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FAIRFAX REHABILITATION AND NURSING CENTER	10701 MAIN STREET FAIRFAX, VA 22030

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted onsite 05/23/23 through 05/25/23. Corrections are required for compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. Sixteen (16) complaints were investigated during the survey. The census in this 200 certified bed facility was 187 at the time of the survey. The survey sample consisted of 28 resident reviews and 8 employee reviews. VA00055507-Compliant with regulations. VA00056140-Compliant with regulations. VA00056162-Non-compliant deficient practice cited. VA00056152-Compliant with regulations. VA00056231-Non-compliant deficient practice cited. VA00056598-Compliant with regulations. VA00057307-Compliant with regulations, unrelated deficient practice cited. VA00057834-Compliant with regulations. VA00057923-Compliant with regulations. VA00058099-Compliant with regulations, unrelated deficient practice cited. VA00058104-Compliant with regulations. VA00058111-Compliant with regulations. VA00058269-Compliant with regulations. VA00058327-Compliant with regulations. VA00058876-Compliant with regulations. VA00058912-Compliant with regulations.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		6/27/23

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

Electronically Signed | 06/19/2023

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 657	Continued From page 1 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure quarterly care plan meetings were held, documented, and included the resident representative for 1 of 28 residents, Resident #7. The findings were:	F 657	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of	

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F 657	Continued From page 2 The facility staff failed to ensure quarterly care plan meetings were held and included Resident #7's representative. Resident #7's annual minimum data set with an assessment reference date of 02/22/23 assigned a brief interview for mental status (BIMS) score of 05 out of 15 in Section C (cognitive patterns). The director of social services (DSS) was interviewed on 05/23/23 at 11:04 a.m. The surveyor requested evidence of Resident #7's comprehensive care planning meetings between September 2022 and March 2023. On 05/24/23 at 10:15 a.m., the DSS reported not finding any care plan meeting notes or sign-in sheets between September 2022 and March 2023. The DSS acknowledged the CP meetings were normally held on a quarterly basis and that if, for example, Resident #7's care planning meeting took place in September, the next one would be due in December. The administrator provided two (2) "INVA-Care Conference Note - V2" documents which noted a care plan meeting was held in person on 04/14/21 with the resident's responsible party (RP) and another son attending via phone conference. The second document noted a meeting held on 04/11/22 with a son (not the RP) in attendance via telephone. Two discharge planning communication with family notes read that family/son were spoken with and sent an email regarding a care plan meeting for 03/01/23. A "Care Plan Signature Page" dated 03/01/23 contained Resident #7's RP, another son, and multiple staff's signatures. No evidence of another care plan meeting was provided. On 05/25/23 at approximately 11:50 a.m., the regional director of clinical services reported the	F 657	correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F657 Care Plan Timing and Revision 1. Resident # 7 care plan meeting was scheduled, held with responsible party, and documented on 06/07/2023. 2. Current residents admitted within the past 90 days will have care plans audited by the Director of MDS or designee to verify quarterly care plan was scheduled, held with responsible party and/or resident (as able) and documented. Any findings will be corrected. 3. The Regional Director of MDS or designee will educate MDS staff on the process for care plan meetings to ensure that care plans are scheduled, held, and documented with responsible party and resident (as able). 4. The MDS staff or designee will audit scheduled care plans to verify completion and documentation. The results of the review will be discussed in the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists. The reviews will be completed on a random basis. The Administrator/Director of Nursing is responsible for implementation of the plan of correction. 5. Date of Compliance 6/27/2023	

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F 657	Continued From page 3 family care plan meetings were expected to take place quarterly, as the policy stated. The director provided a policy titled, "Care Planning" policy number 2602 with an effective date 11/01/19 which read in part, "4. The comprehensive assessment and plan of care will include, at a minimum, input obtained from the attending physician, the nurse, and the nurse assistant who has responsibility for the patient; a member of the food and nutrition services staff, other appropriate staff or professionals as needed or requested by the patient, and to the extent practicable, the participation of the patient and/or representative(s) to participate, a progress note must be entered with explanation into the medical record." And "6. Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment." During a meeting on 05/25/23 at 4:30 p.m., the administrator, regional director of clinical services, director of social services, wound nurse, director of nursing and director of human resources were informed of the above findings. No further information was provided prior to exit.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to	F 661		6/27/23

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F 661	Continued From page 4 include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to complete a post discharge plan of care for 1 of 28 residents, Resident #12. The findings included: The post discharge plan of care was incomplete. There was no documentation under Nursing or Therapy and it did not include any signature from the resident or the responsible party. Resident #12's diagnoses included, but were not limited to, metabolic encephalopathy (primary), sepsis due to escherichia coli, methicillin susceptible staphylococcus aureus infection, urinary tract infection, Alzheimer's, respiratory syncytial virus, and benign prostatic hyperplasia.	F 661	F661 Discharge Summary 1. Resident #12 is no longer a resident in the facility. 2. Current residents scheduled for discharge for this week ending 6/16/2023 will have an audit completed by the discharge planner or designee to verify discharge summary/instructions information is completed by all designated departments including resident and /or responsible party signature. Any findings will be corrected. 3. The Administrator or designee will educate the IDT including all department managers responsible for completing the discharge summary/instructions on the process for completing all information on the discharge summary/instructions with	

