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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted on 7/24/2023 through 7/26/2023 The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 7/24/2023 through 7/26/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code report will follow. Four complaints were investigated during the survey. Complaint VA00056344 was unsubstantiated. Complaint VA00056993 was unsubstantiated. Complaint VA00058060 was unsubstantiated. Complaint VA00059009 was unsubstantiated. The census in this 111 certified bed facility was ninety-four at the time of the survey. The survey sample consisted of nineteen current record reviews and three closed record reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to complete an accurate minimum data set (MDS) for one of twenty-two residents in the survey sample (Resident #19).	F 641		

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

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The findings include:

Resident 19's annual MDS dated 6/23/23 failed to accurately assess the resident's dental problems.

Resident #19 (R19) was admitted to the facility with diagnoses that included Alzheimer's disease, major depressive disorder, anxiety, hypothyroidism, schizoaffective mood disorder, dysphagia, congestive heart failure, and gastroesophageal reflux disease. The MDS dated 6/23/23 assessed R19 as cognitively intact.

On 7/24/23 at 11:12 a.m., R19 was interviewed about quality of care/life in the facility. Resident #19 stated her teeth had been in bad shape for a long time. R19 displayed her teeth, revealing that most of her top teeth were missing and the lower front teeth were broken near the gum line with black/dark discoloration on the teeth surfaces. Several bottom teeth were also missing.

Section L0200 of R19's MDS dated 6/23/23 documented that the resident had no dental problems. This category to indicate obvious or likely cavities or broken natural teeth was not marked. Item Z. was marked indicating R19 had no oral/dental problems.

On 7/25/23 at 1:25 p.m., the registered nurse (RN #2) responsible for MDS assessments was interviewed about R19's dental assessment. RN #2 reviewed the 6/23/23 MDS and stated that R19's dental problems were not indicated on the assessment. RN #2 then stated that R19's poor dentition should have been marked/indicated under section L of the MDS.

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F 641	Continued From page 2 The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual on pages L-1 and L-2 documents regarding oral/dental assessment, "...This item is intended to record any dental problems present in the 7-day look-back period...Check L0200D, obvious or likely cavity or broken natural teeth: if any cavity or broken tooth is seen..." (1) This finding was reviewed with the administrator and director of nursing during a meeting on 7/25/23 at 4:10 p.m., with no further information presented about the inaccurate MDS prior to the end of the survey. (1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, Centers for Medicare & Medicaid Services, Revised October 2019.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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 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	F 656		

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F 656	Continued From page 3 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, the facility staff failed to develop a comprehensive care plan for one of twenty-two residents in the survey sample (Resident #19) The findings include: Resident #19 (R19), assessed with severely	F 656		

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impaired vision, had no plan of care regarding blindness/vision impairment.

Resident #19 was admitted to the facility with diagnoses that included Alzheimer's disease, major depressive disorder, anxiety, hypothyroidism, schizoaffective mood disorder, dysphagia, congestive heart failure, and gastroesophageal reflux disease. The MDS dated 6/23/23 assessed R19 as cognitively intact and with severely impaired vision.

On 7/24/23 at 11:17 a.m., R19 was interviewed about quality of care/life in the facility. R19 stated that she had poor vision and was only able to see "shadows." Resident #19 stated that staff assisted her daily with placing items in familiar places and informing her about the location of needed items.

Resident #19's MDS dated 6/23/23 included vision as a triggered concern in the care area assessment summary and was marked that care planning was done regarding visual function.

Resident #19's comprehensive plan of care (revised 7/10/23) included no problems, goals and/or interventions regarding the R19's vision impairment.

On 7/25/23 at 1:30 p.m., the registered nurse (RN #2) responsible for MDS/care plans was interviewed. RN #2 stated that if a care area triggered on the MDS, the concern should be on the comprehensive plan of care. RN #2 reviewed R19's care plan and stated that there was no plan regarding visual impairment. RN #2 stated, "There should be a care plan regarding poor vision."

