STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	R-C 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS HEALTH CARE C	831 ELLERSLIE AVE COLONIAL HEIGHTS, VA 23834

(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	{E 000}		
{F 000}	. INITIAL COMMENTS An unannounced Medicare/Medicaid First Revisit, to the survey conducted 07/17/2018 through 07/23/2018, was conducted on 4/10/19 through 04/11/19. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated. The census in this 196 certified bed facility was 147 at the time of the survey. The survey sample consisted of 11 resident reviews.	{F 000}		
{F 658} SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review the facility staff failed to follow professional standards of care for two residents (Resident #101 and Resident #108) in a survey sample of 11 residents. 1. For Resident #101, the facility staff failed to document the site of insulin administration on seven occasions from 4/6/19-4/9/19. 2. For Resident #108, the facility staff failed to clarify an order for thickened liquids.	{F 658}	Corrective Action for those residents found to be affected by the alleged deficient practice. Medication error report forms were completed for resident #101 with no adverse events. Physician order sheet and physician order updated to reflect current thickened liquid status for resident #108. Corrective Actions taken for residents with potential to be affected by alleged	4/25/19

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

Electronically Signed | 04/22/2019

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{F 658}	Continued From page 1 The findings included: 1. For Resident #101, the facility staff failed to document the location on the body where the insulin was injected, of administration on seven occasions from 4/1/19-4/9/19. Resident #101 was initially admitted to the facility on 12/16/16 with a recent readmission on 1/14/18. The Resident's diagnoses included but were not limited to: Chronic obstructive pulmonary disease, phantom limb syndrome with pain, diabetes mellitus, conversion disorder with seizures or convulsions, anxiety disorder, major depressive disorder, urinary tract infection, gastro-esophageal reflux disease, pain in right leg, difficulty walking, other symptoms and signs involving the musculoskeletal system, candidiasis, cellulitis of right lower limb, pain in right hip, pain in right knee, pain in right shoulder, hypotension, overactive bladder, pure hypercholesterolemia, anemia insomnia, hypertension, peripheral vascular disease, acquired absence of left leg below knee. Resident #101's most recent MDS with an ARD (assessment reference date) of 3/19/19 was coded as an annual assessment. Resident #101 was coded as having a BIMS (Brief Interview for Memory Status) score of 15, indicating no cognitive impairment. ADL's (activities of daily living), to include transfers, ambulation, dressing, eating, personal hygiene and bathing; were coded as requiring supervision of staff. Review of Resident #101's Medication Administration Record (MAR) for the dates of 4/1/19-4/30/19, revealed that facility staff failed to	{F 658}	deficient practice. Residents who receive insulin and who are on thickened liquids have the potential to be affected. Review completed by the Director of Nurses on residents with insulin orders and who receive thickened liquids with updates made as applicable. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nursing on ensuring injection site is documented and to ensure that accurate thicken liquid status is reflected on both the physician order sheet and the physician order. Monitoring of corrective action to ensure the alleged deficient practice does not recur. Director of Nursing to complete audits on insulin site injections and thickened liquid orders 3x week x 4 weeks and monthly x 2 months. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. Date of compliance-4/25/19	

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{F 658}	Continued From page 2	{F 658}		

document the site of insulin administration on two occasions for 4/6/19, two occasions for 4/7/19, two occasions for 4/8/19 and one occasion for 4/9/19.

An interview was conducted with the Director of Nursing (DON) on 4/10/19, the DON stated that their professional standards of nursing care are based on the Lippincott manual.

The Nursing 2012 Drug Handbook by Lippincott, Williams, and Wilkins gives guidance on the Rights of Medication Administration

1. Right patient
· Check the name on the order and the patient.
· Use 2 identifiers.
· Ask patient to identify himself/herself.
· When available, use technology (for example, bar-code system).

2. Right medication
· Check the medication label.
· Check the order.

3. Right dose
· Check the order.
· Confirm appropriateness of the dose using a current drug reference.
· If necessary, calculate the dose and have another nurse calculate the dose as well.

4. Right route
· Again, check the order and appropriateness of the route ordered.
· Confirm that the patient can take or receive the medication by the ordered route.

