals, Syringes and Needles" was presented. Per the facility policy, "...Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. Facility staff may record the calculated expiration date based on date opened on the medication container."	F 761	12/21/18. Newly hired licensed nurses will receive education regarding medication storage during orientation. 4. ADON/Unit Managers will audit medication room refrigerators 5 x week x 4 weeks then weekly x 4, then monthly x 1. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed.	

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F 761	Continued From page 27 Also presented was the package insert from the Tuberculin PPD box. Per the manufacturer's guidelines, "Storage...Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." The above information was discussed during a meeting with the survey team on 12/13/2018 at approximately 10:00 a.m. with the DON (director of nursing) and Administrator. No further information was obtained prior to the exit conference on 12/13/2018.	F 761		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop and implement an appropriate plan of action for an identified quality deficiency regarding smoking. The facility QAA (Quality Assessment and Assurance)/QAPI (Quality Assurance and Performance Improvement) committee failed to develop and implement an appropriate plan of action for an identified deficiency with residents' smoking; the facility failed to ensure that an action plan was in place to ensure safe smoking	F 867	1. The RDCS wrote a QAPI plan for safe smoking on 12/14/18. A QAPI meeting was held on 12/21/18 with the IDT. 2. All independent smokers were reassessed to ensure they still meet the requirements for independent smoking. There were no negative findings with new assessments. 3. The Regional Nurse provided education to the Administrator and DON regarding QAPI policy on 12/14/18 and 12/20/18. On 12/13/18 the ADON	1/14/19

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F 867	Continued From page 28 for residents. Findings included: A brief summary of an identified concern during the during the survey process on 12/11/18 through 12/13/18 is as follows: A Facility Reported Incident (FRI) was investigated by a surveyor during the survey process. The FRI documented that on 12/3/18, a resident of the facility went out to smoke late that night and at approximately 3:00 AM in the morning, was found to have barricaded the smoking door to the smoking area and was lighting paper on fire, attempting to slide the paper under the door, attempting to catch the facility on fire (per the incident report). On 12/13/18 12:01 PM The administrator and DON (director of nursing) were interviewed for the facility task of QAA/QAPI. The administrator stated that they (the facility) would speak on safe smoking, since this was an identified deficiency. The administrator and DON stated that this has been a known issue the facility had been working on, prior to the above incident on 12/03/18. The administrator stated that he has known about the problem of unsafe smoking for about two weeks (the length of time the interim administrator has been at this facility). The DON stated that she has known about and has had concerns about safety regarding smoking for residents since she came to the facility in June of 2018. The DON stated that we (the facility) has talked about it and have had conversations about it and that they (the facility) have been working on it. The DON was asked to present any information regarding safe smoking that the QAA/QAPI committee has	F 867	provided education to all of the independent smokers about the time changes of the smoking doors being opened. DON/ADON will provide education on the smoking policy to facility staff including the time changes of the smoking doors being locked from 7:30 pm - 9 am and a staff member being assigned to area for the times the doors are open to ensure safety for residents that prefer to smoke by 12/21/18. Newly hired staff will be educated on the smoking policy during orientation. SS will educate new admissions that prefer to smoke on the smoking policy and have smoking contract signed. Nursing staff will complete a smoking assessment on new admissions and update the care plan as indicated. 4. NHA/Designee will perform audits 2 x weekly to assure the doors are locked per the new facility guidelines for a total of 3 months to ensure the resident safety. All findings will be reviewed and brought to QAPI monthly for any follow up that is needed. The Regional Nurse will review monthly QAPI to ensure that plans for facility issues are brought to QAPI as per the policy and provide education as needed every month for 3 months. All findings will be reviewed and brought to QAPI monthly for any follow up as needed.	

