STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495107	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY FOREST HEALTH AND REHABILITATION CENTER	450 PINEY FOREST RD DANVILLE, VA 24540

(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 02/05/19 through 02/07/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Three complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Standard Survey and State Licensure survey were conducted 02/05/19 through 02/07/19. Three complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 113 at the time of the survey. The survey sample consisted of 31 current Resident reviews and 6 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		3/18/19

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

Electronically Signed | 02/22/2019

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 578	Continued From page 1 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to accurately complete a DDNR (durable do not resuscitate) form for 1 of 31 Residents, Residents #111. The findings included: The facility failed to complete sections 1 and 2 of the Residents DDNR.	F 578	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following	

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F 578	Continued From page 2 Per the clinical record review, Resident #111 had been admitted to the facility on 07/15/15 and readmitted on 11/09/18. Diagnoses included, but were not limited to, sepsis, diabetes, hypertension, anemia, and hypothyroidism. The Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/16/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The Residents EHR (electronic health record) included a DDNR order form from the Virginia Department of Health. This form was dated 01/10/19 and read in part. Under section 1 "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision... 2. The patient is INCAPABLE of making an informed decision..." Neither box had been checked. Section 2 read, "If you checked 2 above, check A, B, or C below..." All three boxes had been left blank. The Residents EHR included a physicians order for a DNR. This order was dated 01/11/19. The Resident expired at the facility on 01/17/19. The administrative staff were made aware of the issue with the Residents DDNR on 02/06/19 at 3:31 p.m.	F 578	plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F 578 1. Resident # 111 is no longer in the facility. 2. Current residents were audited to assure that DDNR forms are in place as needed and form is complete with all boxes marked to indicate resident wishes, 3. Staff were educated on the DDNR form and making sure that all boxes are complete and signed appropriately by the Staff Development Coordinator by March 15. 4. New admissions will be monitored at the time of admission for completeness of the DDNR form and placed in DDNR form book 5. Any non- compliance will be reported to the QA committee for tracking and trending and progressive disciplinary action as needed. 6. DATE: March 18, 2019	

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F 578	Continued From page 3 No further information regarding the incomplete DDNR was provided to the survey team prior to the exit conference.	F 578		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, the	F 625	F625 1. Residents #113, #3, #26, # 91 and #	3/18/19

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F 625	Continued From page 4 facility staff failed to provide a written notice of bed hold to 5 of 31 Residents, Resident's #113, #3, #26, #91, and #93. The findings included: 1. For Resident #113, the facility failed to provide a written notice of bed hold prior to the Residents hospitalization. The clinical record review revealed that Resident #113 had been admitted to the facility on 05/09/16. Diagnoses included, but were not limited to, diabetes, acute respiratory failure, dysphagia, benign prostatic hyperplasia, gastro-esophageal reflux disease, and hypertension. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/08/18 included a BIMS (brief interview for mental status) summary score of 11 out of a possible 15 points. Resident #113 was discharged to a local hospital on 01/06/18. During the record review, the surveyor was unable to locate any information indicating the Resident or the Residents responsible party had been offered a written bed hold. On 02/07/19 at 9:43 a.m., admissions person #1 reviewed the regulation with the surveyor. After reading the regulation admissions person #1 stated they did not have anything in writing that they had offered Resident #113 a bed hold. On 02/07/19 at 11:17 a.m., the admissions	F 625	93 were addressed at the time of survey. 2. Current residents that have potential to be transferred out of the facility are at risk for needing bed hold agreement. 3. Licensed staff, Discharge Planner and Admission Director and Coordinator received in-service education regarding sending and documenting that the bed hold policy was reviewed and offered to residents at the time of the discharge by the Staff Development Coordinator by March 15. 4. Current residents that are sent out to Emergency Department will have documentation reviewed by the Unit Manager/ Designee at least 5 times per week for 3 weeks, then one time per week for 2 weeks then monthly for one month. 5. Any non- compliance will be reported to the QA committee for tracking and trending and progressive disciplinary action as needed. 6. DATE March 18, 2019.	