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F 661	Continued From page 5 Section C (cognitive patterns) of Resident #12's admission Minimum Data Set (MDS) assessment with an assessment reference date of 11/10/22 included a BIMS (brief interview for mental status) summary score of 8 out of a possible 15 points. Per the MDS manual a score of 8=moderately impaired. Section O (special treatments/programs) was coded to indicate Resident #12 received IV medications while a resident at the facility. Resident #12's comprehensive care plan included the focus areas of midline venous catheter, isolation, at risk for elopement, and wanderguard to left ankle. A review of the "Discharge Instructions/Post Discharge Plan of Care" was completed by the surveyor. The nursing section and therapy portion of the document was not completed. The patient and/or responsible party had not signed or dated the document. 05/24/23 9:45 a.m., the Discharge Planner stated they had started this position in January 2023 and the previous discharge planner no longer worked at the facility. The previous discharge planner had completed the discharge planning section and e signed the document on 12/23/22. Resident #12 was discharged on 12/24/22. The facility staff provided the survey team with a document titled, "Social Work and Discharge Planning Role in Extended Long Term Care." Effective date 01/06/20. This document read in	F 661	resident and/or responsible party signature. The SDC (staff development coordinator) will educate the licensed nurses and rehab staff on the process of completing all information on their designated sections with resident and/or responsible party signature. 4. The discharge planner or designee will review all planned discharge summaries/instructions weekly x 4 weeks to ensure discharge summary/instructions is complete including resident and/or responsible party signature, any findings will be corrected. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists. The reviews will be completed on a random basis. The Administrator/Director of Nursing is responsible for implementation of the plan of correction. 5. Date of compliance: 6/27/2023	

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F 661	Continued From page 6 part, "...Initiate and coordinate completion of Discharge Instructions/Post Discharge Plan of Care." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 661		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide activity of daily living (ADL) care for a dependent care resident for 1 of 28 residents, Resident #21. The findings included: Resident #21's fingernails and toenails were observed to be long. Resident #21's diagnoses included, but were not limited to, diabetes, mild cognitive impairment, and muscle weakness. Resident #21's comprehensive care plan included the intervention remind resident to ask for assistance with ADL's (12/29/22). Section C (cognitive patterns) of Resident #21's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of	F 677	F677 ADL Care Provided for Dependent Residents 1. Resident #21 fingernails and toenails were trimmed. A Podiatry consult placed and implemented on 5/25/2023. 2. An audit of current residents by the unit manager or designee was conducted to assess if finger and /or toenail care required or podiatry consult needed and submitted, any findings were corrected. 3. The staff development coordinator or designee will educate the licensed nurses and CNAs on the procedures for nail care for fingers and toes and on the process for submitting podiatry consults. 4. The unit manager or designee will audit 10 residents weekly x 4 weeks to assess if finger and /or toenail care is required and if a podiatry consult is needed and submitted. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee	6/27/23

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F 677	Continued From page 7 02/15/23 was coded 1/1/1 to indicate Resident #21 had problems with long and short term memory and had modified independence in cognitive skills for daily decision making. Section G (functional status) had been coded 3/2 for personal hygiene indicating Resident #21 required extensive assistance of one person for this task. 05/25/23 8:45 a.m., Resident #21's fingernails were observed to be long. After observing the residents fingernails Licensed Practical Nurse (LPN) #13 stated to Resident #21 they could cause them to cut themselves and offered to trim the residents nails. Resident #21 stated their nails had never been that long. The surveyor and LPN #13 checked Resident #21's toenails and these were also observed to be long and in need of trimming. 05/25/23 4:25 p.m., during a meeting with the Administrator, Director of Nursing, Nurse Consultant, Social Services, and Wound Nurse the issue regarding Resident #21's nail care was reviewed. The facility provided the survey team with a copy of their policy titled, "Ancillary Nursing Care and Services." Effective date 11/01/19, this policy read in part, "Nursing personnel will provide basic nursing care and services..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 677	determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing is responsible for implementation of the plan of correction. 5. Date of compliance : 6/27/2023	
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		6/27/23