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F 867	Continued From page 29 identified, the action plan for the identified problem and any monitoring of such. The DON and administrator were further interviewed and asked about specific identified issues and concerns with safe smoking. The DON stated that prior to [name of new owner] taking over, which was on September 1st, 2018, the door to the smoking area was always locked at night and then would be opened again in the mornings, the doors to the smoking area would be locked in the late evening hours, and no one could go out of that door until it was unlocked the next morning. The DON stated that when the new company took over (09/01/8) they (the new company) told us that everyone had a right to smoke. The DON stated that at that time, a new smoking policy was implemented that said if the resident is assessed and deemed independent to smoke, that resident has a right to smoke at any time day or night without supervision. The other residents that smoke, who were not assessed to be safe and not deemed independent had to have staff go out with them while smoking. The DON stated that they also implemented a new smoking contract at that time for the residents to sign. The DON stated that we (the facility) have implemented things since the incident happened (12/03/18), even though the concerns were known by the QAA/QAPI committee prior to the incident, which have included changing the smoker policy and the smoker agreement. The DON stated that since yesterday (12/12/18) we have implemented that we are going to lock the door to the smoking area from 7:30 PM to 9:00 AM. and stated that no one can go out during that time. The DON stated that the smoking area will be open during the day from 9:00 AM to 7:30	F 867		

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F 867	Continued From page 30 PM. The DON stated that the independent smokers can go out anytime they want during those open door hours, but the supervised smokers only go out at designated times of 9 AM, 1 PM, 4 PM, and 7 PM. The DON stated that we also have a staff member at the door during the open door hours to monitor who is going in and out and they will also be the person who will go outside and assist with the resident who are supervised smokers. The DON was asked when that started, the DON stated, "Yesterday." The DON stated that the door being locked and the new smoking times were just implemented yesterday, after concerns were raised by a surveyor. The administrator stated that they (the facility) identified quality deficiencies in a variety of ways and listed numerous sources of identification. The administrator further stated that, depending on the magnitude of and identified concern, we decide which area of concern will be addressed first. The administrator stated that when a concern/deficiency has been identified and is going to addressed for the QAA/QAPI committee for intervention, we (the facility) put together a group of people to work on the identified issue and to report back at the next meeting or as needed based on the data gathered. The administrator stated we (the facility) will monitor an issue to determine that it has been corrected, and further stated that he didn't like to put a time on how long an issue would be monitored, but stated, "we want to fix it, we may monitor for 3 months or 6 months and take other action steps if needed." The administrator could not provide information and/or documentation that the above	F 867		

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F 867	Continued From page 31 concerns had taken the appropriate steps as listed above for an identified issue. On 12/13/18 1:05 PM The administrator, DON (director of nursing), and the regional director of clinical services were made aware in a meeting with the survey team of concerns regarding the development and implementation of an appropriate action plan for identified concern/deficiency regarding residents safe smoking, as described above and that the door being locked and monitoring were not implemented until the day before, when questions were asked by a surveyor. The staff were asked if any monitoring had been completed on this since it was identified in June (by the DON) and two weeks ago (by the administrator). The DON stated, "No, we don't have any." The administrator stated that we (the facility) have been discussing this, but no monitoring for this problem has been completed and further stated, "We didn't write anything down." The DON and administrator were reminded, that according to the interview earlier with the DON and administrator, the QAA/QAPI information for an identified issue that is going to be addressed should have the issue identified, which the facility had, who is going to be the 'group of people' (per the administrator) who will work on said issue, what are the interventions with dates of implementation, when and how will the interventions be implemented and how are the interventions going to monitored. The DON stated that we (the facility) had a plan, not a formal plan, even though it had been brought to the committee and we were working on it, we didn't write all of that information down.	F 867		

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F 867	Continued From page 32 The DON was asked how often or how long were the concerns regarding safe smoking going on for. The DON stated that we implemented the smoking policy and contract, went out and bought boxes for smoking materials and did 'all of that.' The DON was asked for the plan or documentation showing the steps and actions taken by the facility to ensure safe smoking for all smokers, supervised and unsupervised and how this plan of action was progressing and what steps still needed to be taken. The DON stated that she did not think she had anything like that, an "action plan" per say, but would look. The DON was asked, how long smoking safety had been a concern. The DON stated that every time the smoking assessments were completed concerns were voiced regarding safety and that was something that we (the facility) decided to keep as an ongoing problem. The DON stated that we (the facility) had been talking about locking the door, but it just got locked yesterday even though that had been a concern the whole time, since back when [name of new owner] turned over (September 1st, 2018). The administrator stated that nothing was written down, as far as the identified concerns with smoking, we (the facility) were looking at this area and other potential areas, we did a walk around the smoking area and outside the building and discussed issues, but didn't write anything down. The DON then spoke up and stated that she had information on her computer that was not logged in the QAA meeting minutes. The DON and administrator were again asked to present any documentation regarding the smoking concerns and was asked for the new policy on smoking and the smoking contract for residents to sign.	F 867		