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F 656	Continued From page 5 This finding was reviewed with the administrator and director of nursing during a meeting on 7/25/23 at 4:10 p.m. with no further information presented regarding the care plan prior to the end of the survey.	F 656		
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 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 apply a wander prevention device as required in the plan of care for one of twenty-two residents in the survey sample (Resident #25). The findings include: Resident #25 (R25) was admitted to the facility with diagnoses that included adult failure to thrive, atherosclerotic heart disease, hypertension, chronic kidney disease, dementia, psychotic/mood disturbance, anxiety and thrombocytopenia. The minimum data set (MDS) dated 5/25/23 assessed R25 with severely impaired cognitive skills. R25's comprehensive plan of care (revised 6/20/23) documented that R25 was at risk of	F 689		

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wandering/elopement due to disorientation, poor safety awareness, aimless wandering, and a history of attempts to leave the facility. Interventions to maintain safety included, "...wander guard on at all times..." R25's treatment administration record for July 2023 documented placement of the wander prevention device each shift, and function of the wander prevention device checked daily on the night shift.

Resident #25's clinical record documented a physician's order dated 6/14/23 to, "Check placement of wander bracelet every shift...Wander bracelet - Check function daily."

On 7/25/23 at 8:36 a.m., R25 was observed seated on the bedside. There was no wander prevention device observed on either wrist or ankle. On 7/25/23 at 9:28 a.m., accompanied by certified nurses' aide (CNA) #1, Resident #25 was observed for use of the wandering prevention device. CNA #1, with R25's permission, displayed the resident's wrists and ankles with no wander prevention bracelet observed in use. CNA #1 stated at this time that R25 previously had a Wanderguard device, but she did not know what happened to it. CNA #1 searched R25's walker, wheelchair, beside table, and storage drawers, and then stated that she had not found the device. CNA #1 stated that R25 got up and walked independently with the walker, as well as self-propelling in the wheelchair.

On 7/25/23 at 9:34 a.m., the registered nurse (RN #3) caring for R25 was interviewed about the wander prevention device. RN #3 checked R25's clinical record and stated that R25 had a physician's order for a wandering device and that she did not know why the device was not in use.

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F 689	Continued From page 7 On 7/25/23 at 3:16 p.m., the licensed practical nurse (LPN #3) unit manager was interviewed. LPN #3 stated R25 had a history of exit seeking, increased confusion when he had a urinary tract infection, but had never eloped from the facility. LPN #3 stated that R25 was supposed to have a wander prevention device and at times had attempted to remove the device. LPN #3 stated that prior to today, the wander prevention device had been observed on R25's right wrist. This finding was reviewed with the administrator and director of nursing during a meeting on 7/25/23 at 4:10 p.m. with no other information presented about the safety device prior to the end of the survey.	F 689		
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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		

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§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 observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure medication was available for administration for two of four residents during the medication pass and pour observation (Resident #8 and Resident #89).

1.

2.

The Findings Include:

1. Resident #8's (R8) Telmisartan 40 milligrams (given for hypertension) was unavailable for administration as ordered by the physician.

During a medication pass and pour observation conducted on 7/25/22 at 8:00 AM, Resident #8 (R8) was scheduled to receive Telmisartan 40 MG at 8AM. Licensed practical nurse (LPN #2) looked into the medication cart and verbalized that the medication was not available to give. LPN #8 then called the pharmacy and relayed

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that it was stated that the medication would be arriving later in the day.

On 7/25/23 at 10:04 AM, LPN #2 was asked when do nurses reorder medications. LPN #2 said that she usually reorders medication when there are 5 pills left to distribute. LPN #2 was then able to look up when the medication was ordered and verbalized that the Telmisartan had been ordered on 7/24/23 (day prior to the medication observation). LPN #2 then reviewed the medication administration record and verbalized that R8 had received the medication on 7/24/23.

The physician's order for R8's Telmisartan was reviewed and documented: "Telmisartan 40 MG Tablet 10 MG one time a day" dispense "9:00 AM."

On 5/25/23 at 4:10 PM, the above finding was presented to the director of nursing, administrator, and nurse consultant.

