STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495178	A. BUILDING _____ B. WING _____	11/09/2021

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CHARLOTTESVILLE HEALTH & REHABILITATION CENTER	505 WEST RIO ROAD CHARLOTTESVILLE, VA 22901

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/7/2021 through 11/9/2021. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/7/2021 through 11/9/2021. No complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 105 certified bed facility was 95 at the time of the survey. The survey sample consisted of 22 current Resident reviews and three closed record reviews.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident	F 655		12/16/21

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

Electronically Signed | 11/23/2021

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F 655	Continued From page 1 including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, the facility staff failed to develop a baseline care plan for one of 22 in the survey sample, Resident #289. Resident #289's baseline care plan failed to include a problems/focus area, goals and interventions for the anticoagulant medication, Apixaban.	F 655	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all	

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F 655	Continued From page 2 The findings include: Resident #289 was admitted to the facility on 10/25/21 with diagnoses that included pulmonary embolism, history of COVID 19, respiratory failure with hypoxia, hypercholesteromia, hypertension, osteoarthritis, and long term use of anticoagulants. The nursing admission assessment dated 10/25/21 assessed Resident #289 as alert and oriented to person, place, time and situation, having intact cognition and with the ability to express ideas/wants. On 11/08/2021 at 2:13 p.m., Resident #289 was interviewed regarding the quality of care since admission to the facility. Resident #289 stated she was admitted after a hospital stay due to testing positive for COVID 19, developing pneumonia and developing weakness and pains in her legs. Resident #289 stated this resulted in blood clots in her legs and she was now on Eliquis to prevent the blood clots. On 11/08/2021 Resident #289's clinical record was reviewed. Observed on the order summary report was the following: "Apixaban [an anticoagulant] Tablet 5 MG (milligram) Give 1 tablet by mouth two times a day for immobility. Order Date: 10/25/2021. Start Date: 10/31/2021." A review of the medication administration report (MAR) documented Resident #289 was receiving the Apixaban as ordered since 10/31/2021. A review of the baseline care plan was completed and it did not include a problem/focus area, goals, and interventions for the use of the Apixaban.	F 655	federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F655 1. Resident # 28□s care plan was updated to include anticoagulant use. 2. Nursing administration will review current residents on anticoagulants to ensure their use is part of the plan of care. Corrections will be made immediately at the time of identification. 3. Current nurses will be educated to include the use of anticoagulants on the resident□s care plan. Nursing administration or designee will review residents on anticoagulants weekly x 4 weeks to ensure they are included in the plan of care. 4. Process will be reviewed in QA committee x 1 quarter. 5. 12-16-2021	

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F 655	Continued From page 3 On 11/09/2021 at 7:45 a.m., the director of nursing (DON) was interviewed regarding the baseline care plan. The DON stated nursing was responsible for completing the careplans. The DON was asked if the Apixaban should have been included on the baseline care plan. The DON stated, "yes." A review of the facility's Care Planning policy effective 11/01/19 documented the following: "1. The computerized baseline Care Plan is initiated and activated within 48 hours." "2... the base line care plan includes, but is not limited to: the initial goals of the patient, a summary of the patient's medications list..." These findings were reviewed with administrator, DON, and regional consultant during a meeting on 11/08/2021 at 4:40 p.m. No additional information was provided to the survey time prior to exit on 11/09/2021.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		12/16/21

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F 656	Continued From page 4 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one of 22 in the survey sample, Resident #60. Resident #60's comprehensive care plan did not include a problem/focus area with goals and interventions for the use the anticoagulant medication, Heparin Sodium Solution. The findings include:	F 656	F656 1. Resident # 60□s care plan was updated to include anticoagulant use. 2. Nursing administration will review current residents on anticoagulants to ensure their use is part of the plan of care. Corrections will be made immediately at the time of identification. 3. Current nurses will be educated to include the use of anticoagulants on the	