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F 867	Continued From page 33 12/13/18 01:28 PM The DON presented documentation from her computer. The information dated 09/28/18 documented, "Transition from [name of old facility owner] [to name of new facility owner] "Smoking Policy"...new smoking policy has been implemented including resident education and smoking contracts signed. A resident meeting was held with the residents that smoke on September 20, 2018 explaining the new smoking policy as well as having a smoking contracts signed. Individual containers were purchased for residents cigarettes and lighters and labeled with each name. These containers are color coded to help staff easily recognize the independent smokers (blue containers)...require assistance (red containers) per the smoking assessments that were completed for each resident...smoking times were changed. A copy of smoking times was posted in rooms of the assisted smokers..." The DON stated the door being locked was not written down, although it was brought up several times in conversation that the door needed to be locked, but the new company said if a resident was deemed independent they could smoke anytime they wanted and prior to the takeover the smoking doors were locked during the night. 12/13/18 01:36 PM The administrator presented hand written documentation of concerns with smoking that had not yet been recorded in the QAA/QAPI book, the concerns were dated as discussed on 09/28/18, 12/07/18, and 12/10/18. The information dated 09/28/18 from the administrator documented, "...Smoking P/P with [name of new owner] reviewed adopted rolled out to smokers/staff 9/1/4/7 smoking times..."	F 867		

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MONROE HEALTH & REHAB CENTER	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

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F 867	Continued From page 34 A hand written document (by the administrator) dated 12/07/18 documented, "...Top Concerns...Safety...Smoking changes in out smoke monitor 9-5:20 change to supervised/unsupervised specific times 9-1-5-7...timeliness of smoke breaks...Needs follow up for safety..." A document dated (by the administrator) 12/10/18 documented, "...smoking area brainstorming 1. change times for non supervised smoking location, times, staffing monitoring, etc..." The policy was presented titled, "Smoking Policy" documented, "....Section: Resident Safety...Revised May 15, 2018...has established smoking areas that takes into account non-smoking residents and complies with applicable federal, state, and local laws regarding smoking , smoking area, and smoking safety...safe smoking evaluation ...admission, readmission, quarterly and with any significant change in...condition...if deemed needing...apron will be provided...any other needed equipment to keep residents safe...only smoke in designated location...deemed unsafe to smoke...specific times for smoking...for those who are deemed safe to smoke independently, per smoking assessment, they may smoke at any time resident chooses in the designated areas...facility is non smoking...may not smoke within facility or on the grounds of the facility...failure to adhere to the provisions outline in this smoking protocol will result in: ...restrictions...risk of discharge if resident imposes on safety of other residents..." The "Smoking contract" was reviewed and documented, "...Smoking is a supervised activity	F 867		

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F 867	Continued From page 35 at this facility which is only permitted in designated areas and at designated times for those residents deemed needing supervised smoking per smoking assessment...For those deemed independent smokers, per smoking assessment, you must utilize designated smoking areas. Unsupervised and careless smoking jeopardizes the health, safety and life of everyone at facility...The supervised resident may only smoke at designed [sic] times and locations. The designated times are...The designated locations for both supervised and unsupervised smokers are:...Smoking is not permitted inside facility..." No further information and or documentation was presented prior to the exit conference on 12/13/18 at 2:00 PM to evidence the facility staff appropriately developed and/or implemented an action plan for smoking to ensure safety to all residents, including supervised, unsupervised residents who smoke, and non smoking residents.	F 867		
F 880 SS=H	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:	F 880		1/14/19

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F 880	Continued From page 36 §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: (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.	F 880		