A policy titled "Ordering and Receiving Non-controlled Medications" read in part " Reorder medications based on estimated refill date on the pharmacy label, or at least three days in advance, to ensure an adequate supply is on hand."

No other information was presented prior to exit conference on 7/26/23.

2. Resident #89's (R 89) Paroxetine 10 milligrams was unavailable for administration as ordered by the physician.

A medication pass observation was conducted on 7/25/23 at 7:54 a.m. with registered nurse (RN

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#3) administering medications to Resident #89 (R89). Medications administered to R89 included Paroxetine 20 mg (milligrams). RN #3 stated at the time of administration that the 10 mg tablet of Paroxetine was not in the medication cart.

Resident #89's clinical record documented a physician's order dated 5/11/23 for Paroxetine 30 mg each day for treatment of depression.

On 7/25/23 at 9:11 a.m., RN #3 was interviewed about the unavailable Paroxetine 10 mg for Resident #89. RN #3 stated the Paroxetine was supplied from the pharmacy with a 20 mg and a 10 mg tablet to equal the ordered 30 mg dose. RN #3 stated the Paroxetine 10 mg was not in the medication cart and was not in the backup supply.

On 7/25/23 at 9:25 a.m., RN #3 stated that the Paroxetine 10 mg had been reordered on 7/23/23 but had not yet arrived from the pharmacy. RN #3 stated that it typically took two to three days for routine delivery of ordered medications and that Paroxetine was not a medication kept in the backup supply.

On 7/25/23 at 1:08 p.m., the director of nursing (DON) was interviewed about the unavailable Paroxetine. The DON stated that nurses were expected to reorder medications three to five days prior to running out in order to maintain a supply. The DON stated that reorders were entered/processed from the computer system.

The facility's policy titled Ordering and Receiving Non-Controlled Medications (revised 08/2020) documented, "...Medication and related products are received from the pharmacy on a timely

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F 755	Continued From page 11 basis...Reordering medications is done in accordance with the order and delivery schedule established by the pharmacy provider...Reorder medications based on the estimated refill date (ERD) on the pharmacy Rx label, or at least three days in advance, to ensure an adequate supply is on hand..." This finding was reviewed with the administrator and director of nursing during a meeting on 7/25/23 at 4:10 p.m. with no further information presented about the unavailable medication prior to the end of the survey.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; 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 ensure a medication error rate of less than five percent. Medication pass observations revealed five errors out of forty-one opportunities, resulting in a 12.2% error rate The Findings Include: 1. Resident #2 (R2) was given the wrong dose of Calcium. During a medication pass and pour observation conducted on 7/25/23 at 8:00 AM, license	F 759		

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practical nurse (LPN #2) began pulling medications out of the medication cart for R2 and handing the medications to this surveyor to document. One of the medications pulled from the medication cart was Calcium 600 MG (milligrams) with Vitamin D 5 mcg (micrograms). LPN #1 dispensed the medication into the medication cup and administered to R2.

R2's physician's orders were then reviewed to verify accuracy of medications given. There was a physician's order to give "Calcium 500 MG/VIT D 400 IU (international units)", a combination medication for osteoporosis, which differed from the calcium that had been administered.

On 7/25/23 at 11:07 AM, the ADON (assistant director of nursing) discussed the observation findings with this surveyor and verbalized that the wrong dosage of calcium and vitamin D had been given, that the nurse practitioner was made aware, and that the order had been changed to the medication that the pharmacy had delivered.

On 7/25/23 at 4:10 PM the above information was presented to the director of nursing (DON) and administrator.

No other information was presented prior to exit on 7/12/23.

2. Resident #8 (R #8) was not given Telmisartan 40 MG as ordered (given for hypertension).

During a medication pass and pour conducted on 7/25/22 at 8:00 AM, Resident #8 (R #8) was scheduled to receive Telmisartan 40 MG. Licensed practical nurse (LPN #2) looked into the

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medication cart and verbalized that the medication was not available to give. LPN #2 then called the pharmacy and relayed the information that the medication would be arriving until later in the day.

On 7/25/23 at 10:04 AM, LPN #2 was asked what is the time period for giving a scheduled medication. LPN #2 verbalized a medication can be given an hour before or after the scheduled time.