5. Right time

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{F 658}	Continued From page 3 · Check the frequency of the ordered medication. · Double-check that you are giving the ordered dose at the correct time. · Confirm when the last dose was given. 6. Right documentation · Document administration AFTER giving the ordered medication. · Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug. 7. Right reason · Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication? · Revisit the reasons for long-term medication use. 8. Right response · Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant? · Be sure to document your monitoring of the patient and any other nursing interventions that are applicable. The Administrator and DON were informed of the failure of staff to document the location on the resident's body where the insulin was injected, to prevent re-injection in the same location, for Resident #102, on 4/11/19 at 10:01am. No further information was provided.	{F 658}		

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{F 658}	Continued From page 4	{F 658}		

2. For Resident #108, the facility staff failed to clarify an order for thickened liquids.

Resident #108 was initially admitted to the facility on 9-29-16. The Resident's diagnoses included but were not limited to: Chronic obstructive pulmonary disease, dysphagia, gastro-esophageal reflux disease, Parkinson's disease, hypertension, anemia, anxiety disorder, asthenia, depression, congestive heart failure, chronic renal failure, and hypokalemia.

Resident #108's most recent MDS coded Resident #108 with a BIMS (Brief Interview for Memory Status) score of 13, indicating no cognitive impairment. ADL's (activities of daily living), to include transfers, ambulation, dressing, eating, personal hygiene and bathing; was coded as requiring extensive assistance to fully dependant on staff.

Review of Resident #108's Medication Record and physician's orders for the month of April 2019, documented the following order for "Diets" on the physicians order sheet (POS).

"Diets; Regular, Thin Thickened Liquid, (no straws), Fortified.

An interview was conducted with the Director of Nursing (DON), and Administrator on 4-10-19, at 4:00 p.m. They stated that their professional standards of nursing practice are derived from the Lippincott manual. It is a standard of practice, to clarify any order that leaves room for interpretation, and is unclear. The DON stated this order "is confusing and wrong, we will fix it

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{F 658}	Continued From page 5	{F 658}		

immediately." The DON went on to say that the family wished to give the Resident thin liquids even though it is a danger to her in regard to aspiration. The DON stated that the doctor's order was intended to be nectar thick liquids. No viscosity of liquid was specified on the physician's order sheet (POS), and on 4-10-19 at 5:45 p.m., the DON obtained a clarification order which allowed staff to administer thin liquids. The new order was presented to surveyors at 9:00 a.m. on 4-11-19.

The Nursing 2012 Drug Handbook by Lippincott, Williams, and Wilkins gives guidance on the Rights of Medication Administration

1. Right patient
· Check the name on the order and the patient.
· Use 2 identifiers.
· Ask patient to identify himself/herself.
· When available, use technology (for example, bar-code system).

2. Right medication
· Check the medication label.
· Check the order.

3. Right dose
· Check the order.
· Confirm appropriateness of the dose using a current drug reference.
· If necessary, calculate the dose and have another nurse calculate the dose as well.

4. Right route
· Again, check the order and appropriateness of the route ordered.
· Confirm that the patient can take or receive the medication by the ordered route.

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{F 658}	Continued From page 6	{F 658}		

5. Right time
· Check the frequency of the ordered medication.
· Double-check that you are giving the ordered dose at the correct time.
· Confirm when the last dose was given.

6. Right documentation
· Document administration AFTER giving the ordered medication.
· Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug.

7. Right reason
· Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication?
· Revisit the reasons for long-term medication use.

8. Right response
· Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant?
· Be sure to document your monitoring of the patient and any other nursing interventions that are applicable.

The Administrator and Director of Nursing were informed of the failure of staff to clarify an ambiguous order which allowed for 2 viscosities of drinking liquids (thin/thickened) for Resident #108, on 4-11-19 at 10:00 am. No further information was presented by the facility.

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{F 758} SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	{F 758}		4/25/19

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{F 758}	Continued From page 8 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure prn (as needed) psychotropic medication orders are limited to 14 days for one resident (Resident #102) in a survey sample of 11 residents. For Resident #102, the facility staff failed to ensure a prn order for a psychotropic medication was limited to 14 days, and the physician failed to document the rational and duration for the order. The findings included: Resident #102 was initially admitted to the facility on 2/25/17 and had a readmission to the facility on 5/26/17. The resident's diagnoses included, but were not limited to: epileptic seizures, unspecified dementia, pain in left knee, repeated falls, and bipolar. Resident #102's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 3/7/19 was coded as a significant change assessment. Resident #102 was coded in ADL's (activities of daily living) to include: transfers, dressing, eating, personal hygiene, bathing and toileting were coded as the	{F 758}	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #102 medication order was updated to reflect the 14 day duration. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents on PRN psychotropic medications have the potential to be affected. Review completed by the Director of Nurses on residents on PRN psychotropic medications and assessed as necessary. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nursing leadership on ensuring that residents PRN psychotropic are evaluated according to policy and procedure for 14 day physician follow-up.	