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F 880	Continued From page 37 §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 staff interview, clinical record review and facility document review, the facility staff failed to implement policies and procedures to prevent the spread of scabies on one of three units in the facility and failed to identify residents affected by the outbreak on the infection control tracking log. Six individual residents (Resident (s) #78, 13, 60, 58, 65 and 104) were all treated with oral and/or topical creams for the treatment of scabies. Residents were not placed on contact precautions to prevent the spread of the infestation resulting in an identified pattern of harm; and the facility staff failed to include information regarding the cases of scabies in the infection control tracking system. Findings were: Resident #78 was admitted to the facility on 07/19/2017. Her diagnoses included but were not limited to: Alzheimer's, dysphagia, hypothyroidism, and atrial fibrillation.	F 880	1. Targeted residents were treated with no further issues noted. The Infection Control Tracking Log has been updated regarding scabies outbreaks from September and November. 2. All residents have the potential to be affected. 100% of skin assessments were completed on all residents from 12/14/18-12/19/18 to ensure that no other residents were affected. No negative outcomes noted. 3. The Regional Nurse provided education to the DON and ADON on the infection control policy and infection control log on 12/14/18. The DON/ADON will provide education to the Licensed Nurses on the scabies policy and procedure and infection control by 12/21/18. 4. The DON/ADON will monitor the infection control tracking log weekly x 3 months then monthly to ensure proper tracking is complete and appropriate measures are taken to isolate residents as deemed necessary due to infection	

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F 880	Continued From page 38 A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 10/29/2018, assessed Resident #78 with severe cognitive impairment with a summary score of "01". On 12/11/2018 at approximately 1:15 p.m., during the initial tour of the facility Resident #78 was observed on the third floor of the facility. She was observed walking in and out of other resident rooms, friendly, shaking hands, patting individuals on the back, talking to other residents, staff and surveyors. The clinical record was reviewed at approximately 3:00 p.m. The following note dated 11/23/2018 contained the following: "Late entry for 11/20 Resident treated with Ivermectin X (times) [number not documented] doses, prophylaxilty [sic] RP [responsible party] is aware of new order." Further review of the clinical record provided the following information from the progress notes: "9/28/2018 22:29 [10:29 p.m.] Resident has a pink-red circular rash all over body. +[plus/positive] pruritis [itching]. Roommate being treated for same symptoms." "9/28/2018 22:31 [10:31 p.m.] Resident with rash allover [sic] body. + pruritis. Roommate being treated for same. Dr. [names] RNP [nurse practitioner] phoned. Received orders for permethrin, Ivermectin tablets (to be repeated in one week.) In am [a.m.] 9/29/18, all clothes and linens need to beset [sic] to the laundry for hot water/hot dryer to kill source of bites. RP notified."	F 880	and/or certain types of rashes (i.e. Scabies). A skin sweep will be conducted for all residents residing on the dementia unit between weeks 6 and 7 status post prophylactic treatment in November to ensure Scabies have been successfully eradicated. All findings will be reviewed an brought to QAPI monthly for any follow that is needed.	

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F 880	Continued From page 39 "9/29/2018 22:41 [10:41 p.m.]Resident with rash allover body. + pruritis. Resident was treated with permethrin cream tonight and will be showered, and receive Ivermectin tablets tomorrow then will be (repeated in one week.) In am [a.m.] 9/30/18, all clothes and linens need to be sent to the [sic] for hot water/hot dryer to kill source of bites." "10/01/2018 10:38 [a.m.] Resident continues with rash on body no s/s [signs/symptoms] of discomfort no s/s of adverse reaction to the medication." The physician orders for September 2018 were reviewed and contained the following: "9/28/2018 Permethrin Cream 5% Apply to body topically one time only for rash for 1 day. Apply topically neck to feet and beneath nails. Wash off after 8 hours." "9/28/2018 Ivermectin tablet 3 mg Give 4 tablets by mouth one time only for rash for 1 day." The physician orders for November contained the following: "11/20/2018 Ivermectin Tablet give 12 mg by mouth one time a day every seven days related to ENCOUNTER FOR PROPHYLACTIC MEASURES UNSPECIFIED until 11/28/2018." The facility medication reference system contained the following information regarding the prescribed medications: "Permethrin Cream 5%...Common Brand Name Elimite. USES: This medication is used to treat scabies, a condition caused by tiny insects called	F 880		

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F 880	Continued From page 40	F 880		

mites that infest and irritate your skin. Permethrin belongs to a class of drugs known as pyrethrins. Permethrin works by paralyzing and killing the mites and their eggs."