The physician's order for R #8's Telmisartan was reviewed and documented: "Telmisartan 40 MG Tablet 10 MG one time a day... dispense 9:00 AM."

On 7/25/23 at 10:45 AM, LPN #2 verbalized R #8's medication had arrived. The medication was reviewed for correct medication and dose and was then administered to R #8.

On 5/25/23 at 4:10 PM, the above finding was presented to the director of nursing, administrator, and nurse consultant. The DON agreed that medications are to be given within the standard administration range of an hour before or after the scheduled time.

No other information was presented prior to exit conference on 7/26/23.

3. Resident #89 (R 89) was given the wrong dose of Paroxetine, Senna instead of Senna with stool softener, and Breo Ellipta was administered but no followed by the mouth rinse.

A medication pass observation was conducted on 7/25/23 at 7:54 a.m. with registered nurse (RN #3) administering medications to Resident #89

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(R89). Medications administered to R89 included Paroxetine 20 mg (milligrams), Geri-kot senna 8.6 mg, and Breo Ellipta 200 mcg/25 mcg. R89 did not rinse her mouth after the inhalation of the Breo Ellipta and there was no prompting or request by RN #3 instructing R89 to do so.

R89's clinical record documented a physician's order dated 5/11/23 for Paroxetine 30 mg each day for treatment of depression, a physician's order dated 6/8/23 for Senna-Docusate sodium 8.6 mg/50 mg two times per day for constipation, and a physician's order dated 5/15/23 for Breo Ellipta inhalation aerosol powder 200-25 mcg/activation, one puff inhaled orally each day for management of emphysema with instructions to, "Rinse mouth after administration to prevent candidiasis [mouth infection]." No physician's order was found for the plain Senna 8.6 mg.

On 7/25/23 at 9:11 a.m., RN #3 was interviewed about the medications observed as being administered not as ordered by the physician. RN #3 stated that the Paroxetine was supplied from pharmacy in a 20 mg and 10 tablet to equal the needed 30 mg dose. RN #3 stated that the 10 mg tablet was not available in the medication cart and it was not in the backup supply. RN #3 stated that the senna products were ordered in-house and she was not sure if the senna-docusate sodium product was in the cart. RN #3 stated that she did not think about prompting or instructing the resident to rinse her mouth after the inhaled dose Breo Ellipta powder.

The facility's pharmacy information for the medication Breo Ellipta (issue date 7/19/23) documented under instructions for administration, "Rinse out mouth after each use. Do not swallow

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F 759	Continued From page 15 the rinse water. Spit it out..." These findings were reviewed with the administrator and director of nursing during a meeting on 7/25/23 at 4:10 p.m. with no further information presented about the medication errors prior to the end of the survey.	F 759		
F 812 SS=F	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 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 observations, interview, record review, and policy review, the facility failed to ensure the kitchen was maintained in a sanitary manner to prevent potential foodborne illness for 93 out of 94 residents (1 resident was receiving tube feedings). Specifically, the main kitchen freezer was found to have improperly labeled foods in the	F 812		

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freezer and three out of four-unit pantry refrigerators were found to be improperly labeled and had expired food items. This failure had the potential to expose residents to expired and/or spoiled food, unknown allergens, and food items that were not in compliance with current dietary orders.

Findings include:

Review of the undated facility policy titled, "Receiving and Storage of Food" revealed, "Foods shall be received and stored in a manger that complies with safe food handling practices. Food Services, or other designated staff, will maintain clean food storage areas at all times ...All foods stored in the refrigerator or freezer will be covered, labeled, and dated ("use by" date.) ...Food items and snacks kept on the nursing units must be maintained as indicated...a. All food items to be kept below 41 degrees Fahrenheit must be placed in the refrigerator located at the nurses' station and labeled with a "use by" date, b. All foods belonging to residents must be labeled with the resident's name, the item and the "use by" date, c. Refrigerators must have working thermometers and be monitored for temperature, d. Beverages must be dated when opened and discarded after 24 hours, e. Other opened containers must be dated and sealed or covered during storage, f. partially eaten food may not be kept in the refrigerator."

