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	495126	A. BUILDING ______ B. WING ______	C **06/24/2021**

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WADDELL NURSING AND REHAB CENTER	**202 PAINTER ST** **GALAX, VA 24333**

(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 6/22/2021 through 6/24/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 06/22/2021 through 06/24/2021. 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. One complaint was investigated during the survey (unsubstantiated) The Life Safety Code survey/report will follow. The census in this 135 certified bed facility was 114 at the time of the survey. The survey sample consisted of 23 current residents and 3 closed record reviews.	F 000		
F 760 SS=E	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 and clinical record review, the facility staff failed to ensure 5 of 26 residents were free of significant medication errors involving insulin. Residents #3, #92, #58, #2, and #20. The findings included:	F 760	This plan of correction is being submitted in compliance with specific regulatory requirements and preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the fεcts alleged or conclusions set forth on the statement of	7/20/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 07/12/2021

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 760	Continued From page 1 06/24/2021 the (DON) director of nursing provided the survey team with a copy of a policy titled, Facilities Receiving Pharmacy Products and Services from Pharmacy. This policy read in part, "...Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following...Verify each time a medication is administered that it is the correct medication at the correct dose..." 1. For Resident #3, the facility staff failed to follow the physician ordered parameters in regards to insulin administration. Resulting in resident #3 not receiving their insulin on 05/07/2021 for a (BS) blood sugar of 180 and receiving insulin on 05/25/2021 for a BS of 159. Resident #3's facesheet in the (EHR) electronic health record included the diagnoses, diabetes, aphasia, hypertension, and major depressive disorder. Section C (cognitive patterns) of Resident #3's annual (MDS) minimum data set assessment with an (ARD) assessment reference date of 06/15/2021 included a (BIMS) brief interview for mental status summary score of 8 out of a possible 15 points. Resident #3's EHR included a physicians order for Novolog insulin inject 12 unit subcutaneously before meals for diabetes. Hold if BS less than 180. The order date was documented as 11/02/2020. A review of Resident #3's (EMARs) electronic medication administration records revealed the	F 760	deficiencies. 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 for F760 All errors were reported to the MD on 06-24-21 for Resident #3, 92, 58, 2, and 20. No harm to these residents. MD has reviewed these orders and their blood sugars as well. Education with all nurses making the errors were completed on reading orders thoroughly and following the orders were completed on 07-8-21. Residents throughout the building having range orders had the potential to be affected by this. A review of current resident with insulin range orders was completed for medication error reporting and MD awareness on 06-24-21. Licensed staff were re-educated by DON/designee regarding range order compliance and the medication administration policy and procedure. Education completed on 07-12-21. Unit Managers or designee will do a weekly audit of insulin orders to assess adherence to the parameters for 3 months to ensure continued compliance and re-educate as needed. Results will be disused in monthly QAPI. AOC 07-20-21	

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following

05/07/2021 the nursing staff documented a "16." Per the preprinted code on the EMAR a 16=Hold/See Nurses Note. This nurse documented Resident #3's BS as 180 and documented in the medication administration note that the insulin was held. Per the physicians order the insulin should have been administered.

05/25/2021 the nursing staff documented a BS of 159 and that the insulin was administered in the right lower quadrant of Resident #3's abdomen. Per the physicians order the insulin should have been held.

06/23/2021 4:05 p.m., the administrator, DON, regional nurse, regional vice president of operations and assistant administrator/ADON (assistant director of nursing) were made aware of the issue regarding Resident #3's insulin. This issue was again reviewed on 06/24/2021 at 4:00 p.m. with these same staff.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #92, the facility staff failed to follow the physician ordered parameters in regards to insulin administration. Resulting in resident #92 not receiving their insulin on 06/13/2021 for a (BS) blood sugar of 210.

Resident #92's facesheet in the (EHR) electronic health record included the diagnoses diabetes and cognitive communication deficit.

Section C (cognitive patterns) of the residents

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Continued From page 3

quarterly (MDS) minimum data set assessment with an (ARD) assessment reference date of 06/03/2021 included a (BIMS) brief interview for mental status summary score of 9 out of a possible 15 points.

Resident #92's EHR included a physicians order dated 05/21/2021 for Novolog insulin inject 10 units subcutaneously two times a day for diabetes. Hold for (BG) blood glucose less 180. Give before lunch and supper.