"Ivermectin 3 mg tablet...Common Brand Name Stromectol. USES: This medication is used to treat certain parasitic roundworm infections...Ivermectin belongs to a class of drugs known as antihelmintics. It works by paralyzing and killing parasites. OTHER USES: This section contains uses of this drug that are not listed in the approved professional labeling for the drug but that may be prescribed by your health care professional....This drug may also be used for other parasitic infections, including lice and scabies."

Resident #78's roommate was identified as Resident #13.

Resident #13 was admitted to the facility on 03/02/2018 with the following diagnoses, including but not limited to: Alzheimer's disease, unspecified dementia, hypertension and major depressive disorder.

The most recent MDS was a quarterly assessment with an ARD of 09/07/2018. Resident #13 was assessed as being severely impaired in her cognitive status with a summary score of "04".

The progress notes section of the clinical record were reviewed on 12/11/2018 at approximately 3:30 p.m., and contained the following:

"09/27/2018 23:50 [11:50 p.m.] Resident c/o [complaining of] severe itching. Bite marks on

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F 880	Continued From page 41 arms, legs, back, buttocks. Stated she saw small black bugs "biting her. Nurse phoned OC [on call] MD for [name of physician]. Permethrin lotion ordered for 9/28/2018. ? [question] need to order Ivermectin for systemic treatment. ? Linens and clothing needs to go to laundry and be washed in hot water. Medicated for Benadryl at HS [hour of sleep]." "9/27/2018 22:47 [10:47 p.m.] Benadryl Tablet 25 mg Give 25 mg by mouth every 06 hours as needed for pruritis 25-50 mg po [by mouth] PRN Administration was: Effective." "09/28/2018 10:17 [a.m.] Resident's bed linen and clothing was sent to laundry no itching or scratching observed by I the writer." "09/28/2018 10:59 [a.m.] Resident has order Ivermectin 3 mg tab give 4 mg tabs then repeat in one week RP notified." "09/28/2018 22:25 [10:25 p.m.] Permethrin cream applied: neck to feer [sic], including fingernails anf [sic] toe nails at 2030 [8:30 p.m.]. Due for a shower in 8 hours at 0430 [4:30 a.m.]. Ivermectin received this eve. Will be given 9/29/18." 09/30/2018 10:19 [a.m.] Ivermectin given per orders. No observations of itching/scratching this am. Faint red patchy areas to arms and torso, scabbing noted." 09/30/2018 22:17 [10:17 p.m.] Res tolerating new med. Ivermectin well and no s/sx of adverse reactions noted...She continues dry, scabby, bumps type rash to face, hands, bilateral UE/LE [upper extremities/lower extremities], torso, back	F 880		

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F 880	Continued From page 42 areas. Res noted with scratch marks from her itching self..." "10/01/2018 10:35 [a.m.] Resident continues with dry bumps on arms back ABD [abdomen] area resident cued not to scratch areas Resident denies any discomfort." "10/01/2018 22:48 [10:48 p.m.] Resident continues to have an extensive pruritic rash all over her body. Needs to be seen by MD." "10/01/2018 23:05 [11:05 p.m.] SBAR [Situation/Background/Assessment/Request] S: Change in condition...extensive round pruritic rash all over her body. Has had permethrin cream and Ivermectin tablets... A: Itching rash scabies or other infestation..." Skin Checks for Resident #13 were reviewed in the clinical record. The bi-weekly skin check dated 9/28/2018 contained the following information: "Scabies treatment in place." The physician orders for September 2018 were reviewed and contained the following: "9/28/2018 Permethrin Cream 5% Apply to body topically one time only for rash for 1 day. Apply topically neck to feet, under finger nails and toe nails at bedtime. Wash off after 8 hours." "9/28/2018 Ivermectin tablet 3 mg Give 4 tablets by mouth one time only for itching for 1 day." The physician orders for November contained the following: "11/20/2018 Ivermectin Tablet give 18 mg by mouth one time a day every seven days related to ENCOUNTER FOR PROPHYLACTIC	F 880		