Review of the undated facility policy titled "Refrigerators and Freezers" revealed, "The facility will ensure safe refrigerator and freezer maintenance, temperatures and sanitation and will observe food expiration guidelines ...All food will be appropriately dated to ensure proper

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rotation by expiration dates ..."Use by" dates may be completed with expiration dates on all prepared food in refrigerator ...Expiration dates on unopened food will be observed and "use by" dates indicated once food is opened ...Supervisors/designee will be responsible for ensuring food items in pantry, refrigerators and freezers are not expired or past perish dates."

A tour of the kitchen on 07/24/23 at 10:22 AM was conducted with the Food Service Manager (FSM)2.

In the main freezer an opened, undated, and unlabeled cake was observed. FSM2 stated that she did not know what the cake was and immediately discarded it. Additionally, an opened, undated, and unlabeled blue plastic bag of unidentified contents was observed. FSM2 stated that they were "lima beans" and immediately discarded the food item.

A tour of the "Unit Pantry" refrigerators, which was where the residents could store their food from outside and where "Food Services" provided beverages and small snacks for the residents, was conducted on 07/26/23 at 8:27 AM, with the corporate Food Service Director (FSD)1 and FSM2.

In the refrigerator on the first-floor unit pantry a white plastic bag was observed on the door of the refrigerator. The bag had a resident's name on it (Resident (R) 54) and was dated 07/12/23. FSM2 opened the bag which appeared to contain sliced meat and cheese. There was also a bag containing bottled "smoothies" with R92's name on them and a date of 07/22/23. (R92's diet order was nothing by mouth (NPO) at the time of the

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tour.) The Licensed Practical Nurse (LPN) 1 on the unit stated that the process [when resident's keep food in the refrigerator] is that "if family brings in a food item for a resident, it should have a name, date, and room number."

On the 2nd floor, observation of the "North" unit pantry revealed that there was no thermometer in the refrigerator. A Certified Nursing Assistant (CNA) 2 who was near the refrigerator area was immediately interviewed. CNA2 stated, "Food that comes in from the residents should be labeled, dated, and have a room number on it." CNA2 stated that it should be three days from when the food item comes in until it is discarded. When questioned, CNA2 did not know where the thermometer was. An observation of the freezer revealed that there was an unlabeled, undated bag of frozen food items in a Walmart bag, with the designation "Room 209" on it.
On the 2nd floor "South" unit pantry, CNA1 stated that when a food item comes in from outside it should be dated and labeled with the resident's room number. CNA1 stated that the 11pm-7am CNA is responsible for doing the temperatures. Observation of the refrigerator revealed the following: 1. an opened, unlabeled, undated 20-ounce container of mayonnaise was observed. CNA1 stated that she didn't know who's that [the mayonnaise] was and that they [the staff] probably just used it if someone [a resident] asked for mayonnaise; 2. an unlabeled, undated 20-ounce container of mustard was observed; 3. an unlabeled, undated 16-ounce container of what looked to be a reddish jar of non-store-bought preserves was observed; 4. an opened, unlabeled, undated 15-ounce bottle of lemon juice was observed; and 6. An unlabeled, undated expired 6-ounce container of yogurt was

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F 812	Continued From page 19 noted in the door of the refrigerator with a manufacturer's expiration date of 07/18/23. Observation of the freezer compartment revealed an unlabeled, undated, one-quart container of ice cream. During the unit pantry tour on 07/26/23 at 8:43 AM, FSM2 was interviewed. FSM2 revealed that the kitchen was responsible for restocking the soda, pudding, apple sauce, and milk, while the nursing staff was responsible for taking the temperatures in the refrigerator and managing the items that came in from resident family members. FSM2 indicated the sign on the refrigerator that stated "Please label resident food items with name and date, place in fridge. Items will be discarded if not labeled and dated. All food items will be discarded after 72 hours."	F 812		
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,	F 880		

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F 880	Continued From page 20 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; (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.	F 880		