A review of Resident #92's (EMARs) electronic medication administration records revealed that the nursing staff documented a "3" on 06/13/2021 at 5:00 p.m. Per the preprinted code on this form a 3=No insulin required. The blood sugar was documented as 210. Indicating the resident should have received insulin per the physician ordered parameters.

06/23/2021 4:05 p.m., the administrator, DON, regional nurse, regional vice president of operations and assistant administrator/ADON (assistant director of nursing) was made aware of the issue regarding Resident #92's insulin. This issue was again reviewed on 06/24/2021 at 4:00 p.m. with these same staff.

No further information regarding this issue was provided to the survey team prior to the exit conference.

3. For Resident #58, the facility staff failed to follow physician's orders for the administration of Novolog (a rapid-acting insulin) on two separate occasions.

Resident #58's diagnosis list indicated diagnoses,

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which included, but not limited to Type 2 Diabetes Mellitus without Complications, Essential Primary Hypertension, Presence of Left Artificial Knee Joint, Aftercare following Joint Replacement Surgery, and Pain Unspecified.

The most recent significant change MDS (minimum data set) with an ARD (assessment reference date) of 6/07/21 assigned the resident a BIMS (brief interview for mental status) score of 13 out of 15 in section C, Cognitive Patterns. In section I, Active Diagnoses, Resident #58 was coded for the diagnosis of Diabetes Mellitus.

Resident #58's active physician's orders included an order for "Novolog FlexPen Solution Pen-Injector 100 UNIT/ML (Insulin Aspart) Inject 4 unit subcutaneously before meals related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9) **Hold for BG (blood glucose) less than 200**".

A review of Resident #58's June 2021 MAR (medication administration record) revealed the resident received Novolog 4 units on 6/15/21 at 5:41 am in the right arm with a documented blood sugar of 104. On 6/16/21 at 5:46 am, the resident received Novolog 4 units in the right lower abdominal quadrant with a documented blood sugar of 117.

On 6/24/21 at 4:00 pm during a meeting with the facility administrative team, surveyor discussed the concern of Resident #58 receiving Novolog on 6/15/21 and 6/16/21 with documented blood sugars below 200.

No further information regarding this issue was presented to the survey team prior to the exit

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F 760	Continued From page 5 conference on 6/24/21. 4. For Resident #2 the facility staff administered insulin outside the physician ordered parameters. Resident #2's face sheet listed diagnoses which included, but not limited to type 2 diabetes mellitus, acute respiratory failure, dysphagia, end stage renal disease, and anxiety. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 06/17/21 assigned the resident a BIMS (brief interview for mental status) of 14 of 15 in section C, cognitive patterns. This indicated the resident is cognitively intact. Resident #2's comprehensive care plan was reviewed and contained a care plan for "Resident is at risk for hypo/hyperglycemia episodes R/T (related to): dx (diagnosis) IDDM (insulin dependent diabetes mellitus); hypoglycemia with recent ER visit." Interventions for this care plan included "medication as ordered; hold as needed per ordered parameters". Resident #2's clinical record was reviewed and contained a physician's order summary for the month of June 2021, which read in part "Humalog Solution (Insulin Lispro). Inject 10 unit subcutaneously before meals for DM (diabetes mellitus). Hold if <180 (less than)." Resident #2's eMARs (electronic medication administration record) for the month of June was reviewed and contained an entry as above. The entry for 06/01/21 at 11:30 am recorded the resident's blood glucose level as 163 and was initialed as insulin given. The notes section of the eMAR indicated the resident had been	F 760		