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F 656	Continued From page 5 Resident #60 was originally admitted to the facility on 07/30/2019 and readmitted on 10/2/2021 with diagnoses that included hyperlipidemia, depression, acute embolism and thrombosis of left popliteal vein, hypothyroidism, osteoarthritis, difficulty walking and orthopedic aftercare. The nursing admission assessment dated 10/21/2021 assessed Resident #60 as alert and oriented to person, place and situation, having intact cognition and the ability to express wants/ideas. On 11/09/2021, Resident #60's clinical record was reviewed. Observed on the order summary report was the following: "Heparin Sodium (Porcine) [an anticoagulant] Solution 5000 Unit/ML Inject 1 ml (milliliter) subcutaneously three times a day for DVT (deep vein thrombosis). Order Date: 10/21/2021. Start Date: 10/21/2021." A review of the medication administration record (MAR) documented Resident #60 was receiving the Heparin Sodium Solution as ordered since 10/21/2021. A review of the comprehensive care plan was completed and it did not include a problem/focus area, goals and interventions for the use of the Heparin Sodium Solution. On 11/09/2021 at 9:49 a.m., the director of nursing was interviewed regarding the care plans. The DON reviewed Resident #60's electronic record including the orders and care plan and stated the Heparin Sodium Solution should have been included on the comprehensive care plan. The findings were reviewed during a meeting with	F 656	resident□s care plan. Nursing administration or designee will review residents on anticoagulants weekly x 4 weeks to ensure they are included in the plan of care. 4. Process will be reviewed in QA committee x 1 quarter. 5. 12-16-2021	

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F 656	Continued From page 6 the administrator, DON and regional consultant on 11/09/2021 at 11:15 a.m. No additional information was provided to the survey team prior to exit on 11/09/2021.	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interview the facility staff failed to follow physicians orders for the administration of the correct formulation of a multi-vitamin for one of 22 residents in the survey sample, Resident # 9. Resident # 9 was ordered "Men's Daily Health Formula" and instead was administered a regular multi-vitamin for a period of five months. Findings include: Resident # 9 was admitted to the facility 6/1/21. Diagnoses for Resident # 9 included, but were not limited to: Malignant neoplasm of the rectum and pancreas, diabetes, depression, congestive heart failure, and peripheral vascular disease. The most recent MDS (minimum data set) was a quarterly assessment dated 9/7/21 with the	F 684	F684 1. Resident #9 is currently receiving multivitamin with mineral tablet according to physician□s order. 2. Nursing administration will review current residents on gender specific vitamins to ensure they are available. Corrections will be made immediately at the time of identification. 3. Current nurses will be educated to review gender specific vitamin orders on admission with physician and request change to house stock multivitamin if applicable. Nursing administration or designee will review 3 admissions weekly x 4 weeks to ensure gender specific vitamins ordered are available. 4. Process will be reviewed in QA committee x 1 quarter.	12/16/21

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F 684	Continued From page 7	F 684		

resident being scored with moderate impairment in cognition with a score of 11 out of 15.

On 11/8/21 a medication pass and pour observation was conducted with LPN (licensed practical nurse) # 1 beginning at 7:55 a.m. Medications administered to Resident # 9 were then reconciled against physician orders. Resident # 9 was observed having been administered a standard multi-vitamin and mineral formula; the order, carried forward from 6/2/21 read "Daily Men's Health Formula Tablet-Give one tablet by mouth one time a day for supplement." The MAR (medication administration record) was then reviewed. The supplement was identified as "Men's Health Formula" on the MAR, and staff initials were documented as having administered that formula, rather than the multivitamin he was actually receiving.

On 11/8/21 at approximately 9:30 a.m. LPN # 2 was interviewed about the supplement as LPN # 1 had been pulled from the medication cart to do a treatment. LPN # 2 was asked about the difference in the formulas. LPN # 2 stated "I don't really know; I see where he's ordered the men's health formula, but that's not what we have in the house stock; that doesn't come from the pharmacy. I am agency; I am helping [name of LPN # 1] get a list together of meds we need to order so I can put that one on the list..."