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F 625	Continued From page 5 director verbalized to the surveyor that they had spoken with the Residents granddaughter regarding a bed hold but they did not have anything in writing. The facility policy/procedure titled "BED RESERVED POLICY" read in part, "The Health & Rehabilitation Center charges the prevailing room rate for any bed reservation arrangement whenever a resident in not in the Health & Rehabilitation Center for the day or when reserving a bed for in-house transfer...the resident and/or the responsible representative...must pay to hold the bed if the resident wishes to ensure that he/she can return to the bed he/she has been occupying...To make arrangements the resident and/or responsible representative must (1) promptly complete and sign a formal "Voluntary Bed Retention Agreement"..." The DON (director of nursing) and the nurse consultant were notified of the issue regarding the Residents bed hold on 02/07/19 at 10:47 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference. THIS IS A COMPLAINT DEFICIENCY 2. For Resident #3 the facility staff failed to offer a bed hold when Resident was transferred to hospital. Resident #3 was admitted to the facility on 03/27/17 and readmitted on 10/19/18. Diagnoses included but not limited to hypertension, peripheral vascular disease, hyperlipidemia, dementia, seizure disorder, depression, asthma,	F 625		

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F 625	Continued From page 6 sepsis, atrial fibrillation, dysphagia, and gastroesophageal reflux disorder. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/02/19 coded the Resident as 12 of 15 in section C, cognitive status. This is a quarterly MDS. Resident #3'a clinical record was reviewed 02/06/19. It contained a notice of transfer/discharge, which indicated the Resident was transferred to the hospital on 10/15/18. The surveyor could not locate information that indicated a bed hold had been offered to the Resident. Surveyor informed the DON (director of nursing) on 02/07/18 at approximately 0745 that information regarding the offering of a bed hold could not be located. The concern of the facility not offering a bed hold was discussed with the administrative team during a meeting on 02/06/19 at approximately 1500. No further information provided prior to exit. 3. For Resident #26 the facility failed to offer a bed hold when Resident was transferred to the hospital. Resident #26 was admitted to the facility on 04/08/16 and readmitted on 11/21/18. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, hepatitis, diabetes mellitus, hyperlipidemia, dementia, depression, and asthma.	F 625		

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F 625	Continued From page 7 The most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/30/18 coded the Resident as 15 of 15 in section C, cognitive status. This is a quarterly MDS. Resident #26's clinical record was reviewed on 02/06/19. It contained a notice of transfer/discharge, which indicated the Resident was transferred to the hospital on 11/20/19. The surveyor was unable to locate information that indicated a bed hold had been offered to the Resident. Surveyor informed the DON (director of nursing) on 02/07/18 at approximately 0745 that information regarding the offering of a bed hold could not be located. The concern of the facility not offering a bed hold was discussed with the administrative team during a meeting on 02/06/19 at approximately 1500. No further information provided prior to exit. 4. For Resident #91 the facility staff failed to offer a bed hold when Resident was transferred to the hospital. Resident #91 was admitted to the facility on 10/03/14 and readmitted on 10/18/18. Diagnoses included but not limited to hyperlipidemia, dementia, anxiety, depression and psychotic disorder. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 01/21/19 coded the Resident as 2 of 15 in section C, cognitive patterns. This is a quarterly MDS.	F 625		

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F 625	Continued From page 8	F 625		

Resident #91's clinical record was reviewed on 02/06/19. It contained a notice of transfer/discharge, which indicated the Resident was transferred to the hospital on 10/06/18. The surveyor was unable to locate information that indicated a bed hold had been offered to the Resident.

Surveyor informed the DON (director of nursing) on 02/07/18 at approximately 0745 that information regarding the offering of a bed hold could not be located.

The concern of the facility not offering a bed hold was discussed with the administrative team during a meeting on 02/06/19 at approximately 1500.

No further information provided prior to exit.

5. For Resident #93 the facility staff failed to offer a bed hold when Resident was transferred to the hospital.

Resident #93 was admitted to the facility on 11/17/18 and readmitted on 11/25/18. Diagnoses included but not limited to atrial fibrillation, coronary artery disease, deep venous thrombosis, hypertension, septicemia, urinary tract infection, diabetes mellitus, Alzheimer's disease, seizure disorder, and dysphagia.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/01/18 coded the Resident as having both long and short term memory loss with severely impaired cognitive skills for daily decision making. This is an admission MDS.