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{F 758}	Continued From page 9 resident required extensive assistance of one staff member. Review of Resident #102's physician order sheet for April 1-30, 2019, revealed that the physician signed it on 4/4/19. On the sheet was an order for "Lorazepam 1 mg, one tab po (my mouth) q (every) 4 hours prn (as needed) for anxiety, with no end date noted. Review of Resident #102's Medication Administration Record (MAR) dated April 1-30, 2019, revealed an order for "Lorazepam 1mg, one tab po (by mouth) q (every) 4 hours prn (as needed). dx: (diagnosis) anxiety." Resident #102's Physician Progress Note dated 4/2/19, read "anxiety: stable/controlled, continue Ativan PRN." The physician failed to document his/her rationale in the resident's medical record and indicate the duration for the PRN order. Review of the "Target Behavioral Symptoms" form, the facility was monitoring to determine the need for administration of the Ativan; (Lorazepam is the generic name); was "irritability." No description was given as to how this "irritability" was manifested by the resident or how it should be assessed by staff. Review of Resident #102's careplan with a revision date of 3/20/19 read: "at risk for adverse effects related to use of antianxiety medication." The careplan goal read: "will show no side effects of medication use" and "will show improvement in mood/behavior." No non-pharmacologic interventions were in the careplan.	{F 758}	Monitoring of corrective action to ensure the alleged deficient practice does not recur. Director of Nursing completed audits on PRN psychotropic medications for 14 day physician follow-up weekly x 4 weeks and monthly x 2 months. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. Date of compliance-4/25/19	

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{F 758}	Continued From page 10	{F 758}		

Review of the facility policy titled: "Psychopharmacologic Medication Policy" with an effective date of 10/1/12 and a revision date of 9/6/18, read: "Diagnoses alone do not warrant the use of antipsychotic medication. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met:
*the behavioral symptoms present a danger to the resident or others ; AND:
* the symptoms are identified as being due to mania or psychosis (such as auditory, ,visual, or other hallucinations; delusions, paranoia, or grandiosity); or
* behavioral interventions have been attempted and included in the plan of care, except in an emergency"

The policy also stated: "the need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order."

Review of the facility policy titled "Medication Orders" version 2.0 (H5MAPR0183), read: "PRN Medication Orders- when recording PRN medication orders, specify the type, route, dosage, frequency, strength and the reason for administration."

An interview with the DON was conducted on 4/11/19 at 9:44am. When the DON was asked about Resident #102's lorazepam order she stated; "that should not be for anxiety, he has uncontrolled seizures. I understand what the guidelines say, it has to have a stop date." When the DON was shown the "Target Behavioral Symptoms" form, which indicated, that they were

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{F 758}	Continued From page 11 monitoring for "irritability" to determine if the medication needed to be administered. The DON was asked, if Resident #102 gets irritable and staff are to medicate, what does "irritable" look like. The DON then stated "that is what the document says." The Administrator and Director of Nursing were made aware of the findings on 4/11/19 at 10:01am. No further information was provided.	{F 758}		
{F 760} SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review the facility staff failed to document administration of medication for one resident (Resident #101) in a survey sample of 11 residents. For Resident #101, the facility staff failed to administer insulin on two occasions. The findings included: Resident #101 was initially admitted to the facility on 12/16/16 with a recent readmission on 1/14/18. The Resident's diagnoses included but were not limited to: Chronic obstructive pulmonary disease, phantom limb syndrome with pain, diabetes mellitus, conversion disorder with seizures or convulsions, anxiety disorder, major	{F 760}	F760-D Corrective Action for those residents found to be affected by the alleged deficient practice. Medication error report forms were completed for resident #101 with no adverse events. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Residents admitting into the facility have the potential to be affected. Review completed by the Director of Nurses on residents who use insulin for proper administration and documentation and addressed as applicable.	4/25/19