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F 684	Continued From page 8 § 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 staff interview, clinical record review, and during a medication pass and pour observation, the facility staff failed to ensure the highest practicable well being for 1 of 28 residents, Resident #25. The findings included: For Resident #25, the facility staff failed to administer the oral medication Pravastatin as ordered by the physician. Pravastatin is a statin medication used to lower cholesterol and triglycerides. Resident #25's diagnosis list indicated diagnoses, which included, but not limited to Cerebral Infarction, Aphasia, Dysphagia, Hemiplegia and Hemiparesis, Hyperlipidemia, and Paroxysmal Atrial Fibrillation. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 5/12/23 coded Resident #25 as being moderately impaired in cognitive skills for daily decision making with short-term and long-term memory problems. On 5/25/23 at 8:25 am during a medication pass	F 684	F684 Quality of Care 1. Resident #25 the physician was informed medication was not administered on 5/25/2023. The resident continues to receive ordered medication per physician orders. 2. The unit manager will conduct an audit on current residents to assess missed medications on 5/25/2023 and verify the process for missed medications was followed, any findings will be corrected. 3. The staff development coordinator or designee will educate the licensed nurses on the process for medication administration, obtaining unavailable medications and informing the physician for unavailable or missed medications with documentation. 4. The unit manager or designee will audit medications not administered weekly x 4 weeks to verify process was followed for missed or unavailable medications, physician notified with documentation, any findings will be corrected. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the	

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F 684	Continued From page 9	F 684		

and pour observation, surveyor observed registered nurse (RN) #8 prepare Resident #25's morning medications. RN #8 stated the resident's medication Pravastatin was not in the medication cart. At 8:48 am, the surveyor accompanied RN #8 to the Omnicell in-house medication supply to check for the availability of the Pravastatin, however, RN #8 stated the medication was not present in the Omnicell. RN #8 then stated they would contact the pharmacy for a STAT delivery and notify the physician and the responsible party.

Resident #25's current physician's orders included an order dated 5/10/23 for Pravastatin Sodium 20 mg by mouth one time a day. According to the resident's May 2023 Medication Administration Record (MAR), Pravastatin was signed as being administered from 5/11/23 through 5/24/23.

On 5/25/23 at 11:47 am, surveyor contacted the facility's contract pharmacy and spoke with the Director of Quality (DOQ) regarding Resident #25's Pravastatin. The DOQ stated they received a new script for Resident #25's Pravastatin on 5/10/23 and 30 tablets were dispensed on 5/11/23 but a return for the medication was processed. Surveyor again spoke with the DOQ at 12:05 pm who stated all 30 tablets of Pravastatin were returned to the pharmacy, but the return did not indicate the reason. DOQ stated the pharmacy processed the return on 5/22/23 but that did not necessarily mean the tablets were returned that day but sometime prior to 5/22/23. DOQ stated the Pravastatin was ordered again on 5/25/23 at 9:43 am and would be delivered.

On 5/25/23 at 12:18 pm, surveyor met with the

problem no longer exists. The reviews will be completed on a random basis. The Administrator/Director of Nursing is responsible for implementation of the plan of correction.

5. Date of compliance: 6/27/2023

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F 684	Continued From page 10 administrator, director of nursing, and the regional director of clinical services and discussed the concern of Resident #25's Pravastatin being returned to the pharmacy and unavailable in the facility onsite supply, however, staff had signed the MAR indicating the medication had been administered from 5/11/23 through 5/24/23. On 5/25/23 at 12:27 pm, surveyor spoke with licensed practical nurse (LPN) #19 who signed Resident #25's May 2023 MAR on 5/23/23 indicating they administered the resident's Pravastatin and asked where the medication was located at the time of administration. LPN #19 stated the medication would have been in the cart. On 5/25/23 at 12:29 pm, surveyor spoke with RN Unit Manager #1 who stated they did not see Pravastatin on the list of medications available in the Omnicell. On 5/25/23 at 1:53 pm, surveyor spoke with LPN #20 who signed the resident's May MAR on 5/24/23 indicating they administered the Pravastatin. When asked about the Pravastatin, LPN #20 stated whatever they saw they signed and gave it. LPN #20 stated they did not obtain any medication for Resident #25 from the Omnicell on 5/24/23. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/25/23.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F 690		6/27/23

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F 690	Continued From page 11 §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility document review, and clinical record review, the facility staff failed to address urinary incontinence for one (1) of 28 sampled residents (Resident #10).	F 690	F 690 Bowel/Bladder Incontinence, Catheter, UTI 1. Resident #10 no longer resides at the facility.	

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	495099	A. BUILDING _____ B. WING _____	C 05/25/2023