On 11/8/21 at 10:00 a.m. the DON (director of nursing) was informed of the above findings, and asked what the difference in the vitamin formula's were, how long he had been administered the plain multivitamin, and what was the expectation for documenting what was given. The DON

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F 684	Continued From page 8 stated she would call the pharmacy and get back to me. On 11/8/21 at 11:00 a.m. the DON and the regional director of clinical services returned to the conference room. The DON stated "I called the pharmacy, and there are a few things in the men's formula that aren't in the regular vitamins. I also found out that [name of Resident # 9] has only gotten the regular formula since the order date in June (2021). That is a 'house stock' item, and does not come from our pharmacy. We are going to take this opportunity to educate the staff about notifying administration immediately that what is available is not what's ordered; this should have been resolved immediately, and staff should not have documented that the resident was getting something he was not. The nurse has notified the doctor and he has changed the order today to give the regular multivitamin." Documentation provided by the DON evidenced that there were five additional ingredients in the men's formula than in the regular formula: Vit. E, Vit. K, Vit. B1 and B2, and Folic Acid. The administrator, DON, and regional director of clinical services were informed of the above findings during a meeting with facility staff 11/8/21 beginning at 4:40 p.m. No further information was provided prior to the exit conference.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686		12/16/21

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F 686	Continued From page 9 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to perform a pressure ulcer dressing change in a manner to prevent infection for one of twenty-two residents in the survey sample, Resident #33. A nurse failed to perform hand hygiene between glove changes during dressing changes to Resident #33's pressure ulcers. The findings include: Resident #33 was admitted to the facility on 5/26/17 with a re-admission on 10/20/21. Diagnoses for Resident #33 included atherosclerotic heart disease, glaucoma, peripheral vascular disease, benign prostatic hypertrophy, atrial fibrillation, chronic kidney disease, anemia, gastroesophageal reflux disease, depression, dysphagia, urinary tract infection and congestive heart failure. The minimum data set (MDS) dated 10/22/21 assessed Resident #33 with moderately impaired cognitive skills. Resident #33's clinical record documented the	F 686	F686 1. Resident #33 is currently receiving wound care according to appropriate infection control practices. 2. Current licensed nurses will be observed by nursing leadership or designee during a pressure ulcer dressing change to ensure infection control practices are being followed. Any issues will be immediately corrected at the time of observation. 3. Licensed nurses will be educated regarding hand hygiene in between glove changes. Pressure ulcer treatment observations will be observed by nursing leadership 3x weekly x 4 weeks to ensure appropriate infection control practices are being followed. 4. Process will be reviewed in QA committee x 1 quarter. 5. 12-16-2021	

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F 686	Continued From page 10	F 686		

resident had three stage 3 pressure ulcers on his buttocks. A consultant wound practitioner documented on 11/2/21 the following pressure ulcers: "...full thickness ulceration of the right upper buttock that measures 3.1 x 1.2 x 0.2 cm [length by width by depth in centimeters]...full thickness ulceration of the right mid buttock that measures 1.3 x 3.1 x 0.2 cm...full thickness ulceration of the right lower buttock that measures 2.1 x 1.4 x 0.2 cm..." The resident was also assessed with moisture associated skin damage (MASD) on the left buttock.

Resident #33's clinical record documented physician orders dated 11/3/21 to cleanse each pressure ulcer with wound cleanser, pat dry and apply a hydrocolloid dressing each day shift. The record also documented a physician's order dated 11/3/21 to cleanse the moisture associated skin damage on the left buttock with wound cleanser, pat dry and apply zinc paste cream each day and night shift.

On 11/8/21 11:25 a.m., with the resident's permission, licensed practical nurse (LPN) #4 was observed performing dressing changes and wound care to the pressure ulcers. LPN #4 washed her hands, put on clean gloves, removed a foot cushion from the bed, assisted the resident to turn/reposition in bed and pulled back the resident's incontinence brief. LPN #4 removed her gloves and without prior hand hygiene, placed a clean pad on the bedside. LPN #4 then opened gauze pads and clean dressings positioning them on the pad. LPN #4 sprayed wound cleanser onto the gauze pads and applied a dollop of zinc paste onto the pad. LPN #4 then put on clean gloves. LPN #4 cleansed the MASD on the left buttock and then each of the right buttock

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F 686	Continued From page 11	F 686		

pressure ulcers with a separate cleanser soaked gauze and then patted each area dry with a separate clean gauze pad. There were no gloves changes or hand hygiene performed between the cleansing and drying of each wound. LPN #4 then applied the zinc paste using her gloved finger to the MASD on the right buttock. LPN #4 removed her gloves and without prior hand hygiene, put on new gloves and applied hydrocolloid dressings to the left buttock pressure ulcers. LPN #4 then put on clean gloves, assisted to replace the resident's incontinence brief, adjusted the resident's bed covers, replaced the foot cushion, discarded used supplies, removed gloves and then washed her hands.

