STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	R-C 08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 revisit to the standard survey conducted 6/4/19 through 6/7/19 and 6/10/19, was conducted 8/13/19 through 8/14/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. No complaints were investigated during the survey. The census in this 180 certified bed facility was 174 at the time of the survey. The survey sample consisted of 17 current Resident reviews.	{F 000}		
{F 657} SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	{F 657}		8/26/19

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

Electronically Signed | 08/23/2019

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{F 657}	Continued From page 1 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to review and revise the care plan for two of 17 residents in the survey sample, Residents #102 and #107. The findings include: 1. For Resident #102, the facility staff failed to revise the care plan to reflect her skin tear from a fall on 7/27/19. Resident #102 was admitted to the facility on 12/14/18 and readmitted on 5/14/19 with diagnoses that included but were not limited to anemia, heart failure, high blood pressure, and diabetes. Resident #102's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/30/19. Resident #102 was coded as being intact in cognitive function scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #102's nursing notes revealed that she had a fall on 7/27/19. The following nursing note was written: "Resident was found on the floor in front of chair. Resident stated she didn't think she was hurt bad she just felt pain in her right hand. Resident was assisted	{F 657}	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 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. F657 1. Resident #102□s care plan has been reviewed and revised to reflect current needs. Resident #107 discharged from the facility. 2. Residents with skin impairment were reviewed to ensure that their care plans accurately reflected the skin impairment. 3. Charge Nurses were educated on: " Revision of the care plan for skin impairment " Revision of the care plan for resolution of the skin impairment 4. The Unit Managers will review care plan revision on a random weekly basis to	

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{F 657}	Continued From page 2 up and sat in chair. Skin tear noted to right upper arm. Steri Strips applied. On call was called and made aware...Will continue to monitor." Review of Resident #102's fall care plan dated 12/14/18, revealed that her care plan was revised on 7/29/19 with the following intervention: "Pt (physical therapy) to eval (evaluate) as ordered and PRN (as needed)." There was no evidence that Resident #102's care plan reflected her skin tear from the fall. There was no evidence in the clinical record of any monitoring of her skin tear. On 8/14/19 at 10:31 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #102's nurse. When asked who was responsible for updating the care plan, LPN #2 stated that all floor nurses can update the care plans. When asked if she would expect skin alterations such as skin tears be on the care plan, LPN #2 stated that should would revise the care plan after a skin tear. LPN #2 stated that she was the nurse working when Resident #102 fell and obtained the skin tear on 7/27/19. LPN #2 stated that she did not revise the care plan at the time. LPN #2 stated that her skin tear had healed the next day (7/28/19). When asked if she could provide documentation of when the skin tear had healed, LPN #2 stated that she would expect to see a nursing note but that she could not find one on Resident #102. On 8/14/19 at 10:50 a.m., an interview was conducted with LPN #1, the unit manager for the 100 hallway. When asked who was responsible for updating the care plan, LPN #1 stated that all floor nurses can update the care plans. When	{F 657}	ensure that care plans were revised to reflect skin impairment and resolution of skin impairment. 5. Issues noted during the monitoring of care plan revision will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: August 26, 2019	

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{F 657}	Continued From page 3	{F 657}		

asked when the care plan would be updated, LPN #1 stated that they would update the care plan for any new orders, changes in condition, wounds, skin tears, falls etc. When asked if she would expect Resident #102's care plan to reflect her skin tear obtained on 7/27/19, LPN #1 stated that she would. LPN #1 confirmed that her skin tear was not addressed on Resident #102's care plan with revisions.

On 8/14/19 at approximately 11:20 a.m., ASM (administrative staff member) #2, the Director of Nursing and ASM #3, the corporate nurse, were made aware of the above concerns.

Facility policy titled, "Care Planning," documents in part, the following: "Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment."

2. For Resident #107, facility staff failed to revise the care plan when her skin graft site to her left upper arm had healed on 8/12/19.