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F 690	Continued From page 12 The findings include: Resident #10's documented care failed to provide evidence of facility staff members addressing Resident #10's development of incontinence. Resident #10's "Resident Evaluation," with an "Effective Date" of 7/11/22 at 4:18 p.m., had the resident assessed as being continent of bowel and bladder; this assessment also indicated the resident used a urinal. Resident #10's clinical documentation included a progress note, dated 7/11/22 at 10:29 p.m., which stated the resident was continent of bowel and bladder. Resident #10's clinical documentation included a progress note, dated 7/15/22 at 1:33 p.m., which stated the resident was continent of bowel and bladder. Resident #10's activity of daily living (ADL) documentation indicated the resident experienced urinary/bladder incontinence during the 11p.m. to 7a.m. shift on the following dates: 7/12/22, 7/13/22, 7/14/22, 7/15/22, 7/16/22, 7/18/22, and 7/19/22. Resident #10 was documented as experiencing urinary/bladder incontinence during the 7a.m. to 3p.m. shift on 7/13/22. On 5/25/23 at 12:29 p.m., Licensed Practical Nurse (LPN) #18 reviewed Resident #10's clinical documentation. LPN #18 reported Resident #10's admission assessment indicated the resident was continent of bladder and continent of bowel. LPN #18 reviewed Resident #10's orders and plan of care. No orders or plan of care to	F 690	2. The MDS staff or designee will audit current residents with documented incontinence to verify a care plan for incontinence has been initiated with interventions. 3. The staff development coordinator or designee will educate the licensed nurses, MDS staff, on the process for care plan initiation, revisions /updates with interventions for residents that experience incontinence. 4. The MDS staff or designee will audit weekly x 4 weeks new admissions and residents with documented change in condition continence to verify a care plan has been initiated, revised/updated, any findings will be corrected. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists. The reviews will be completed on a random basis. The Administrator/Director of Nursing is responsible for implementation of the plan of correction. 5. Date of compliance: 6/27/2023	

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F 690	Continued From page 13	F 690		

address preventing incontinence or reducing the episodes of incontinence were found. (Resident #10's plan of care included interventions to: (a) address skin care related to incontinence and (b) assess if incontinence contributed to any falls.)

The following information was found in a facility polity titled "Ancillary Nursing Care and Services" (with an effective date of 11/1/19):
- "Nursing personnel will provide basic nursing care and services following accepted standards of practice guidelines recognized by state boards of nursing as informed by national nursing organizations and as evidenced by hiring individuals who graduate from an approved nursing school and/or nurse aide curriculum and have successfully passed a licensing and/or certification examination."
- "Specifics of care will be reflected in the patient's plan of care."

Resident #10's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 7/18/22, was dated as being completed on 7/30/22. (This was a Skilled Nursing Facility Prospective Payment System (PPS) assessment.) Resident #10 was assessed as being able to make self understood and as being able to understand others. Resident #10's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition. Resident #10 was documented as requiring extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. For toilet use Resident #10 was documented as requiring the assistance of two or more individuals.

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F 690	Continued From page 14 The survey team met with the facility's Administrator, DON, and Regional Director of Clinical Services on 5/25/23 at 4:25 p.m. During this meeting, the surveyor discussed the facility's failure to implement care and/or interventions to address Resident #10's episodes of incontinence.	F 690		
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 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 store	F 761	F 761 Label/Store Drugs and Biologicals 1. Unit 1 medication room door closed	6/27/23

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F 761	Continued From page 15 all drugs and biologicals in a locked and secure manner on 1 of 4 resident care units, 1st Floor. The findings included: On 5/25/23 at 8:45 am, during a medication pass and pour observation, surveyor accompanied registered nurse (RN) #8 to the 1st Floor Central Supply room to retrieve house stock medications. The Central Supply room was located on the 1st floor behind an unlocked door labeled "Maintenance" located beside the nurse's desk. Once entering the "Maintenance" door, the Central Supply room was located on the right with a door divided in half horizontally so the bottom half could remain shut while the top half opened. On observation, the top half of the door was open, and RN #8 reached over the bottom half of the closed door and turn the knob opening the lower half of the door and went inside the room. There were no staff present in the Central Supply room. The area contained multiple bottles of over-the-counter medications and various medical supplies. On 5/25/23 at 9:28 am, surveyor returned to the Central Supply room and again observed the top half of the door open, and the bottom half closed, surveyor reached over the lower door, turned the knob opening the door but did not enter the room. Surveyor observed two maintenance staff members in the hall near the Central Supply room and no one in the Central Supply room. On 5/25/23 at 9:40 am, surveyor spoke with a Central Supply staff member and described observations of Central Supply room door and asked if it should be open and unlocked and they stated they were new and did not know. The	F 761	and locked on 5/25/2023. 2. All current residents have the potential to be affected. The other units doors were closed and locked and verified by the unit managers on 5/25/2023. 3. The staff development coordinator or designee will educate the licensed nurses on the process for medication storage rooms that rooms must be contained behind a closed door and locked. 4. The unit manager or designee will audit weekly x 4 weeks to verify rooms with medication storage are closed and locked; any findings will be corrected. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists. The reviews will be completed on a random basis. The Administrator/Director of Nursing is responsible for implementation of the plan of correction. 5. Date of compliance: 6/27/2023	

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F 761	Continued From page 16	F 761		

director of nursing (DON) was present and stated the door was supposed to be locked.

On 5/25/23 at 10:01 am, the maintenance director (MD), regional director of clinical services (RDSC), and two surveyors went to the Central Supply room and observed the top and bottom halves of the door to be closed and locked. The maintenance director stated the nurses have a key to the door and the door stays closed and locked at all times. Surveyor demonstrated the earlier observations of the top half of the door open with the bottom half closed and reached over the door opening it. The maintenance director then stated somebody had left it open.