LPN #4 performed no hand hygiene between any of the glove changes during the dressing changes. There were no glove changes or hand hygiene performed between the three separately assessed pressure ulcers on the right buttock.

On 11/8/21 at 11:40 a.m., LPN #4 was interviewed about hand hygiene between glove changes. LPN #4 stated, "We are supposed to hand sanitize in-between glove changes."

On 11/9/21 at 10:10 a.m., the director of nursing (DON) was interviewed about the observed dressing changes without hand hygiene between gloves changes and wounds. The DON stated best practices for wound care included hand hygiene after each glove change and glove changes between each separate ulcer.

The facility's policy titled Handwashing Requirements (effective 2/6/20) documented, "...Employees will wash hands at appropriate times to reduce the risk of transmission and

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CHARLOTTESVILLE HEALTH & REHABILITATION CENTER	505 WEST RIO ROAD CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 12 acquisition of infections...The following is a list of some situations that require hand hygiene...before and after direct patient contact...After handling soiled equipment...After removing gloves...After any contact with potentially contaminated materials (used wound/treatment dressings..." (Sic) The Lippincott Manual of Nursing Practice 11th edition documents on page 843, "Hand hygiene is the single most recommended measure to reduce the risks of transmitting microorganisms...Hand hygiene should be performed between patient contacts; after contact with blood, body fluids, secretions, excretions, and contaminated equipment or articles; before donning and after removing gloves is vital for infection control. It may be necessary to clean hands between tasks on the same patient to prevent cross-contamination of different body sites..." (1) These findings were reviewed with the administrator and director of nursing during a meeting on 11/8/21 at 4:40 p.m. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2019.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		12/16/21

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F 689	Continued From page 13 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to implement use of safety devices for one of twenty-two residents in the survey sample, Resident #36. Resident #36 was observed in a wheelchair without anti-rollback devices as required in his plan of care for fall/injury prevention. The findings include: Resident #36 was admitted to the facility on 9/23/20 with diagnoses that included cerebral infarction with right side hemiplegia, atherosclerotic heart disease, hypertension, vascular dementia, osteoarthritis, anxiety disorder, depression, gastroesophageal reflux disease, chronic kidney disease, mood disorder and urinary tract infection. The minimum data set (MDS) dated 9/22/21 assessed Resident #36 with short and long-term memory loss and moderately impaired cognitive skills. On 11/8/21 at 9:09 a.m., Resident #36 was observed seated in his wheelchair, self-propelling about in his room. No anti-rollback devices were installed or in use on the wheelchair. Resident #36 was observed again on 11/8/21 at 9:50 a.m. and on 11/9/21 at 8:12 a.m. in his wheelchair without installed anti-rollback devices. Resident #36's clinical record documented the resident had a history of recent falls and attempts to stand from the wheelchair without assistance. Nursing notes documented the following regarding falls and poor safety awareness.	F 689	F689 1. Resident #36 currently has anti-roll backs on his wheelchair according to plan of care. 2. Current residents requiring anti-roll backs to decrease risk for falls will be observed to ensure anti-roll back devices are in place. Corrections will be made immediately at the time of identification. 3. Licensed nursing staff will be educated on verifying the placement of anti-roll back devices every shift according to the plan of care. Nursing administration or designee will observe 3 residents with anti-roll back devices weekly x 4 weeks to verify placement according to the care plan. 4. Process will be reviewed in QA committee x 1 quarter. 5. 12-16-2021	

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F 689	Continued From page 14	F 689		

9/17/21 - "...unwitnessed fall...no injuries, walks unsafely, impulsive...Recommendations: rollbacks to wc [wheelchair]..."
9/19/21 - "...resident slid from W/C [wheelchair]...Hx [history] of falls..."
9/21/21 - "...resident stood up to wash his hands...Repeated falls..."
10/20/21 - "...Resident has been up in wheel chair today. Stood up and fell back in wheel chair did not have wheels locked chair rolled back was observed no injuries..."

Resident #36's plan of care (print date 11/8/21) documented the resident had experienced actual falls and was at risk of further falls due to right sided hemiplegia/hemiparesis, impaired balance, history of falling and dementia. Interventions to prevent serious injuries from falls included, "Anti rollbacks to wheelchair."