Resident #107 was admitted to the facility on 7/15/19 with diagnoses that included but were not limited to high blood pressure, oral cancer, and muscle weakness. Resident #107's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 7/29/19. Resident #107 was coded as being intact in cognitive function scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #107's clinical record

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{F 657}	Continued From page 4	{F 657}		

revealed that she was admitted to the facility with a skin graft wound to her left inner arm. The following in part, was documented: "...skin graft site to left forearm with wound care in place."

Review of Resident #107's wound evaluation dated 7/2/19 documented the following: "Type: Surgical...Location: Left Inner forearm."

Review of Resident #107's wound evaluation dated 8/12/19 documented her skin graft site as healed to the left inner arm. Review of Resident #107's August 2019 physician order summary revealed that her order for dressings to the left inner arm was discontinued on 8/13/19.

On 8/14/19 a review of Resident #107's comprehensive care plan dated 7/19/19, was conducted. The following was documented, "The resident has a non-pressure related surgical incision site of the right forearm...The resident will have no complications r/t (related to) surgical site of the right forearm through the next review date...dressing changes to surgical site." Resident #107's care plan was also inaccurate documenting the wrong location of the skin graft site.

On 8/14/19 at 8:49 a.m., an observation was made of Resident #107. She did not have any skin areas to her right inner arm. Resident #107 had a healed area to her left inner forearm from the previous skin graft site.

On 8/14/19 at 10:36 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #5, Resident #107's nurse. When asked the purpose of the care plan, LPN #5 stated that the purpose of the care plan was to serve as a care

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{F 657}	Continued From page 5 guide for the whole interdisciplinary team. When asked if it was important that it was accurate, LPN #5 stated that it was. When asked where Resident #107's surgical site was located, LPN #5 stated that her skin graft site was to her left inner arm and that it had healed on Monday (8/12/19). When asked who was responsible for updating the care plan, LPN #5 stated that any nurse can revise the care plan. When asked if Resident #107's care plan should have been resolved or revised to reflect that her left arm graft site had healed, LPN #5 stated that she should have resolved the care plan. LPN #5 confirmed that Resident #107's care plan was also inaccurate. On 8/14/19 at approximately 11:20 a.m., ASM (administrative staff member) #2, the Director of Nursing and ASM #3, the corporate nurse, were made aware of the above concerns.	{F 657}		
{F 755} SS=D	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.	{F 755}		8/26/19

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{F 755}	Continued From page 6 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §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 the facility's medication storage observation of 4 medication carts and 2 medication rooms, staff interview, and facility documentation review, the facility staff failed to ensure expired medications were not available for use for 2 of 17 residents in the survey sample, Resident #116 and Resident #117. The findings include: 1. Resident #116 was admitted to the facility on 06/18/19 from an acute care facility with diagnoses that included but not limited to Type 2 Diabetes mellitus and hyperlipidemia. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/24/2019 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 99. This indicated Resident #116's as having short term and long term memory problems.	{F 755}	F755 1. The discontinued medication for Resident #117 was removed and properly stored on August 13, 2019. The expired medication for Resident #116 was removed and properly stored on August 13, 2019. 2. The medication rooms and medication carts were reviewed to ensure that discontinued and expired medications were properly stored. 3. Charge Nurses were educated on: " Removal of discontinued or expired medications from medication refrigerators and medication carts " Proper storage of discontinued or expired medications 4. Nursing Administration will monitor storage of medications on a random weekly basis to ensure that discontinued or expired medications are properly	