Surveyor requested and received the facility policy entitled "Storage of Medications" with an effective date of 9/2018 and revision date of 8/2020 which read in part " ...2. Only licensed nurses, pharmacy personnel and those lawfully authorized to administered medications (such as medication aides) are permitted to access medications. Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access ..."

On 5/25/23 at 4:26 pm, the survey team met with the management team including the administrator, director of nursing, RDCS, director of social services, director of human resources, and the treatment nurse and discussed the concern of the Central Supply room with multiple over the counter medications being observed unlocked and accessible on two separate occasions.

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

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F 761	Continued From page 17 conference on 5/25/23.	F 761		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility document review, the facility staff failed to provide a well-balanced diet as evidence by the use of serving utensils which provided smaller portions than the portion size identified on the facility's menu. The findings include: On 5/23/23, a dietary staff member (Staff Member (SM) #17) was observed using incorrect serving utensils while plating residents' meal trays. On 5/23/23 at 11:52, SM #17 was interviewed with the Dietary Manager present. SM #17 was the individual plating the residents' food on the tray line. SM #17 was unable to explain how the serving utensils were selected to ensure the correct portion size. The Dietary Manager reported the serving size was written on the menu. The Dietary Manager provided the surveyor with a copy of the menu with serving sizes. On 5/23/23 at 11:58, the SM #17 had started	F 800	F800 Provided Diet Meets Needs of Each Resident 1. Time has passed to correct. Serving sizes are currently being served per dietary guidelines. 2. All current residents have the potential to be affected. 3. The dietary manager or designee will educate the dietary staff on the process for utilizing the appropriate serving size utensils for meal preparation to meet dietary requirements. 4. The dietary manager or designee will audit weekly x 4 weeks to verify the dietary staff are utilizing appropriate serving size utensils for meal preparation, any findings will be corrected. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists. The reviews will be completed on a random basis. The Administrator/Director of Nursing is responsible for implementation of the plan of correction.	6/27/23

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F 800	Continued From page 18 plating residents' midday meal. The serving utensils, for the beef brown gravy, the seasoned beets, and the scalloped potatoes, were observed with the Dietary Manager. The Dietary Manager reported the incorrect serving utensils were being used for the beef brown gravy, seasoned beets, and scalloped potatoes. The brown gravy utensil being used was four (4) ounces but should have been two (2) ounces. The scalloped potatoes serving utensil being used was two (2) ounces but should have been four (4) ounces. The seasoned beets serving utensil being used was three (3) ounces but should have been four (4) ounces. The Dietary Manager immediately replaced the incorrect serving utensils with the correct size serving utensils. The following information was found as part of the facility's policy and procedure titled "Accuracy and Quality of Tray Line Service" (this document was not dated): - "All meals will be checked for accuracy by the food and nutrition services staff, and by the service staff prior to serving the meal to the individual." - "The menu extensions display food items and amounts for each regular or therapeutic diet." - "Each meal will be checked for: ... Proper portion sizes ..." The following information was found as part of the facility's policy and procedure titled "Portion Control" (this document was not dated): - "Individuals will receive the appropriate portions of food as outlined on the menu. Control at the point of service is necessary to assure that accurate portions sizes are served." The survey team met with the facility's	F 800	5. Date of compliance: 6/27/2023	

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F 800	Continued From page 19 Administrator, DON, and Regional Director of Clinical Services on 5/25/23 at 4:25 p.m. During this meeting, the surveyor discussed, for a final time, the observation of SM #17 using the incorrect serving utensil when plating residents' 5/23/23 midday meal trays.	F 800		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance	F 842		6/27/23

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F 842	Continued From page 20 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility document review, and clinical record review, the facility staff failed to maintain a complete and/or accurate	F 842	F842 Resident Records - Identifiable Information	

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F 842	Continued From page 21 clinical record for three (3) of 28 sampled residents (Resident #10, Resident #12, and Resident #25). The findings include: 1. Resident #10's clinical record failed to include documentation which would provide evidence of the resident being provided a shower while at the facility. Resident #10's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 7/18/22, was dated as being completed on 7/30/22. (This was a Skilled Nursing Facility Prospective Payment System (PPS) assessment.) Resident #10 was assessed as being able to make self understood and as being able to understand others. Resident #10's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition. Resident #10 was documented as requiring extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. For toilet use Resident #10 was documented as requiring the assistance of two or more individuals. Resident #10's activities of daily living (ADL) documentation indicated, between 7/12/22 and 7/20/22, that Resident #10 was provided at least one bath a day. This documentation detailed how much assistance was required for "How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair)". This did not detail if the bathing occurred as a shower, tub, or bed-bath.	F 842	1. Resident #10 no longer resides in the facility. Resident #12 no longer resides in the facility. Resident #25 the physician was notified of medication not administered on 05/25/2023 and is being administered per physician order. 2. All residents have the potential to be affected. 3. The staff development coordinator or designee will educate the CNAs on the process for completion of documentation in the clinical record to support shower or bed bath was offered, given or declined. The licensed nurses will be educated on the processes for completion of documentation in the clinical record to support central lines are discontinued and wander guard are removed and for medication administration, obtaining unavailable medications and informing the physician for unavailable or missed medications with documentation. 4. The unit manager or designee will complete audits weekly x 4 to assess showers and/or bed bath offered, given, and documented. Will audit central lines and wander guards to ensure presence of documentation to support removal or presence. The unit manager will audit medications not administered to verify the process was followed for missed or unavailable medications, Physician notification per policy. Any findings will be corrected- the results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists. The reviews will	