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F 760	Continued From page 6 administered insulin subcutaneously in the right lower abdomen. The concern of administering insulin outside physician ordered parameters was discussed with the administrative team (administrator, director of nursing, regional nurse consultant, regional vice president of operations, assistant administrator) during a meeting on 06/24/2021 at approximately 4:00 pm No further information was provided prior to exit. 5. For Resident #20 the facility failed to hold the resident's Novolog (insulin) according to the provider's written order. The resident's electronic clinical record was reviewed and the facesheet listed diagnoses to include but not limited to: Type 2 diabetes mellitus with hyperglycemia, schizoaffective disorder, malignant neoplasm of larynx, and chronic obstructive pulmonary disease. Resident #20's MDS (minimum data set) with an ARD (assessment reference date) of 04/04/2021 noted in Section C (cognitive patterns) the resident had a BIMS (brief interview for mental status) score of 11 out of 15. One of the resident's medication orders, with a 04/03/2021 start date, read "NovoLOG FlexPen Solution Pen-Injector 100 UNIT/ML (Insulin Aspart) Inject 6 unit [sic] subcutaneously before meals related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65) Hold for BG [blood glucose] less than 180." Resident #20's MAR (medication administration record) was reviewed and for the month of June 2021, there were three (3) times facility staff documented the	F 760		

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F 760	Continued From page 7 medication was administered when the resident's blood glucose was noted less than 180; on 06/01/2021 at 4:30 p.m. the resident's blood glucose was 177, on 06/03/2021 at 4:30 p.m., the resident's blood glucose was 178, and on 06/06/2021 at 6:30 a.m. the resident's blood glucose was 138. On 06/24/21 at 11:30 a.m. the director of nursing (DON) was interviewed about the facility's staff documenting they administered insulin to Resident #20 when the resident's blood glucose was less than the ordered parameter of 180. The DON acknowledged Resident #20's June 2021 MAR contained evidence the resident received insulin with blood glucose levels less than 180. The DON reported becoming aware of this concern while recently completing an insulin audit and reported discussing the concern with the medical director. The DON, administrator, assistant administrator, regional director of clinical services, and regional vice president of operations were informed of the medication findings described above on 06/24/2021 at 4:00 p.m. No further information was provided prior to the exit conference.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		7/20/21

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F 761	Continued From page 8 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to keep a controlled medication in a separately locked, permanently affixed compartment on 1 of 3 units, Unit 2. The findings included: The facility staff failed to secure the medication, Gabapentin (a schedule V controlled substance under Virginia state law used to treat seizures and nerve pain) in a separately locked, permanently affixed compartment in the medication cart. On 6/24/21 at 11:40 am, the surveyor accompanied by LPN (licensed practical nurse) #2, observed two separate bubble pack cards of	F 761	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 for F761 Re-education on proper medication storage including narcotics in double locked secured areas of medication cart with LPN nurse #2 was completed on 06-24-21. No actual harm to any resident. Residents throughout the building had the potential to be affected by this. All medication carts were assessed to ensure medications were stored properly. Audit was completed on 06-24-21 by Tammy Eichner RN, DON. Licensed staff were re-educated by DON/designee regarding the appropriate storage of all medications on the	

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F 761	Continued From page 9 Gabapentin in an open area of the medication cart drawer beside the separately locked, permanently affixed, metal compartment containing controlled medications. One bubble pack card was labeled Gabapentin 300 mg and contained 13 capsules and had the Controlled Substance Sheet folded around the card, the sheet indicated there were 13 capsules remaining. The second bubble pack card was labeled Gabapentin 300 mg and contained 21 capsules and also had a Controlled Substance Sheet folded around the card, the sheet indicated there were 21 capsules remaining. LPN #2 stated the resident went home yesterday and the unit manager comes around and picks up the medications. At 11:55 am, LPN #2 stated "I just pulled them this morning to prevent an error". The director of nursing was also present and stated they have called the pharmacy to bring a new cart with a single locking door with two compartments for the narcotics drawer. Surveyor requested and received the facility policy entitled "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" which states in part: Procedure 3. General Storage Procedures: 3.1 Facility should store Schedule II - V Controlled Substances, in a separate compartment within the locked medication carts and should have a different key or access device, i.e. 3.1.1 Store all drugs and biologicals in locked compartments, including the storage of Schedule II - V medications in separately locked, permanently affixed compartments, permitting	F 761	medication carts including narcotics being in double locked secured areas by review of the medication administration policy. Education completed on 07-13-21. DON/designee will do a weekly medication cart check for 3 months to ensure continued compliance and re-educate and or disciplinary actions as needed. Results will be discussed in QAPI monthly. AOC 07-20-21	

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F 761	Continued From page 10 only authorized personnel to have access On 6/24/21 at 4:00 pm during a meeting with the facility administrative team, surveyor discussed the concern of the facility staff not properly storing the medication Gabapentin in the Unit 2 medication cart. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/24/21.	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 accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		7/20/21