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{F 755}	Continued From page 7 On 08/13/19 at approximately 1:00 PM an inspection of the medication cart was conducted on Unit 1(Short Hall). Licensed Practical Nurse (LPN) #2 assisted with the cart inspection. Upon inspection of the medication cart, 16 expired pills of Amiodarone 200 mg (a medication used for the treatment of heart arrythmias and atrial fibrillation)with an expiration date of 07/31/19 was observed. LPN #2 was asked what should have been done. She stated that "We normally send expired medications back to the pharmacy." She also said that "we normally check medications and a pharmacist will check periodically." LPN #2 was asked if Resident #116 had received the above medications today and she stated, "Yes." Policy entitled: Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles. Application: LTC Facilities Receiving Pharmacy Products and Services from Pharmacy. Effective Date: 12/01/07.Revision Date: 05/10/10. Applicability: This policy 5.3 sets for the procedures relating to storage and expiration dates of medications, biologicals, syringes and needles. Procedure: 4. Facility should ensure that medications and biologicals that: Have an expired date on the label; are stored separate from other medications until destroyed or returned to the supplier. 2. Resident #117 was admitted to the facility on 11/07/18 from an acute facility with diagnoses that included but not limited to Major Depressive Disorder and Muscle weakness. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/14/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring	{F 755}	stored. 5. Issues noted during the monitoring of storage of discontinued and expired medications will be referred to the Quality Assurance Committee for review and recommendation. 6. Completion date: August 26, 2019	

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{F 755}	Continued From page 8 99. This indicated Resident #117's as having short term and long term memory problems. On 08/13/19 at approximately, 1:20 PM a medication room inspection was conducted on Unit 1 with Licensed Practical Nurse (LPN) #3. Upon inspection of the refrigerator 3 syringes filled with 1ML (milliliter) of Vancomycin with an expiration date of 07/19/19 was observed. LPN #3 was asked what should have been done with the expired medications. She stated, "We should send them back to the pharmacy." The medication was not administered to Resident #117. On 08/14/19 at approximately 3:45 PM a pre-exit interview was conducted with the Director of Nursing (DON) and with the Corporate Nurse Consultant concerning the above issues. The DON was asked what should have been done with the expired medications. She stated, "The medication should have been taken out so that no one could get it."	{F 755}		
{F 812} SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	{F 812}		8/26/19

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{F 812}	Continued From page 9 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that facility staff failed to wear the appropriate hair restraints while in the facility kitchen. The findings include: On 8/13/19 at 10:35 a.m., an observation of the kitchen was conducted. OSM (other staff member) #1, the dietary aid, was observed in the kitchen area without a beard restraint and visible short facial hair. OSM #1 was observed in the dishwashing area. After seeing this writer, OSM #1 then walked from the dishwashing area through the food preparation area and put on a beard restraint. On 8/13/19 at 10:50 a.m., an interview was conducted with OSM #1. When asked if he had put the beard restraint on after he saw this writer, OSM #1 stated that he was just on the floor pulling in carts and it slipped his mind to put on the beard restraint when he walked into the kitchen. OSM #1 stated he knew he was supposed to wear the beard restraint while in the kitchen. On 8/14/19 at approximately 11:20 a.m., ASM (administrative staff member) #2, the Director of Nursing and ASM #3, the corporate nurse, were	{F 812}	F812 1. Hair restraints were available for use by food service staff. 2. Food service staff present on August 14, 2019 were re-educated on use of hair restraints prior to entering food areas. 3. All food service staff were educated on use of hair restraints. 4. Administrative staff will monitor use of hair restraints by food service staff when in food areas. 5. Results of the monitoring will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: August 26, 2019	

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{F 812}	Continued From page 10 made aware of the above concerns. Facility policy titled, "Dining Services Policies and Procedures" documents in part, the following: "All persons in the food preparation and food storage areas shall wear hair restraints such as hair coverings, hair nets, or beard guards where necessary, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens, and unwrapped single -use articles." No further information was presented prior to exit.	{F 812}		
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. (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,	F 842		8/26/19

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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.