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F 880	Continued From page 21 §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 practices regarding hand hygiene during a dressing change for one of twenty-two residents in the survey sample (Resident #25) and on one of two units during the medication pass (unit 2). The findings include: 1. Infection control practices regarding hand hygiene were not followed during a dressing change to Resident #25's foot callous. Resident #25 (R25) was admitted to the facility with diagnoses that included adult failure to thrive, atherosclerotic heart disease, hypertension, chronic kidney disease, dementia, psychotic/mood disturbance, anxiety and thrombocytopenia. The minimum data set (MDS) dated 5/25/23 assessed R25 with severely impaired cognitive skills. Resident #25's clinical record documented the resident had a callous on the plantar surface of the right foot with a physician's order dated 7/18/23 for Bacitracin and a dry dressing applied to the wound each day shift.	F 880		

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On 7/24/23 at 3:25 p.m., registered nurse (RN #3) was observed performing a dressing change to R25's right foot callous. RN #3 washed hands and directly touched the faucet handles when turning off the water and prior to drying her hands with a paper towel. RN #3 then put on clean gloves, removed the soiled dressing from the right foot and discarded it. Without performing hand hygiene or changing gloves, RN #3 applied Bacitracin to the new dressing and applied the clean dressing to the right foot callous. The calloused area was approximately dime sized, flat, intact with pink/red skin surrounding the callous.

On 7/24/23 at 3:35 p.m., RN #3 was interviewed about the handwashing and not changing gloves after removing the soiled dressing. RN #3 stated that she forgot and was aware to perform hand hygiene and change gloves after removing an old dressing.

2. RN #3 performed improper hand hygiene during a medication pass observation on unit 2.

A medication pass observation was conducted on 7/25/23 at 7:54 a.m. with registered nurse (RN #3) administering medications to Resident #89 (R89) and Resident #25 (R25). Prior to preparing medications for R89, RN #3 washed her hands and directly touched the faucet handle when turning off water and prior to drying hands with a paper towel. RN #3 then administered medications to R89 and washed hands again, touching the faucet handle prior to drying her hands. RN #3 then prepared and administered medications to R25. RN #3 washed her hands after the medication administration in the same manner, directly touching the faucet handle with a

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bare hand prior to drying her hands with a paper towel.

On 7/25/23 at 8:38 a.m., RN #3 was interviewed about washing hands and then touching the faucet handles. RN #3 stated, "Sometimes I forget when I'm rushing." RN #3 stated she was "nervous" and knew she was noy supposed to touch the faucet handles after washing hands.

On 7/26/23 at 8:53 a.m., the licensed practical nurse (LPN #4) responsible for infection prevention programs was interviewed about hand hygiene. LPN #4 stated nurses were not expected to touch faucet handles after washing hands but instead use their elbow or paper towel to turn off the water. LPN #4 stated a glove change and proper hand hygiene were expected after removal of a soiled dressing. LPN #4 stated RN #3 had been educated before about improper hand hygiene.

The facility's policy titled Clean Dressing (undated) documented steps for a clean dressing change that included, "...Wash and dry your hands thoroughly...Put on clean gloves. Loosen tape and remove soiled dressing...Pull glove over dressing and discard into plastic or biohazard bag...Wash and dry your hands thoroughly...Open, dry, clean dressing...Wash and dry your hands thoroughly...Put on clean gloves...Apply the ordered dressing and secure with tape or bordered dressing per order..."

The facility's policy titled Hand Hygiene (undated) documented, "...This facility promotes hand hygiene as a simple and effective method for preventing the spread of infections. Glove use is not a substitute for hand hygiene..." Procedures

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F 880	Continued From page 24 for proper handwashing included, "...Wet hands and wrist...Apply enough soap to cover all of hand surfaces...Vigorously rub lathered surfaces...for at least 20 seconds...Rinse wrists and hands thoroughly under a stream of running water...Dry hands completely with a clean paper towel...Use dry paper towel to turn faucet off..." These findings were reviewed with the administrator and director of nursing during meetings on 7/25/23 at 4:10 a.m. and on 7/26/23 at 12:30 p.m.	F 880		