On 11/9/21 at 8:30 a.m., accompanied by licensed practical nurse unit manager (LPN #5), Resident #36 was observed in his wheelchair without anti-rollback devices in place. LPN #5 was interviewed at this time about the anti-rollback devices. LPN #5 stated he did not see the anti-rollback devices on Resident #36's wheelchair. LPN #5 stated the resident's current wheelchair looked like a newer model and not the chair previously in use that had anti-rollbacks in place.

On 11/9/21 at 8:50 a.m., LPN #5 stated therapy staff worked with Resident #36 during this past weekend. LPN #5 stated therapy staff removed the anti-rollbacks from the wheelchair during a therapy session and the anti-rollback devices were not put back in place.

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F 689	Continued From page 15 These findings were reviewed with the administrator and director of nursing during a meeting on 11/9/21 at 11:25 a.m.	F 689		
F 880 SS=E	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	F 880		12/16/21

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F 880	Continued From page 16 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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow infection control practice during a medication pass observation on one of two units. Thirteen oral medications were	F 880	F880 1. Nurse was immediately educated on proper infection control practices during med pass 2. The nurse will be observed during a	

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F 880	Continued From page 17 touched by the nurse's bare hands/fingers prior to administering them to residents during a medication pass on unit two. The findings include: On 11/8/21 at 7:37 a.m., a medication pass observation was conducted on unit two with registered nurse (RN) # 1 administering oral medications to Resident #23. During this observation, RN #1 touched and/or handled each of seven medication tablets with her bare hands and/or fingers prior to administering them to the resident. RN #1 popped six of the seven tablets from the medication supply cards into her bare hand prior to placing them in a cup. RN #1 reached her index finger into the supply bottle and retrieved an aspirin tablet before placing in the medication cup. Tablet medications touched then administered to Resident #23 included vitamin D, ferrous sulfate, aspirin, Fenofibrate, lisinopril, metformin and metoprolol. RN #1 used hand sanitizer after administering the medications. On 11/8/21 at 8:02 a.m., RN #1 prepared oral medications for Resident #42. RN #1 popped three out of four medications from the supply card directly into her bare hands before placing in the medication cup. RN reached her index finger into a bottle and retrieved a vitamin before placing the pill into the cup. With her bare hands, RN #1 handled and then broke in half a bumetidine tablet. Medications administered to Resident #42 included a probiotic tablet, omeprazole, multivitamin and 1.5 tablets of bumetidine. RN #1 used hand sanitizer after administering medications to Resident #42.	F 880	med pass observation x 2 to ensure infection control practices are being followed. Corrections will be made immediately at the time of identification. 3. Current nursing staff will be educated on hand hygiene. A nursing employee will be observed performing hand hygiene 3x weekly x 4 weeks to ensure appropriate infection control practices are being followed. 4. Process will be reviewed in QA x 1 quarter. 5. 12/16/21	

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F 880	Continued From page 18	F 880		

On 11/8/21 at 8:08 a.m., RN #1 prepared and administered a pain medication to Resident #41. RN #1 popped a Tramadol tablet from the supply card into her bare hand prior to placing in the medication cup. The resident dropped this medication prior to taking it. RN #1 discarded the tablet and prepared another tablet of Tramadol in the same manner, popping the pill into her bare hand prior to administration.

On 11/8/21 at 8:21 a.m., RN #1 was interviewed about contacting all the oral medications with her bare fingers and/or hands prior to placing in the medication cup. RN #1 stated she was nervous. RN #1 stated she should have put gloves on to handle the medicines or popped them directly into the medication cup.

On 11/9/21 at 10:15 a.m., the director of nursing (DON) was interviewed about RN #1 touching the oral medications barehanded. The DON stated the accepted practice was not to touch pills directly with hands or fingers. The DON stated nurses were supposed to use a spoon if necessary to retrieve pills from bottles or place them directly into the medication cup from the supply card or bottle.

The facility's policy titled General Guidelines for Medication Administration (revised 8/2020) documented, "Medications are administered as prescribed in accordance with good nursing principles and practices...The person administering medications adheres to good hand hygiene, which includes washing hands thoroughly...Before beginning a medication pass...Prior to handling any medication...Examination gloves are worn when necessary..."

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F 880	Continued From page 19 These findings were reviewed with the administrator and director of nursing on 11/8/21 at 4:40 p.m.	F 880		