§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

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F 842	Continued From page 12 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 observation, staff interview, clinical record review and facility document review, it was determined that facility staff failed to maintain a complete and accurate clinical record for two of 17 residents in the survey sample, Residents #102 and #107. The findings include: 1. For Resident #102, facility staff failed to document any monitoring of her skin tear obtained on 7/27/19; and failed to document when her skin tear had healed. Resident #102 was admitted to the facility on 12/14/18 and readmitted on 5/14/19 with diagnoses that included but were not limited to anemia, heart failure, high blood pressure, and diabetes. Resident #102's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/30/19. Resident #102 was coded as being intact in cognitive function scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #102's nursing notes revealed that she had a fall on 7/27/19. The following nursing note was written: "Resident was found on the floor in front of chair. Resident stated she didn't think she was hurt bad she just felt pain in her right hand. Resident was assisted up and sat in chair. Skin tear noted to right upper arm. Steri Strips applied. On call was called and made aware...Will continue to monitor."	F 842	F842 1. The medical record for Resident #102 has been reviewed and revised to reflect accurate information. Resident #107 discharged from the facility. 2. The medical records for residents with skin impairment were reviewed to ensure that the records accurately reflect the resident. 3. Charge nurses were educated on: " Revision of the care plan to reflect accurate needs of the resident on the plan of care to include monitoring of impairment and correct location 4. Nursing Administration will monitor accuracy of medical records on a random weekly basis to ensure that resident records reflect accurate information. 5. Results of the monitoring will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: August 26, 2019	

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There was no evidence in the clinical record of any monitoring of her skin tear.

Resident #102's comprehensive care plan dated 12/18/18 failed to reflect her skin tear obtained on 7/27/19.

On 8/13/19 an observation was made of Resident #102. She did not have any skin areas to her right upper arm. Resident #102 stated that her skin tear had healed "not too long ago."

Further review of Resident #102's clinical record failed to evidence that her skin tear had healed.

On 8/14/19 at 10:31 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #102's nurse. When asked the process when a resident obtains a skin tear from a fall, LPN #2 stated that she would notify the medical doctor and monitor the skin tear until steri strips fall off. When asked if monitoring of the skin tear would be documented anywhere in the clinical record, LPN #2 stated "Not necessarily." LPN #2 stated that nurses would not write orders to monitor the skin tear, that nurses would know to do it. When asked how nurses were made aware to monitor a skin tear, LPN #2 stated that it was passed down in report. When asked if the skin tear should be on the care plan, LPN #2 stated that it should. When asked if a nursing note should be documented if the skin tear heals, LPN #2 stated that she would expect to see a note documenting that the skin tear had healed. LPN #2 stated that Resident #102's skin tear had healed the next day after her fall (7/28/19). LPN #2 confirmed that there was no nursing note documenting when Resident #102's

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skin tear had healed. LPN #2 confirmed that she did not update the care plan after the skin tear was obtained on 7/27/19.

On 8/14/19 at approximately 11:20 a.m., ASM (administrative staff member) #2, the Director of Nursing and ASM #3, the corporate nurse, were made aware of the above concerns.

Facility policy titled, "Nursing Policies and Procedures," documents in part, the following: "Licensed Nurses and CNAs (certified nursing assistants) will document all pertinent nursing assessments, care interventions, and follow up actions in the medical record...Every change in the patient's condition or significant patient care issues will be noted and charted until the condition is resolved or stabilized. Documentation that provides evidence of follow-through is critical."

2. For Resident #107, facility staff failed to ensure an accurate care plan and document the correct location of her skin graft site.

Resident #107 was admitted to the facility on 7/15/19 with diagnoses that included but were not limited to high blood pressure, oral cancer, and muscle weakness. Resident #107's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 7/29/19. Resident #107 was coded as being intact in cognitive function scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #107's clinical record revealed that she was admitted to the facility with a skin graft wound to her left inner arm. The

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following in part, was documented: "...skin graft site to left forearm with wound care in place."

Review of Resident #107's wound evaluation dated 7/2/19 documented the following: "Type: Surgical...Location: Left Inner forearm."

Review of Resident #107's comprehensive care plan dated 7/19/19, documented the following: "The resident has a non-pressure related surgical incision site of the right forearm...The resident will have no complications r/t (related to) surgical site of the right forearm through the next review date."