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F 625	Continued From page 9 Resident #93's clinical record was reviewed on 02/06/19. It contained a notice of transfer/discharge, which indicated the Resident was transferred to the hospital on 11/20/18. The surveyor was unable to locate information that indicated a bed hold had been offered to the Resident. Surveyor informed the DON (director of nursing) on 02/07/18 at approximately 0745 that information regarding the offering of a bed hold could not be located. The concern of the facility not offering a bed hold was discussed with the administrative team during a meeting on 02/06/19 at approximately 1500. No further information provided prior to exit.	F 625		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and Resident interview, the facility staff failed to provide palatable and attractive food for 1 of 31 Residents in the survey sample, Resident # 19.	F 804	F804 1. The facility failed to provide palatable and attractive food for resident #19. On 2/06/19, the facility served resident #19	3/18/19

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F 804	Continued From page 10 The findings included The facility staff failed to serve Resident # 19 sausage that was attractive and palatable. Resident # 19 was an 85-year-old-feamale who was originally admitted to the facility on 9/25/09, with a readmission date of 1/24/18. Diagnoses included but were not limited to, heart failure, peripheral vascular disease, hypertension, and anemia. The clinical record for Resident # 19 was reviewed on 2/6/19 at 9:59 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 11/21/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 19 had a BIMS (brief interview for mental status) score of 11 out of 15, which indicated that Resident # 19's cognitive status was moderately impaired. The plan of care for Resident # 19 was reviewed and revised on 2/5/19. The facility staff documented a focus area for Resident # 19 as "Nutrition Risk r/t (related to) slow healing venous wounds. There is significant 10% 180 day weight loss related to diuretic use. Diet is Regular with Regular Textures. BMI (body mass index) = 26.1." Interventions included but were not limited to, "Provide, serve diet as ordered. Monitor intake and record q (every) meal." Resident # 19 had current orders that were initiated by the physician on 1/24/18. Orders included but were not limited to, "Regular diet	F 804	sausage on the breakfast tray that was hard and crumbly. Nursing notified the dining services manager at the time of observation and the resident was offered another piece of sausage which was declined. 2. The Dining Services Manager in-serviced/reeducated dietary staff on the requirement regarding proper procedures for preparing meals by the most acceptable and appealing methods to ensure quality and palatability. 3. A tray service evaluation will be completed by the Corporate Registered Dietician or designee weekly x 4 weeks, twice-monthly x 4 weeks, and monthly X 1 to ensure compliance with corrective actions, food preparation and quality control standards. Any deficient practice identified through the tray service evaluation will result in reeducation or disciplinary action as indicated. All new hires will receive in-service education by Dietary Services Manager on proper procedures for preparing foods to ensure quality and palatability. 4. Findings from the tray service evaluation will be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed. 5. Any non- compliance will be reported to the QA committee for tracking and trending and progressive disciplinary action as needed. 6. Completion date March 18, 2019.	

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F 804	Continued From page 11 Level 7 Regular texture, Regular Liquids consistency, for Nutrition." On 2/06/19 at 8:51 am, the surveyor was in the room with Resident # 19 conducting a Resident interview. The surveyor observed that Resident # 19 had French toast, sausage, grits, cranberry juice, and chocolate milk on her tray. The surveyor asked Resident # 19 how she liked the food in the facility. Resident # 19 stated, "The food ain't right here." "It ain't fit for a dog to eat." The surveyor observed Resident # 19 as she picked up her sausage and broke it. The sausage was hard and crumbly. Resident # 19 stated, "I live off of crackers, grits, and juice." On 2/06/19 at 9:07 am, CNA # 1 (certified nursing assistant) came into the room to pick up Resident # 19's tray. The surveyor asked CNA # 1 to look at Resident # 19's sausage. Resident # 19 picked up the sausage again and broke it in the presence of CNA # 1. The surveyor and CNA # 1 observed that Resident # 19's sausage was hard and crumbly. CNA # 1 stated there was another resident whose sausage was like that. CNA # 1 stated that she would let the dietary manager know. On 2/6/19 at 3:30 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 2/7/19.	F 804		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		3/18/19

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F 842	Continued From page 12 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

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F 842	Continued From page 13 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate clinical record for 1 of Residents 31, Resident #91. The findings included: For Resident #91 the facility staff failed to ensure a complete and accurate clinical record. Resident #91 was admitted to the facility on 10/03/14 and readmitted on 10/18/18. Diagnoses included but not limited to hyperlipidemia,	F 842	F 842 1. Resident□s route of taking medication was clarified at the time of the survey. 2. Current resident with tube feeding orders were audited to assure that all medication routes were written as to the correct way they take medications. 3. Licensed staff were in serviced on following MD orders for the correct medication routes by the Staff Development Coordinator by March 15. 4. Any new tube feeder□s medication orders will be checked by the unit	