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F 842	Continued From page 22 On 5/25/23 at 12:29 p.m., Licensed Practical Nurse (LPN) #18 reviewed Resident #10's clinical documentation (this included Resident #10's activities of daily living (ADL) documentation). LPN #18 reported no documentation was found stating Resident #10 had received showers; LPN #18 reported that some of the aforementioned bathing documentation could have been for showers. The following information was found in a facility policy titled "Documentation Summary" (with an effective date of 11/1/19): - "Licensed Nurses and CNAs will document all pertinent nursing assessments, care interventions, and follow up actions in the medical record." - "Document all the facts and pertinent information related to an event, course of treatment, patient condition, response to care, and deviations from standard treatment along with the reason for the deviation." The survey team met with the facility's Administrator, DON, and Regional Director of Clinical Services on 5/24/23 at 2:20 p.m. and on 5/25/23 at 4:25 p.m. During these meetings, the surveyor discussed the failure of the facility staff to document the type of baths Resident #10 received resulting in no documented evidence of the resident being provided a shower during their stay at the facility. 2. For Resident #12, the facility staff failed to document that a midline venous catheter and wanderguard were removed prior to the residents discharge from the facility. This was a closed record review.	F 842	be completed on a random basis. The Administrator/Director of Nursing is responsible for implementation of the plan of correction. 5. Date of compliance: 6/27/2023	

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Resident #12's diagnoses included, but were not limited to, metabolic encephalopathy (primary), sepsis due to escherichia coli, methicillin susceptible staphylococcus aureus infection, urinary tract infection, Alzheimer's, respiratory syncytial virus, and benign prostatic hyperplasia.

Section C (cognitive patterns) of Resident #12's admission Minimum Data Set (MDS) assessment with an assessment reference date of 11/10/22 included a BIMS (brief interview for mental status) summary score of 8 out of a possible 15 points. Per the MDS manual a score of 8=moderately impaired. Section O (special treatments/programs) was coded to indicate Resident #12 received IV medications while a resident at the facility.

Resident #12's comprehensive care plan included the focus areas of midline venous catheter, isolation, at risk for elopement, and wanderguard to left ankle.

Resident #12's clinical record included the following provider orders.
12/17/22-Reinsert midline venous catheter for IV access.
12/20/22-Wanderguard to the left ankle.

12/24/22 2:39 p.m., Licensed Practical Nurse (LPN) #6 documented Resident #12 had been discharged and picked up by transport at 1:00 p.m. The surveyor was unable to find any documentation in the clinical record to indicate the midline venous catheter or wanderguard had been removed prior to the residents discharge.

LPN #6 had checked the administration block on

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the medication administration record (MAR) for 12/24/22 on day shift for the midline catheter to left upper arm.

05/23/23 3:00 p.m., LPN #6 stated they did not remember if this resident had a wanderguard in place and if they had an IV it should have been discontinued prior to discharge. LPN #6 stated someone else would do the paperwork and they just basically took the resident out of the building.

05/25/23 10:43 a.m., Director of Nursing (DON) and Nurse Consultant was asked about the missing documentation regarding the midline venous catheter and wanderguard. These staff stated they had no service concerns regarding the residents IV or wanderguard after discharge and if they had a wanderguard in place they could not have gotten out of the building

05/25/23 10:45 a.m., Nurse Consultant and DON provided the surveyor with a copy of a document titled, "Skilled Daily Documentation." This document was dated 12/23/22 23:10 (11:10 p.m.) under number 10a. the facility staff marked "No" for the question "Does the resident have any intravenous access."

The surveyor reviewed this document further in the clinical record and it included the following documentation for question number 16 "...Continues on ABT (antibiotic) for upper respiratory infection via PICC line to left upper arm...PICC line site clean with no signs of infection noted..."

The facility staff provided the survey team with a copy of a policy titled, "Documentation Summary." This policy read in part, "...Document all the facts

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and pertinent information related to an event, course of treatment..."

No further information regarding the documentation related to the midline venous catheter or wanderguard was shared with the survey team prior to the exit conference.

3. For Resident #25, the facility staff documented the administration of the oral medication Pravastatin on 14 separate occasions, however, the medication was unavailable in the facility. Pravastatin is a medication used to lower cholesterol and triglycerides.