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F 880	Continued From page 11 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. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880		

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F 880	Continued From page 12 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to follow established infection control procedures during wound care observations for 2 of 26 residents. Residents #74 and #58. The findings included: 06/24/2021 the (DON) director of nursing provided the survey team with a copy of a policy titled, Hand Hygiene/Handwashing Policy date of revision 01/31/2020. This policy read in part, "Hand washing is the most important component for preventing the spread of infection. Use of gloves does not replace the need for hand cleaning by either hand rubbing or hand washing...Perform hand hygiene...Before and after having direct contact with residents...After removing gloves...After contact with body fluids or excretions, mucous membranes, non-intact skin and/or wound dressings...If moving from a contaminated body site to a clean body site during resident care..." 1. For Resident #74, the facility staff failed to complete hand hygiene during a wound care observation. Resident #74 had three stage IV pressure ulcers and an excoriated area to their sacrum. Resident #74's facesheet in the (EHR) electronic health record included the diagnoses, adult failure to thrive, (MS) multiple sclerosis, nutritional deficiency, and major depressive disorder.	F 880	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 for F880 Re-education on proper hand hygiene during wound care was completed with LPN #3 and LPN #1 on 06-24-21. No actual harm to the residents number 74 and 58. Residents throughout the building receiving wound care had the potential to be affected by this. Random spot checks of staff were conducted on all shifts to reinforce the importance of use of appropriate hand hygiene as well as observed wound care during wound rounds to ensure proper hand washing is being completed. Observations were completed on 07-08-21. Licensed staff were re-educated by DON/designee regarding appropriate hand hygiene with dressing changes. Hand washing policy was reviewed. Education completed on 07-12-21. Leadership will do unannounced 2 audits during wound care weekly for 3 months to ensure continued compliance and re-educate and or disciplinary actions as needed. Results will be discussed in QAPI monthly. AOC 07-20-21.	

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	495126	A. BUILDING ______ B. WING ______	C 06/24/2021

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Section C (cognitive patterns) of Resident #74's quarterly (MDS) minimum data set assessment with an (ARD) assessment reference date of 05/23/2021 included a (BIMS) brief interview for mental status summary score of 6 out of a possible 15 points. Section G (functional status) was coded (4/3) for bed mobility, transfers, locomotion of unit, dressing, and toilet use to indicate the resident required total assistance of two people for these tasks. Section M (skin conditions) was coded to indicate the resident was at risk for pressure ulcers and had three stage IV pressure ulcers.

Resident #74's (CCP) comprehensive care plan included the focus areas at risk for infection related to history of recurrent infections pneumonia, urinary tract infections, sepsis, and wound. Total assistance for all activities of daily living, quadriplegia. Risk for skin breakdown related to decreased mobility, function and weakness diagnosis MS, skin is fragile, resistive to care such as turning and repositioning, pressure relief positioning and devices actual skin breakdown to right hip right buttocks, left hip, and sacrum.

Resident #74's EHR included physician orders for contact isolation, dakins solution to left hip, right hip and right buttock topically every shift for wound care.

06/23/21 2:00 p.m., wound care observation with (LPN) licensed practical nurse #3 and the (IP) infection preventionist. These staff were observed to wear a protective mask, gown, and gloves due to Resident #74's contact isolation status. LPN #3 was observed to remove the old dressings from the excoriated area and two stage IV pressure

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F 880	Continued From page 14 ulcers. LPN #3 changed their gloves and then cleaned these three areas with (DWC) dermal wound cleanser, applied skin prep to the sacral area X2 and a protective dressing, opened kerlix, changed gloves, poured the dakins solution onto the kerlix, applied the dakins soaked kerlix to two stage IV pressure ulcers, applied a protective dressing to the left hip wound, and then changed their gloves. LPN #3 was unable to cover wound #2 with a protective dressing due to the residents position. LPN #3 and the IP repositioned Resident #74 to their left side, removed the dakins gauze from wound #2, placed new dakins soaked kerlix into the wound bed, and applied a protective dressing. LPN #3 changed their gloves, cleaned wound #3 with DWC, applied dakins soaked kerlix to the wound bed, and then applied a protective dressing. 06/24/21 10:09 a.m., interview with IP. This nurse stated LPN #3 washed their hands before starting the treatments and after completion of the treatments but did not complete any hand hygiene during wound care. The IP stated LPN #3 should have washed her hands during wound care and they had discussed it after the observation. 06/24/21 4:00 p.m., the administrator, DON, nurse consultant, assistant administrator, and regional vice president of operations were made aware that LPN #3 did not complete hand hygiene during a treatment observation of three stage IV wounds. No other information regarding this issue was provided to the survey team prior to the exit conference.	F 880		