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F 842	Continued From page 14 dementia, anxiety, depression and psychotic disorder. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 01/21/19 coded the Resident as 2 of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #91's clinical record was reviewed on 02/06/19. It contained a POS (physician's order summary) for the month of February which read in part "Xanax 0.25 mg (Alprazolam) Give 0.25 mg by mouth two times a days related to anxiety disorder, unspecified". Resident #91's MAR (medication administration record) for the months of January and February 2019 were reviewed and contained an entry, which read in part "Xanax Tablet 0.25.mg by mouth two times a day related to anxiety disorder, unspecified. Order date: 01/01/19". The Resident's clinical record also contained a physician's order dated 01/21/19, which read in part "Alprazolam 0.25.tablet (generic for Xanax) take 1 tab via PEG (percutaneous endoscopic gastrostomy tube) twice daily". Surveyor spoke with LPN (licensed practical nurse) #1 on 02/06/19 at approximately 1030 regarding Resident #91. Surveyor asked LPN #1 how Resident receives her medications and LPN #1 stated that all meds are given by PEG. LPN #1 also stated that some orders might read by mouth, "Because she used to get her meds by mouth". The concern of the inaccurate record was discussed with the administrative team during a meeting on 02/06/19 at approximately 1500.	F 842	managers in a timely manner within 24 hours of the admission to assure that all orders are entered correctly. Unit Manager/Designee will do medication pass observations 2 times per week for 3 weeks then, one time per week for 3 weeks then random audit one time a month for 3 months. 5. Any non- compliance will be reported to the QA committee for tracking and trending and progressive disciplinary action as needed. 6. DATE March 18, 2019	

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F 842	Continued From page 15 No further information provided prior to exit.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		3/18/19

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F 880	Continued From page 16 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview it was determined the facility staff failed to follow the facility's infection control policy for 1 of 31 residents (Resident #77) and staff failed to ensure an effective infection control program for 1 of 2 units (south wing). Findings:	F 880	F880 1. Resident□s isolation precautions were discontinued at the time of survey. The nurse that did not do hand hygiene was in-serviced as to procedure on hand washing. 2. Current residents that have isolation precautions were audited to assure that all	

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F 880	Continued From page 17 1. The facility staff failed to follow the facility's infection control policy for Resident #77. Resident #77's clinical record was reviewed on 2/5/19 at 3:00 PM. Resident #77 was admitted to the facility on 1/3/19. His admission diagnoses included hypertension, peripheral vascular disease, diabetes, hemiplegia and anxiety. The latest MDS (minimum data set) dated 1/16/19 coded the resident with slightly diminished cognitive ability. The resident required staff assistance for all the ADLs (activities of daily living) with oversite only to eat. Resident #77's CCP (comprehensive care plan) did not address infection control. On 1/26/19 Resident #77's physician ordered Macrobid 100 mg to be provided two times a day. This medication was to treat an ESBL (Extended Spectrum Beta-Lactamase) infection in the resident's urine. The physician also ordered contact precautions for ESBL and infection control. On 1/26/19 at 2:42 PM the nursing staff documented the receipt of a new order to start the antibiotic, Macrobid, and the implementation of contact precautions. A review of the MARs (medication administration records) indicated the Medication was provided per the physician's orders between 1/26/19 and 2/2/19. On 2/5/19 at 11:56 AM the resident was observed to have a caddy on the side of his door. The caddy contained gloves, gowns and masks.	F 880	signs are in place. 3. Licensed staff were in-serviced by the staff development coordinator on having signs in place for isolation precautions and also on proper hand hygiene by March 15. 4. SDC will monitor on rounds at least 5 times per week that isolation signs are in place, Unit Manager/Designee will do medication pass observations 2 times per week for 3 weeks then, one time per week for 3 weeks then random audit one time a month for 3 months. 5. Any non- compliance will be reported to the QAA committee for tracking and trending and progressive disciplinary action as needed 6. DATE March 18, 2019	