Resident #25's diagnosis list indicated diagnoses, which included, but not limited to Cerebral Infarction, Aphasia, Dysphagia, Hemiplegia and Hemiparesis, Hyperlipidemia, and Paroxysmal Atrial Fibrillation.

The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 5/12/23 coded Resident #25 as being moderately impaired in cognitive skills for daily decision making with short-term and long-term memory problems.

On 5/25/23 at 8:25 am during a medication pass and pour observation, surveyor observed registered nurse (RN) #8 prepare Resident #25's morning medications. RN #8 stated the resident's medication Pravastatin was not in the medication cart. At 8:48 am, the surveyor accompanied RN #8 to the Omnicell in-house medication supply to check for the availability of the Pravastatin, however, RN #8 stated the medication was not present in the Omnicell. RN #8 then stated they would contact the pharmacy

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for a STAT delivery and notify the physician and the responsible party.

Resident #25's current physician's orders included an order dated 5/10/23 for Pravastatin Sodium 20 mg by mouth one time a day. According to the resident's May 2023 Medication Administration Record (MAR), Pravastatin was signed off as being administered as ordered from 5/11/23 through 5/24/23.

On 5/25/23 at 11:47 am, surveyor contacted the facility's contract pharmacy and spoke with the Director of Quality (DOQ) regarding Resident #25's Pravastatin. The DOQ stated they received a new script for Resident #25's Pravastatin on 5/10/23 and 30 tablets were dispensed on 5/11/23 but a return for the medication was processed. Surveyor again spoke with the DOQ at 12:05 pm who stated all 30 tablets of Pravastatin were returned to the pharmacy, but the return did not indicate the reason. DOQ stated the pharmacy processed the return on 5/22/23 but that did not necessarily mean the tablets were returned that day but sometime prior to 5/22/23. DOQ stated the Pravastatin was ordered again on 5/25/23 at 9:43 am and would be delivered.

On 5/25/23 at 12:18 pm, surveyor met with the administrator, director of nursing, and the regional director of clinical services and discussed the concern of Resident #25's Pravastatin being returned to the pharmacy and unavailable in the facility onsite supply, however, staff had signed the MAR indicating the medication had been administered from 5/11/23 through 5/24/23.

On 5/25/23 at 12:27 pm, surveyor spoke with licensed practical nurse (LPN) #19 who signed

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F 842	Continued From page 27 Resident #25's May 2023 MAR on 5/23/23 indicating they administered the resident's Pravastatin and asked where the medication was located at the time of administration. LPN #19 stated the medication would have been in the cart. On 5/25/23 at 12:29 pm, surveyor spoke with RN Unit Manager #1 who stated they did not see Pravastatin on the list of medications available in the Omnicell. On 5/25/23 at 1:53 pm, surveyor spoke with LPN #20 who signed the resident's May MAR on 5/24/23 indicating they administered the Pravastatin. When asked about the Pravastatin, LPN #20 stated whatever they saw they signed and gave it. LPN #20 stated they did not obtain any medication for Resident #25 from the Omnicell on 5/24/23. Surveyor requested and received the facility policy entitled "Documentation Summary" with the effective date of 11/01/19 which read in part " ...12. Document all the facts and pertinent information related to an event, course of treatment, patient condition, response to care, and deviations from standard treatment along with the reason for the deviation ..." No further information regarding this concern was presented to the survey team prior to the exit conference on 5/25/23.	F 842		
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	F 880		6/27/23

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infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(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

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F 880	Continued From page 29 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, facility document review, and clinical record review, the facility staff failed to implement infection control processes and/or procedures to decrease the potential of and/or risk for infection transmission for three (3) of 28 sampled residents (Resident #23, Resident #24, and Resident #25). The findings include: 1. Licensed Practical Nurse (LPN) #10 was observed to touch Resident #23's oral medication, with their bare fingers, prior to administering the medication to the resident.	F 880	F-880 Infection prevention and control 1. LPN#10, RN#5, RN#8 were provided one-on-one education on facility□s infection control policy, preparation, dispensing, and administering of medication, recognizing break in infection control as pertaining to medication administration on 5/25/2023. 2. All residents have the potential to be affected. 3. The Infection Preventionist will educate all licensed nurses on infection control practices related to preparation, dispensing, and administration of	