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F 880	Continued From page 43 MEASURES UNSPECIFIED until 11/28/2018." On 12/11/2018 at approximately 4:15 p.m., the DON (director of nursing) was asked about the treatment provided to Resident #78 and #13 on the third floor. She was asked to provide any information that was available regarding the original treatment of the two residents in September and the prophylactic treatment in November. At approximately 4;40 p.m., the DON came to the conference room. She stated, "We got a call from the health department in November around the 13th...a resident had transferred out to a facility in [place] and had a rash...the resident was being treated for scabies in the new facility..she wanted to know if anyone else had broken out and I told her no...then we talked again around November 20 just to follow-up...I told her we had two more people [Resident #58 and Resident #65] who had gotten rashes and were being treated with the Ivermectin...we never did a scraping to confirm that it was scabies...she said that if anyone else broke out she would recommend that we do a BIT [burrow ink test] and she told me how to do it." The DON was asked what a BIT test was and how it was done. She stated, "Well you take a marker and put a mark on the bumps and then wipe it off...if it's scabies then the ink goes down under the skin, into their burrows...On that very day that I talked to her [health department nurse] we had another resident [Resident #104] get a rash on her left arm so [name of unit manager] and I did the BIT test and it was positive...we notified [name of medical director] and we treated the whole floor at that point." The DON was asked if she had let the nurse at the health department know about the positive test. She	F 880		

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F 880	Continued From page 44 stated, "Yes, I believe so." The DON was asked if she had any tracking as to who the residents were who had a rash or any documentation regarding her conversation with the health department. She stated, "No, just my notes...we also did skin sweeps and we inserviced the staff on the policy." She presented an inservice record and the facility policy titled: "Scabies". The policy contained the following information: "It is the policy of the facility to teat resident infected with and sensitized to Sarcopetes scabiel (scabies) and to prevent the spread of scabies to other residents and staff...General Guidelines: Scabies is an itching skin irritation caused by microscopic human itch mite, which burrows into the skin's upper layers and eventually causes itching, tiny irregular red lines just above the skin and an allergic rash...Incubation period can be 2-6 weeks before onset of itching for persons with no previous exposure...Symptoms sometimes include severe itching which worsens at night...Scabies is spread by skin to skin contact with the infected area, or through contact with bedding, clothing, privacy curtains and some furniture. Diagnosis may be established by recovering the mite from its burrow and identifying it microscopically. Failure to identify scraping as positive does not necessarily exclude the diagnosis. It is difficult to obtain a positive scraping because only one or two mites may cause multiple lesions. Often diagnosis is made from signs and symptoms and treatment followed without scrapings, although scrapings are preferred. Affected residents should remain on Contact Precautions until twenty four (24) hours after treatment. Family and friends of residents	F 880		

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F 880	Continued From page 45 who have had close contact should be notified and given instruction...A resident sharing a room with someone infected with scabies should be examined carefully for scabies. If signs and symptoms are present, the resident should be treated in accordance with these procedures. If symptoms are not present, daily assessments should be made until the case has resolved...PRE_TREATMENT PROCEDURE: While the resident is being treated remove four (4) sets of clothing from the resident's room. bag the clothing in a bag and send the bag to the laundry for processing. Place all remaining clothing of the infected resident into a bag. Seal the bag and label "Do Not Open Until (date 14 days from storage date). STEPS IN THE PROCEDURE: Implement Contact Isolation. Should scrapings be ordered, obtain before treatment (Note: Negative scraping do not exclude the diagnosis. Treatment should be administered if symptoms are present)...Continue Contact Precautions until twenty -four (24) hours after treatment..." The policy also contained guidelines for departmental responsibilities and environmental services. Guidelines for cleaning the environment included but were not limited to: "Clean lobbies, lounges, etc before resident bathing and treatment times so that "treated" residents do not use unclean areas, Vacuum furniture made of fabric in the resident's room. Wrap furniture in plastic and store for two (2) weeks...." The policy was reviewed and the DON was asked if any of the residents had been put on Contact Isolation/Precautions. She stated, "In November when we treated the whole unit, we isolated all the residents to the floor..we didn't let them leave the floor..we didn't isolate them to their room just	F 880		