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F 880	Continued From page 18 There was no signage observed to indicate the purpose of the PPE (personal protective equipment) contained in the door caddy. CNA I was asked the purpose of the infection control supplies on the door. The CNA said Resident #77 had ESBL in his urine and the staff were using gowns and gloves with both residents while providing care. On 2/6/19 at 3:30 PM the administrator, DON and CCN (corporate consultant nurse) were informed of the lack of signage. The DON said it was their policy to put a sign on the door when infection control precautions were implemented on a resident. The surveyor requested and received a copy of the facility's infection control policy. The policy for TBPs (transmission based precautions--general practice) was effective on 12/26/17. It included the following as one of many steps to implement one the type of TBPs to be used is identified,"a sign will be posted according to policy....." No additional info was received prior to the survey team exit. 2. The facility nursing staff failed to complete hand hygiene during a medication administration observation on 1 of 2 units (south wing). On 02/06/19 beginning at approximately 8:17a.m the surveyor observed LPN (licensed practical nurse) #1 preparing medications for administration. During this time surveyor did not observe LPN#1 wash hands or use hand sanitizer prior to preparing medications. After preparing the medications LPN #1 entered unsampled Resident #117's room and administered unsampled	F 880		

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F 880	Continued From page 19 Resident #117's medications. LPN #1 exited unsampled Resident #117's room without washing hands or using hand sanitizer. LPN #1 proceeded to set up medications for the next Resident (unsampled Resident #115) without washing hands, using hand sanitizer or donning gloves. After preparing the medications LPN #1 entered unsampled Resident #115's room and administered unsampled Resident #115's medications. LPN #1 exited unsampled Resident #115's room without washing hands or using hand sanitizer. The administrative team was notified of the above issue regarding hand hygiene during an end of day meeting on 02/06/19 at 3:00 p.m. On 02/06/19 at approximately 4:00 p.m. the surveyor interviewed the designated infection control nurse. The infection control nurse verbalized to the surveyor that this was not facility practice and education was being implemented on every shift regarding hand hygiene. The facility policy/procedure titled "Hand washing Requirements" read in part under the section titled procedure "1.) Hand hygiene can consist of handwashing with soap and water or use of an alcohol based hand rub (ABHR). ABHR should be used instead of soap and water in all clinical situations except when hands are visibly soiled ...".The section titled "A. Hand Hygiene" read in part "1. The following is a list of some situations that require hand hygiene: (b.) ...before and after direct patient contact (for which hand hygiene is indicated by acceptable professional practice)". No further information regarding this issue was provided to the survey team prior to the exit	F 880		

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F 880	Continued From page 20 conference on 02/07/19.	F 880		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to maintain an effective pest control program. The findings included Roaches were observed on and around the dishwasher in the facility kitchen. On 2/05/19 at 11:35 am, the surveyor was conducting an initial tour of the facility kitchen. During the initial kitchen tour, the surveyor observed a small live roach crawling on the dishwasher. The surveyor looked underneath of the dishwasher and observed dead roaches on the dishwasher, on the wall behind the dishwasher, on the floor, and on the sanitizer barrels beneath the dishwasher. The surveyor also observed several live roaches crawling on the wall behind the dishwasher, crawling up the tubes that connected the sanitizer to the dishwasher, and on the floor underneath the dishwasher. The dietary services manager was present during the observation. The surveyor asked the dietary services manager if the facility had issues with roaches. The dietary services manager stated that she was not aware of any issues with roaches.	F 925	F925 1. The facility failed to maintain to maintain an effective pest control program.On 02/05/19, roaches were observed underneath the dishwasher, on the dishwasher, on the wall behind the dishwasher, on the floor and on the sanitizer barrels under the dishwasher during the initial kitchen tour. The facility pest control agency was notified and treated/sprayed the facility on 02/05/19. 2. All Dining Services employees were in-serviced/reeducated by the dining services manager regarding proper procedures for cleaning and sanitizing the dish machine and surrounding area. All Dining Services employees were in-serviced/reeducated by the maintenance director regarding the proper procedures for reporting pest sightings, pest control and management. 3. A sanitation inspection will be conducted by Corporate Registered Dietician or designee weekly x 4 weeks, twice-monthly x 4 weeks, and monthly X 1 to ensure compliance with corrective actions, sanitation standards and pest control procedures. Any deficient practice identified through the sanitation	3/18/19

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F 925	Continued From page 21 On 2/5/19 at 11:49 am, the surveyor and the maintenance director observed the roaches in the areas as stated above. The maintenance director informed the surveyor that the pest control company comes monthly and sprays for roaches. On 2/5/19 at 3:00 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 2/7/19.	F 925	inspections will result in reeducation or disciplinary action as indicated. All new hires will receive in-service education by Dietary Services Manager on proper procedures for cleaning, sanitizing and procedures for pest control and management. 4. Findings from sanitation inspections will be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed. 5. Person responsible for Implementing: Susan Anderson, Dietary Manager. 6. Completion date March 18, 2019	