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F 880	Continued From page 30 Resident #23's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 4/17/23, was dated as being completed on 4/20/23. Resident #23 was assessed as sometimes being able to make self understood and as sometimes being able to understand others. Resident #23 was documented as having short-term memory problems and long-term memory problems. Resident #23 was documented as requiring extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. On 5/25/23 at 8:30, LPN #10 touched the two (2) medications, being provided to Resident #23, with their bare fingers. The two (2) medications were: (a) an amantadine 100mg capsule and (b) a prednisone 5mg tablet. LPN #10 crushed the prednisone tablet and removed the contents of the amantadine capsule prior to administering the medications to Resident #10. On the afternoon of 5/25/23, the facility's Director of Nursing (DON) was interviewed about the observation of LPN #10 touching Resident #23's medication with their bare fingers. The DON reported the facility did not have a policy and/or procedure which specifically addresses not touching medications with bare fingers. The DON reported LPN #10 should not have touched Resident #23's medications with their bare fingers. The survey team met with the facility's Administrator, DON, and Regional Director of Clinical Services on 5/25/23 at 4:25 p.m. During this meeting, the surveyor discussed the observation of LPN #10 touching Resident #23's	F 880	medication. recognizing break in infection control practices, what to do when contamination of medication has occurred during preparation of medication from blister pack, bottles, and containers. Education to all licensed nurses on performing hand hygiene, best practices in preparations, dispensing and administration of medications. Hand hygiene before and after using medical equipment during medication pass, when to use hand sanitizer vs hand washing with soap and water. 4. The infection preventionist will conduct medication observation audits weekly X 4 to assess compliance with infection control policy and to ensure medication passing observation is adhered by all nurses. Any findings will be corrected- the results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists. The audits will be completed on a random basis. The Administrator/Director of Nursing is responsible for implementation of the plan of correction. 5. Date of completion: 6/27/2023	

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medication, with bare fingers, prior to administering the medication. No additional information, related to this issue, was provided prior to the conclusion of the survey.

2. For resident #24, the facility staff were observed handling medications with bare hands during a medication pass and pour observation.

On 5/25/23 at approximately 8:28 AM, surveyor began observing Registered Nurse (RN) #5 on their morning medication pass, preparing resident #24's medications. RN #5 popped each pill out, and into their bare hand before placing the pills in the medicine cup.

Prior to entering resident #24's room, surveyor asked RN #5 if they should have touched each pill with their bare hands before placing them in the medicine cup. RN #5 stated, "Yes, it's ok". When asked if they knew if there was a policy in place that stated it was ok to touch the medications, they stated, "I will take a look and ask my manager about a policy. I think only chemotherapy medications and such requires gloves. I will apply gloves when I enter the room".

Surveyor interviewed the unit manager at approximately 9:03 AM. When asked if it was an acceptable practice to pop oral medications out of the card into one's bare hands before placing them in the medicine cup, they stated, "No, the nurse should put the card over the cup and pop the pill directly into the cup".

Surveyor interviewed the Director of Nursing (DON) on 5/24/23 at 2:41 PM. Surveyor asked if it was an acceptable practice to touch a resident's medications with bare hands during medication

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pass. They stated "No, it's not an acceptable practice. Surveyor asked the DON if there were a policy that spoke to this issue and they stated "No, but it is the expectation".

On 5/24/23 at approximately 4:45 PM, the surveyor discussed this concern during a meeting with the Administrator, DON, Regional Director of Clinical Services, wound nurse and Director of Social Services.

No further information was provided to the survey team prior to exit.

3. For Resident #25, the facility staff failed to perform hand hygiene prior to the administration of an enoxaparin injection. Enoxaparin is an anticoagulant medication used to help prevent the formation of blood clots.

Resident #25's diagnosis list indicated diagnoses, which included, but not limited to Cerebral Infarction, Aphasia, Dysphagia, Hemiplegia and Hemiparesis, Hyperlipidemia, and Paroxysmal Atrial Fibrillation.

The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 5/12/23 coded Resident #25 as being moderately impaired in cognitive skills for daily decision making with short-term and long-term memory problems.

On 5/25/23 at 8:31 am during a medication pass and pour observation, surveyor observed registered nurse (RN) #8 check Resident #26's oxygen saturation using a finger sensor. RN #8 removed the sensor from Resident #26's finger, returned to the medication cart and applied

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gloves without performing hand hygiene. RN #8 then obtained the enoxaparin syringe with their gloved hands, proceed into Resident #25's room and administered the injection into the resident's stomach at 8:38 am.

On 5/25/23 at 9:10 am, surveyor asked RN #8 when should hand hygiene be completed during a medication pass and RN #8 stated before and after each administration.

On 5/25/23 at 1:42 pm, surveyor spoke with the Infection Preventionist (IP) regarding observations from RN #8's medication pass. IP stated that was unacceptable and staff were supposed to wash their hands between residents and if no sink was available, they were to use hand sanitizer. IP further stated they had provided hand washing education last week. IP returned at 1:58 pm with documentation indicating RN #8 had received additional education on hand washing on 5/25/23.

Surveyor requested and received the facility policy entitled "Handwashing Requirements" with an effective date of 2/06/20 which read in part:
1. A. Hand Hygiene
1.A.1.c. Before and after performing any invasive procedure (e.g. fingerstick blood sampling)
1.A.1.k. Upon and after coming in contact with a patient's intact skin. (e.g., when taking a pulse or blood pressure, and lifting a patient)

On 5/25/23 at 4:26 pm, the survey team met with the administrator, director of nursing, regional director of clinical services, director of social services, director of human resources, and the treatment nurse and discussed the concern of RN #8 failing to perform hand hygiene prior to

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F 880	Continued From page 34 administering an injection to Resident #25. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/25/23.	F 880		