On 8/14/19 at 8:49 a.m., an observation was made of Resident #107. She did not have any skin areas to her right inner arm. Resident #107 had a healed area to her left inner forearm from the previous skin graft site.

On 8/14/19 at 10:36 a.m., an interview was conducted with LPN (licensed practical nurse) #5, Resident #107's nurse. When asked the purpose of the care plan, LPN #5 stated that the purpose of the care plan was to serve as a care guide for the whole interdisciplinary team. When asked if it was important that it was accurate, LPN #5 stated that it was. When asked where Resident #107's surgical site was located, LPN #5 stated that her skin graft site was to her left inner arm and that it had healed on Monday (8/12/19). LPN #5 confirmed that Resident #107's care plan was inaccurate.

On 8/14/19 at approximately 11:20 a.m., ASM (administrative staff member) #2, the Director of Nursing and ASM #3, the corporate nurse, were made aware of the above concerns.

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{F 880}	Continued From page 16	{F 880}		
{F 880} SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	{F 880}		8/26/19

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{F 880}	Continued From page 17 (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 observations and staff interviews the facility staff failed to follow infection control practices for hand hygiene for 2 of 17 residents, Resident #114 & #106, in the survey sample. The findings included: 1. The facility staff failed to remove gloves and perform hand hygiene while performing wound	{F 880}	F880 1. Resident #114 is receiving wound care with proper infection control measures. Resident #106 is receiving incontinent care with proper infection control measures. 2. Residents with wounds are at risk of improper infection control measures	

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{F 880}	Continued From page 18 care on Resident #114. Resident #114 was originally admitted to the facility 01/10/19. Resident #114 diagnoses included Major Depressive Disorder and Muscle Weakness. The Quarterly Review Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/02/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident # 114's cognitive abilities for daily decision making were intact. On 08/14/19 at approximately 11:15 AM (Licensed Practical Nurse) LPN #3 was observed performing wound care to Resident #114's right buttock with assistance from LPN #1, the Unit Manager in the following manner: LPN #3 retrieved the treatment cart then performed hand hygiene. She then disinfected Resident #114 over bed table, taped biohazard trash bag to sides of the over bed table and applied sterile drape to over bed table. LPN#3 placed treatment supplies on the drape. After performing hand hygiene and donning gloves, LPN #3 removed the soiled dressing, applied normal saline to gauze and cleaned the area around the wound. She used a 4x4 dressing to pat wound dry. Without performing hand hygiene after removing the soiled dressing, LPN #3 applied skin prep around the wound bed. She then applied Santyl Ointment to dry gauze and applied it to the wound. LPN # 3 proceeded to cover the wound with a dry dressing. LPN #3 removed her gloves and placed them in a biohazard bag, removed some items/supplies from the over bed table. No hand hygiene was performed. LPN #1, Unit Manager, handed LPN	{F 880}	during provision of treatment. Incontinent Residents are at risk of improper infection control measures during provision of incontinent care. 3. Charge Nurses were educated on: " Proper infection control measures during wound treatment CNAs were educated on: " Proper infection control measures during provision of incontinent care 4. Nursing Administration will monitor for proper infection control measures during provision of wound care and incontinent care. 5. Results of the monitoring will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: August 26, 2019	

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#3 the remainder of the items/supplies from the table. LPN #3 exited the residents room and placed the biohazard bag in soiled utility room then washed her hands in soiled utility room.

On 08/14/19 at approximately 11:30 AM an interview was conducted with LPN #3 concerning the wound care observation. LPN Unit Manager #1 was present. They were asked if she should have disinfected the over bed table when wound care was completed? She stated, "I should have used sanitizer to wipe down the table when I was done." LPN #3 was also asked if she should have removed her gloves, washed her hands and put on gloves (donning gloves) after removing the soiled dressing, cleaning the wound and applying the santyl? She stated, "I should have removed old gloves with dressing and washed my hand and donned new gloves."