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{F 760}	Continued From page 12 depressive disorder, urinary tract infection, gastro-esophageal reflux disease, pain in right leg, difficulty walking, other symptoms and signs involving the musculoskeletal system, candidiasis, cellulitis of right lower limb, pain in right hip, pain in right knee, pain in right shoulder, hypotension, overactive bladder, pure hypercholesterolemia, anemia insomnia, hypertension, peripheral vascular disease, acquired absence of left leg below knee. Resident #101's most recent MDS with an ARD (assessment reference date) of 3/19/19 was coded as an annual assessment. Resident #101 was coded as having a BIMS (Brief Interview for Memory Status) score of 15, indicating no cognitive impairment. ADL's (activities of daily living), to include transfers, ambulation, dressing, eating, personal hygiene and bathing; was coded as requiring supervision. On 4/11/19 during review of Resident #101's Medication Administration Record, (MAR) facility staff failed to document that the resident had been administered the scheduled dose of insulin at 4:30pm on 4/8/19 and 4/9/19, as ordered by the physician. The DON was unable to state if the medication was administered and not documented, or simply not administered. The Administrator and Director of Nursing were informed of the failure of staff to document the administration of insulin for Resident #101, on 4/11/19 at 10:01am. No further information was provided.	{F 760}	Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nurses on following physician orders for insulin orders and sliding scales. Monitoring of corrective action to ensure the alleged deficient practice does not recur. Director of Nursing will complete audits on resident diabetic flow sheets and progress notes to identify missed administrations 3x week x 4 weeks and monthly x 2 months. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. Date of compliance-4/25/19	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		4/25/19

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F 761	Continued From page 13 §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 documentation review, the facility staff failed to lock and secure two medication carts on one of three nursing units. 1. The facility staff failed to secure medications, in a locked compartment, on unit 1 nursing station medication and ensure only authorized personnel have access. 2. LPN A failed to lock and secure her assigned	F 761	Corrective Action for those residents found to be affected by the alleged deficient practice. Immediate education completed by the DON to LPN A on ensuring that the medication cart is locked if not in use at all times. Corrective Actions taken for residents with potential to be affected by alleged	

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F 761	Continued From page 14 hall medication cart, on unit 1, during the course of medication administration. The findings included: 1. The facility staff failed to secure medications, in a locked compartment, on unit 1 nursing station medication and ensure only authorized personnel have access. On 4/10/19 at 10:58am a medication cart at the 100 wing nursing station was observed to be unlocked. The cart was approximately 4 feet tall, 2 feet deep and 3 feet wide, with multiple drawers that held blister packs of 30 days worth of medication in each blister pack. Blister packs were filed by dividers for each of 30 residents residing on a hallway. Observation of the cart revealed hundreds of medications, insulin syringes, alcohol prep pads, and other supplies such as bandages in the cart and accessible to anyone walking by. During observation of the unsecured cart 13 residents, 14 visitors and 21 staff were observed to walk by the cart. The cart was unsecured from 10:58am until 11:41am. At 11:41am the QA (Quality Assurance) nurse, LPN B was asked to observe if she saw anything wrong. Once the medication cart was pointed out to her, she stated, "it is not locked." She acknowledged that they do have "confused residents" that could have accessed the cart. She stated, "LPN A is assigned to the cart and the only person that has the key." RN A, a Supervisor, approached the cart and stated she had observed the surveyor at the desk for an extended period of time and "I can't believe I didn't notice it, I've come up here several times."	F 761	deficient practice. Review completed by the Director of Nurses on medication carts to ensure that all carts were locked as appropriate. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nurses on ensuring that medication carts are locked when they step away from the cart immediately. Monitoring of corrective action to ensure the alleged deficient practice does not recur. Director of Nursing will complete audits on each unit medication carts 3x week x 4 weeks and monthly x 2 months. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. Date of compliance-4/25/19	

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F 761	Continued From page 15	F 761		

Review of the facility policy titled, "Storage of Medications", version date 1.1(H5MAPL0851), read, "compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others."

The Administrator and Director of Nursing were informed of the failure of the staff to ensure medications are secured, in a locked compartment, and ensure only authorized personnel have access on 4/11/19 at 10:01am.

No further information was provided.

2. LPN A failed to lock and secure her assigned medication cart during the course of medication administration.

On 04/10/2019 at approximately 11:05 AM, while performing the Medication Administration Task, LPN A was observed leaving her medication cart unlocked and unsecured in the common hallway on Unit 1, between Rooms 102 and 104, and entered Room 102 to administer medications to Resident #103. When asked how the medication cart should be left while administering meds, she replied "It should be locked when I am away from it".

On 04/10/2019 at approximately 11:40 AM, the Unit Manager (RN A) verified that LPN A was the only staff member assigned to medication

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F 761	Continued From page 16	F 761		

administration for the current shift on Unit 1 and was responsible for 2 out of 2 medication carts located on Unit 1.

On 04/10/2019 at approximately 11:45 AM, an unattended medication cart located outside of Room 104 on Unit 1 was observed to be unlocked and unsecured. At 11:50, LPN A was observed exiting from Room 104. She locked the cart and rolled it down the hallway in the direction of the Unit 1 Nursing Station.