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F 880	Continued From page 46 to the unit...we tried to keep the same staff going in and out." She was asked if the other residents that were identified and treated in November prior to the positive BIT test, had been isolated. She stated, "No." She was asked if either Resident #78 or Resident #13 had been isolated during their treatment in September. She stated, "No, we didn't." She was asked if the furniture had been wrapped in plastic after cleaning either in September or November. She stated, "No, we didn't do that either." On 12/11/2018 at approximately 5:44 p.m. the medical director was interviewed about scabies and the treatment used. He stated that he hesitated to use the topical creams on residents with dementia. He stated, "You have to paint them from head to toe and then shower them off after so many hours...it can be traumatic for them." He stated that he was aware of the resident who had been transferred to a different facility and had spoken with the family. He was asked if since Resident #78 was a wanderer on the unit should the entire unit have been treated at that time. He stated, "It's hard to isolate someone like that...what maybe could have been done for the 24 hours after her treatment would be maybe one to one or put gloves on her, like a reverse precaution thing...I don't know if that would have worked but it could have been tried." On 12/12/2018 the clinical records of Resident #58, Resident #60 and Resident #104 were reviewed. The following information was obtained. Resident #60 was admitted to the facility on 01/15/2018 with the following diagnoses but not limited to: Unspecified Dementia, major	F 880		

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	495326	A. BUILDING _____ B. WING _____	C 12/13/2018

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F 880	Continued From page 47 depressive disorder, cerebral infarction and myocardial infarction. The most recent MDS was a quarterly assessment with an ARD of 10/16/2018. Resident #60 was assessed as being severely impaired with a cognitive summary score of "0". Review of the progress notes contained the following: "11/18/2018 13:18 [1:18 p.m.] Resident observed to have rash/scabs covering entire body. Resident picking and scratching at skin..." "11/18/2018 20:07 [8:07 p.m.] Resident skin assessed. He is covered all over with red marks. Orders in computer to treat for scabies. Linen collected, double bagged and placed in bathroom until taken to laundry." Review of the MAR (medication administration record) for November contained the following: "Ivermectin Tablet 3 mg Give 1 tablet by mouth one time only related to ENCOUNTER FOR OTHER PROCEDURES FOR PURPOSES OTHER THAN REMEDYING HEALTH STATED for one day repeat does in 1 week." The medication was given on 11/20/2018 and 11/26/2018. Resident #58's record was reviewed. She was admitted on 1/11/2011 with the following diagnoses, but not limited to: Dementia, hypertension, diabetes mellitus and major depressive disorder. Her most recent MDS was a quarterly assessment with an ARD of 10/12/2018. Her cognitive status was assessed as having difficulty	F 880		

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F 880	Continued From page 48 with both long and short term memory and severe impairment in daily decision making skills. Her progress notes contained the following information: "11/18/2018 15:06 [3:06 p.m.] SBAR S: change in condition...red bumps/rash to multiple areas on skin...A:...Skin changes: Itching Rash to have scabies on multiple areas to skin..." "11/18/2018 21:33 [9:33 p.m.] Resident has been visiting with family today...continues with rash on body, started on Ivermectin..." Resident #104 was admitted to the facility on 8/03/2018 with the following diagnoses, including but not limited to: Unspecified Dementia, diabetes mellitus, fronto-temporal dementia, and anxiety. The most recent MDS was a quarterly assessment with an ARD of 11/9/2018. Resident #104 was assessed as having a cognitive summary score of "01", indicating severe impairment with her cognitive status. The progress notes were reviewed and contained the following: "11/20/2018 10:22 [a.m.] SBAR Change in Condition: Rash A: Skin changes: Rash to have rash on back legs, arms...R: Order obtained for Ivermectin 3 mg" "11/20/2018 11:17 [a.m.] Resident linen and clothing double bagged and sent to laundry." There was no documentation in the clinical record regarding the BIT test conducted on Resident #104.	F 880		

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F 880	Continued From page 49 Skin sweeps conducted on the third floor from September to November were requested from the DON on 12/12/2018. Review of the skin sweeps identified a sixth resident treated with a rash and treatment, Resident #60. Review of the clinical record revealed the following: "11/09/2018 18:15 [6:15 p.m.] ...Resident with bite marks on back and rt [right] lateral buttock + pruritis. Has scratched 4 areas of open skin on rt lateral posterior buttock...orders received for treatment of possible scabies. Orders to start 11/10/2018 at HS..." The MAR contained the following information: "Permethrin Cream 5% Apply to affected skin areas, topically one time only for skin bites for 1 day. Apply X 1 at HS. Shower and rinse cream off 8 hours later." The medication was signed off as given on 11/12/2018. The Director of Housekeeping and Laundry was interviewed on 12/12/2018 at 10:57 a.m. He stated that in November all of the rooms on third floor were treated because of scabies. He stated the curtains, walls, resident clothing, common areas, etc. were all cleaned with bleach. "We started on the far side of the room at the ceiling and worked our way down..." He presented a calendar of which rooms were cleaned and the order they were cleaned. He stated, "We started on November 19th and had them all done by the 21st...We did the same thing in the same order a week later stating on November 26...we wiped down the chairs and cleaned the lobby the same way." He stated the residents clothing was bagged, washed, stored for one week. He was asked about any cleaning done in September. He	F 880		