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2. For Resident #58, the facility staff failed to perform hand hygiene while performing treatments to multiple pressure areas.

Resident #58's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus without Complications, Essential Primary Hypertension, Presence of Left Artificial Knee Joint, Aftercare following Joint Replacement Surgery, and Pain Unspecified.

The most recent significant change MDS (minimum data set) with an ARD (assessment reference date) of 6/07/21 assigned the resident a BIMS (brief interview for mental status) score of 13 out of 15 in section C, Cognitive Patterns. In section M, Skin Conditions, Resident #58 was coded for the presence of two (2) unstageable pressure ulcers with slough and/or eschar and five (5) unstageable pressure areas presenting as deep tissue injury.

Resident #58's active physician's orders included the following current orders for the treatment of pressure ulcers:
1. Apply sure prep to right heel and right 5th metatarsal and cover with bordered gauze every day shift
2. Apply sure prep to left heel, left lateral malleolus, and left mid foot, cover with bordered gauze every day
shift
3. Cleanse wound to left lower extremity lateral aspect with normal saline, apply santyl to wound bed, cover
with bordered gauze every day shift
4. Cleanse wound to right buttock with wound cleanser, apply santyl and calcium AG to wound bed and cover

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F 880	Continued From page 16 with bordered gauze, change every day and as needed On 6/23/21 at 4:58 pm, surveyor entered Resident #58's room to observe wound treatments. LPN (licensed practical nurse) #1 had already prepared the over bed table with dressings, treatment solutions had been poured into clear medication cups and ointment was also placed in a clear medication cup. Surveyor was unable to verify the solutions in each medication cup. LPN #1, with the assistance of RN (registered nurse) #1 turned the resident on their left side and discovered the resident had recently had a bowel movement. With gloved hands, LPN #1 cleaned the bowel movement from the resident's skin and placed a new pad under the resident and immediately proceeded to treatment the pressure area to the right buttock and apply the clean dressing without removing gloves and performing hand hygiene. LPN #1 removed gloves but did not wash hands or use hand sanitizer and obtained two clean gloves and carried them out of the resident's room. LPN #1 returned to the room with two gloves and a wash cloth in their hands. LPN #1 donned the gloves and cleaned the pressure areas to the resident's right lateral foot, left heel, left mid foot, and applied the treatment to the left mid foot and left lateral malleolus without performing hand hygiene or changing gloves. There was a knock at the resident's door and LPN #1 touched the door handle and opened the door with the same gloved hands. With the same gloved hands, LPN #1 returned to the resident and applied a dressing to right heel. LPN #1 then removed gloves and left the room without performing hand hygiene.	F 880		

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F 880	Continued From page 17 LPN #1 returned to the room and donned clean gloves and cleaned the area to the resident's left lower extremity and applied the treatment. With the same gloved hands, LPN #1 pulled an ink pen from their hair and dated a clean dressing and applied it to the left lower extremity. With the same gloved hands, LPN #1 applied a dressing to the right lateral foot. On 6/24/21 at 10:12 am, surveyor discussed treatment observations with the infection control nurse who stated the nurse should have done hand hygiene and changed gloves during the treatments. On 6/24/21 at 10:25 am, surveyor spoke with LPN #1 and asked about their hand hygiene during the treatment observation. LPN #1 immediately replied "I didn't do it like I was supposed to". LPN #1 further stated that they should have washed their hands and changed gloves after cleaning the resident's bowel movement and between each wound, LPN #1 stated they did use hand sanitizer between one. On 6/24/21 at 4:00 pm during a meeting with the facility management staff, surveyor discussed the concerns of the lack of hand hygiene identified during the observation of treatment administrations performed by LPN #1. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/24/21.	F 880		