On 04/10/2019 a copy of the facility policy regarding medication administration and medication storage was requested and provided by the DON (Director of Nursing, Employee B). Line item #2 of the facility's policy entitled "Medication Administration, General Guidelines for the Administration of Medications" (effective date: January 2015) read, "While administering medications, the nurse ensures that the medication cart is locked any time it is out of his/her direct line of vision". Line item #7 of the facility's policy entitled "Storage of Medications" (revised April 2007) read, "Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others".

On 04/10/2019 at approximately 4:00 PM, the DON (Director of Nursing, Employee B) was interviewed. When asked what was normally kept in the medication carts, she replied "medications, alcohol swabs, glucometer [device used to check blood sugars], insulin syringes [a syringe with a

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F 761	Continued From page 17 pre-attached needle], and a secured sharps container [a container used to dispose of sharp items such as used needles]." When asked about her expectations with respect to securing medication carts as well as the need to secure them, she replied "They should be locked if not right there working at them. They are secured to ensure that nobody can access them that is not authorized or assigned to them". On 04/10/2019 at approximately 5:00 PM, the Administrator (Employee A) and the DON (Director of Nursing, Employee B) were notified of the findings. No further information was received.	F 761		
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	F 880		4/25/19

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F 880	Continued From page 18 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the 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.	F 880		

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F 880	Continued From page 19 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to administer medications in a manner to prevent the spread of infection for 1 resident (Resident #103) in a sample size of 11 residents. For Resident #103, LPN A failed to wash her hands prior to putting on non-sterile gloves in preparation for the administration of his eye drops. The Findings included: Resident #103, an 80 year old male who was admitted to the facility on 04/01/2018 with diagnoses to include but not limited to previous stroke, atrial fibrillation (abnormal heart rhythm), dementia, cataracts, and depression. Resident #103's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/24/2019 was coded as a Quarterly Assessment. Resident #103 was coded with a Brief Interview of Mental Status (BIMS) score of "9" out of possible 15 indicating moderately impaired cognition. On 04/10/2019 at approximately 11:30 AM, LPN A was observed preparing to administer eye drops to Resident #103. She put on her non-sterile gloves but did not wash her hands prior to putting them on. She administered the eye drops and washed her hands after removing her gloves.	F 880	Corrective Action for those residents found to be affected by the alleged deficient practice. Education completed by the DON to the charge nurse on ensuring that hand washing is completed per protocol prior to administering eye drops. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Review completed by the Director of Nurses on residents with eye drops to ensure that nurses are washing their hands prior to, in between, and after administration of eye drops. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nurses on ensuring that hand washing is completed as appropriate during medication administration. Monitoring of corrective action to ensure the alleged deficient practice does not recur.	

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F 880	Continued From page 20 When asked about her handwashing procedures, LPN A stated, "I should have washed my hands prior to putting my gloves on, I usually do but I must have forgot, I'm sorry". On 04/10/2019 a copy of the facility policy regarding handwashing was requested and provided by the DON (Director of Nursing, Employee B). The facility policy entitled "Handwashing/Hand Hygiene" (reviewed 03/04/2019) had a "Policy Statement" that read, "This facility considers hand hygiene the primary means to prevent the spread of infections". The "Handwashing/Hand Hygiene" facility policy also contained a subheading, "Policy Interpretation and Implementation" with line item #2 that read, "All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors" and line item #7 that read, "Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:" (b.) "Before and after direct contact with residents" and (c.) "Before preparing or handling medications". Line item #9 read, "The use of gloves does not replace handwashing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections". The "Handwashing/Hand Hygiene" facility policy also contained a subheading, "Procedure--Applying and Removing Gloves" line item #1 that read, "Perform hand hygiene before applying non-sterile gloves". On 04/10/2019 at approximately 4:00 PM, the DON (Director of Nursing, Employee B) was	F 880	Director of Nursing will complete observation audits on each unit medication carts 3x week x 4 weeks and monthly x 2 months. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. Date of compliance-4/25/19	

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F 880	Continued From page 21 interviewed. When asked about her expectations with respect to handwashing during the administration of medications she stated, "Before and after and in between" and "wash hands before putting on gloves to do eye drops and if there is a glove change, and after taking them off". On 04/10/2019 at approximately 5:00 PM, the Administrator (Employee A) and the DON (Director of Nursing, Employee B) were notified of the findings. No further information was received.	F 880		