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F 880	Continued From page 50	F 880		

stated, "We cleaned one room like that Room [number]...we cleaned all the common areas too, but we just deep cleaned that one room."

The unit manager was interviewed on 12/12/2018 at approximately 11:30 a.m. She was asked what precautions had been taken in September and November when the treatment for scabies was being done. She stated, "With [name of Resident #78] you really can't isolate her...she is a wanderer...we tried to redirect her...then in November we isolated the whole unit and tried to keep everyone up here."

On 12/12/2018 at approximately 1:45 p.m. the DON and the corporate nurse consultant were asked if there was any additional documentation. Concerns were voiced regarding the number of residents treated on the third floor for scabies and the facility not following the policy to isolate the residents initially involved (Resident #78 and 13). The Corporate nurse consultant stated, "The cases weren't identified until November and we treated and isolated the unit." The corporate nurse consultant was informed that review of the clinical records and facility documentation revealed that at least six cases were treated before the unit was isolated. This did not include the resident that was transferred out to another facility. She stated, "I wasn't aware we had that many."

On 12/12/2018 at approximately 2:00 p.m., the nurse at the local health department was contacted regarding her involvement and conversation with the DON in November. She stated she was the epidemiologist nurse for the area. She stated she remembered speaking with the DON regarding the resident that was

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F 880	Continued From page 51 transferred but she would need to review her notes and call this surveyor back. The infection control tracking manual was reviewed on 12/13/2018 at approximately 8:00 a.m. There was no tracking or documentation in the manual regarding the treatment of possible scabies in the facility or the case that was confirmed by the BIT testing in November. The DON was interviewed and asked about the documentation. She stated, "Yes, it should have been documented and tracked in there...I didn't do it." A form in the infection log titled "...CDC Criteria for Signs/Symptoms of...Scabies" was shown to the DON. The form contained the following: "Scabies Both Criteria 1 and 2 Must be Satisfied 1). A maculopaular and/or itching rash; 2). At least one (1) of the following scabies subcriteria (circle all that apply) a. Physician diagnosis; b. Laboratory Confirmation (scraping or biopsy); c. Epidemiological linkage to a case of scabies with laboratory confirmation." The DON was asked if the facility was suppose to be using the form. She stated, "I don't think so...let me check." She returned and stated, "Yes, we should have used that." A meeting was held with the DON, the administrator and the corporate nurse consultant on 12/13/2018 at approximately 10:00 a.m. The above information was discussed and the facility staff was notified that possible harm had been identified. The facility staff was asked to present any additionally documentation that may be available. The DON came to the conference room at	F 880		

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F 880	Continued From page 52 approximately 12:30 and stated, "We don't have anything additional to give you." No further information was obtained prior to the exit conference on 12/13/2018. After exit from the facility a call was received from the nurse at the health department. She stated, "I am sorry I am just getting back to you... I needed to review my notes...I am the epidemiologist for the area and I've never had a state surveyor call me before...this is what I remember and have in my notes...I spoke with the DON on 11/14/2018 regarding the resident who transferred out...I asked her if there had been any cases of scabies there or residents with rashes...She told me they had not had a problem at the facility. I asked her to keep in touch with me and to let me know if there were any residents with rashes and if there were any positive cases, since it take someone who has never been infected before up to six weeks to get a rash and exhibit symptoms." The nurse was asked if they had been notified of a positive BIT test at the facility with resulting treatment of the unit. She stated, "No, no one let me know they had a positive case...we like to be involved when something like that occurs, especially on a dementia unit...we may or may not have recommended the whole unit be treated...I wish she had contacted me...I actually have it on my calendar to contact her six weeks from when we first talked to see if she had any more problems." No further information was obtained.	F 880		