On 08/14/19 at approximately 3:45 PM a pre-exit interview was conducted with the Director of Nursing (DON) and the Corporate Nurse Consultant. The DON was asked what should have been done. She stated, "She should have washed her hands." The facility hand hygiene policy was not received.

2. Resident #106 was admitted to the facility on 10/15/98 and readmitted on 9/25/2000 with diagnoses that included but were not limited to anoxic brain damage, autistic disorder, and cerebral palsy. Resident #106's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/10/19. Resident #106 was coded a being severely impaired in cognitive function scoring 99 on the BIMS (Brief Interview for Mental Status) exam. Resident #106 was coded as being

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totally dependent on staff with all ADLs (Activities of Daily Living). Resident #106 was coded as being incontinent of bowel and bladder.

On 8/14/19 at 10:05 a.m., observation of incontinence care was conducted with CNA (certified nursing assistant) #1. CNA #1 donned gloves and unzipped Resident #106's posey bed. CNA #1 was then observed removing Resident #106's brief. CNA #1 threw the brief away in the trash can; without a bag or liner in the trash can. CNA #1 then proceeded to clean Resident #106. The towel used to clean Resident #106 had fallen on the floor after use. CNA #1 was then observed putting a clean brief on the resident. CNA #1 used the same gloves to put on the clean brief that was used to clean Resident #106. CNA #1 then pulled up Resident #106's pants using the same gloves. CNA #1 was observed turning Resident #106 and placing a positioning wedge underneath Resident #106. CNA #1's gloves were touching Resident #106's shirt and the positioning wedge. CNA #1 was then observed picking up the towel that had fallen on the floor and placed it on top of Resident #106's bed sheet. CNA #1 then moved the bed up using the bed controls and still wearing the same contaminated gloves. CNA #1 then threw the towel in the same trash can as the dirty brief. CNA #1 then zipped up the posey bed using the same gloves. Next, CNA #1 threw her gloves away and walked out of Resident #106's room. CNA #1 walked into room 58, grabbed trash bags and walked back into Resident #106's room. CNA #1 then placed the plastic bag on top of the trash can and tilted the can upside down in order to get the brief and towel inside the plastic bag. CNA #1 then put a new bag in the trash can. CNA #1 did not sanitize the trash can after the dirty brief and towel had been removed from the can. CNA #1

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was then observed to put on a new pair of gloves and started repositioning the roommate, Resident #115, in bed. CNA #1 did not wash or sanitize her hands in between residents.

On 8/14/19 at 11:49 a.m., an interview was conducted with CNA #1. When asked how to maintain infection control during incontinence care, CNA #1 stated that she should have washed her hands before and after care. When asked when she should change her gloves, CNA #1 stated that she would change her gloves when she was finished with care. When asked if she should change her clothes when going from dirty to clean, CNA #1 stated that she would only change her gloves if they were visibly soiled. When asked if her hands should be washed in between residents, CNA #1 agreed that she should have and stated that she was so overwhelmed that she forgot. When asked if dirty items should be left on the floor and then placed on clean sheets, CNA #1 stated no. When asked if trash and soiled linens should be thrown in the trash can without a liner, CNA #1 stated that a liner was in the trash can. When told CNA #1 about the above observation, CNA #1 stated that the trash can did have a liner and that she did not tilt the trash can upside down to put the brief and towel in the plastic bag. CNA #1 confirmed that she should not have put the brief and towel in the same plastic bag. CNA #1 stated that trash and linens were usually separated.

On 8/14/19 at approximately 11:20 a.m., ASM (administrative staff member) #2, the Director of Nursing and ASM #3, the corporate nurse, were made aware of the above concerns.

Facility policy titled, "Giving Male Perineal Care,"

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{F 880}	Continued From page 22 did not address the above concerns. No hand hygiene policy was received. No further information was presented prior to exit.	{F 880}		