| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 495177 | A. BUILDING _____ B. WING _____ | 05/03/2023 |

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| COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER | 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970 |

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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 5/2/2023 through 5/3/2023. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 5/2/2023 through 5/3/2023. No complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census in this 140 certified bed facility was 87 at the time of the survey. The survey sample consisted of 18 current Resident reviews and two closed record reviews. | F 000 | | |
| F 607 SS=D | Develop/Implement Abuse/Neglect Policies<br>CFR(s): 483.12(b)(1)-(5)(ii)(iii)<br><br>§483.12(b) The facility must develop and implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br><br>§483.12(b)(4) Establish coordination with the QAPI program required under §483.75. | F 607 | | 6/16/23 |

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

Electronically Signed | 06/02/2023

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| F 607 | Continued From page 1<br><br>§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.<br><br>§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.<br><br>§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of employee files, staff interview, and review of facility policy, the facility failed to implement their abuse prevention policy for the screening of new employees. The facility failed to obtain a Sworn Statement from seven of 24 new hired employees.<br><br>The findings were:<br><br>At approximately 1:30 p.m. on 5/3/2023, a review of 24 randomly selected personnel files of facility employees hired in the last two years was conducted. Two employees from the Human Resources Department assisted in the review. Documents included in the review were the Sworn Statement, Criminal Record Check, License (if applicable), and References.<br><br>The review identified seven employees who did not have a Sworn Statement in their individual personnel file. The seven employees included the following: | F 607 | 1. No residents experienced any adverse outcomes due to this deficient practice.<br><br>2. To identify residents having the potential to be affected a review of new hires is being performed to ensure compliance.<br><br>3. To address completeness of prehire sworn statements the practice has been updated to require documentation for completed sworn statements from contractor/agency prior to start date of contract workers. HR onboarding will review this document to ensure compliance for new contract/agency workers.<br><br>To ensure ongoing compliance VCUHS HR team (Talent Acquisition, onboarding, and compliance) will attend a mandatory inservice/training on the end to end process for new hire team members to | |

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| F 607 | Continued From page 2<br>A CNA (Certified Nursing Assistant) hired on 4/13/2023<br>A CNA hired on 3/27/2023<br>A CNA hired on 3/17/2023<br>A CNA hired on 3/13/2023<br>A CNA hired on 3/6/2023<br>A CNA hired on 2/6/2023<br>A LPN (Licensed Practical Nurse) hired on 11/28/2022<br><br>The Human Resources (HR) Director explained that with the exception of the CNA hired on 2/6/2023, the other six were contract employees, although not all were from the same contractor. The CNA hired on 2/6/2023 was from an agency.<br><br>According to the HR Director, the contractors/agency conduct their own background checks, including a criminal record check, license check, and obtaining a Sworn Statement. The HR Director went on to say the contractors/agency provide an attestation that the documents/checks were done, but they do not provide copies of the documents.<br><br>The second HR staff member stated the facility's HR Department conducts their own criminal record check with the Virginia State Police, as required by law, as well as a license check and a check of references. Those documents were in the personnel files of the above referenced seven employees. Both the HR Director and the second HR staff member indicated they have to specifically request the Sworn Statement from the contractors/agency if they want them.<br><br>Review of the facility's Abuse policy noted the following: | F 607 | include the completion of required steps for sworn statements.<br><br>4. To monitor performance to ensure the solutions are sustained the HR compliance team will conduct a quality control review to ensure all required components are present for the hiring and onboarding process. This will include audits of all new LTC hires. Periodic checks of compliance will occur at least quarterly over the next 12 months and reported to QAPI quarterly by the HR Business Partner or designee. | |

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| F 607 | Continued From page 3<br>SCREENING: 1.3.1 "State licensure and certification agencies, and applicable registries, will be contacted, prior to hire, to validate current licensure or certification requirements and to determine if the potential employee is in good standing with the agency, including disciplinary actions from licensing or registration boards. Each applicant will provide a sworn statement or affirmation disclosing any criminal convictions or any pending criminal charges, whether within or outside the Commonwealth."<br><br>The Administrator was advised of the findings at 2:00 p.m., prior to the Exit Conference. | F 607 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in | F 657 | | 6/16/23 |

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| F 657 | Continued From page 4<br>disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to revise the comprehensive care plan for one of twenty residents in the survey sample (Resident #47).<br><br>The findings include:<br><br>Resident #47's care plan was not revised to include interventions for injury prevention following bruising to the resident's hand/finger.<br><br>Resident #47 was admitted to the facility with diagnoses that included Parkinson's disease, dementia, atrial fibrillation, gout, hypertension, congestive heart failure, arthritis, and depression. The minimum data set (MDS) dated 3/1/23 assessed Resident #47 with moderately impaired cognitive skills and as requiring total assistance of one person for bed mobility.<br><br>Resident #47's clinical record documented a nursing note dated 4/15/23 stating the resident's left hand was bruised during ADL (activities of daily living) care. A nursing note dated 5/1/23 documented the resident hit his right ring finger on the bed rail when turned in bed.<br><br>Resident #47's plan of care (revised 5/1/23) documented the resident had compromised skin integrity due to impaired mobility, upper extremity swelling and was at risk for injury related to side | F 657 | 1. Resident #47's careplan was updated on 5/3/23 to place pillows at side rails when turning resident.<br><br>2. Other residents with bruises to their hands were assessed and careplans updated for preventive measures.<br><br>3. Nursing staff has been educated to update careplans for preventive measures for residents who obtain bruises. During morning start up meeting the IDT will review and discuss residents that have obtained bruising and review the plan of care to ensure it has been updated with interventions to prevent further injury.<br><br>4. Clinical Coordinators or designees will review the plan of care for 50% of residents that obtain bruises weekly x4 weeks then monthly and report findings to DON weekly. DON will report findings to QAPI monthly. | |

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| F 657 | Continued From page 5 | F 657 | | |

rail use. The care plan was documented, "...4/16/23 bruise at fingers on left hand...5/01/23 redness, swelling at right ring finger, with black finger nail..." Resident #47's plan of care included no interventions regarding the injuries of 4/16/23 and 5/1/23 other than "continue to monitor" and was not revised with any actions taken for injury prevention.

On 5/3/23 at 9:00 a.m., the registered nurse (RN #2) responsible for MDS and care planning was interviewed about care plan revisions regarding Resident #47's hand positioning issues/injuries. RN #2 stated the unit managers were responsible for adding acute issues to the care plan.

On 5/3/23 at 9:12 a.m., the certified nurses' aide (CNA #1) that routinely cared for Resident #47 was interviewed. CNA #1 stated the resident's hands were swollen and required care with positioning during turning/bathing. CNA #1 stated she now used pillows for hand positioning to protect the resident during ADL care and/or turning in bed.

On 5/3/23 at 9:15 a.m., the unit manager (RN #1) was interviewed about any care plan updates regarding Resident #47's hand injuries. RN #1 stated the resident was reassessed on 4/23/23 regarding use of bed rails and staff members were now using pillows for positioning and protection during ADL care and turning in bed. RN #1 reviewed the current plan and stated the interventions for injury prevention had not been added to the care plan. RN #1 stated, "That's [pillows, bed rail reassessment) not on the care plan. It just says to continue to monitor."

This finding was reviewed with the administrator

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| F 657 | Continued From page 6<br>and director of nursing during a meeting on 5/3/23 at 11:30 a.m. | F 657 | | |
| F 684 SS=E | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, and clinical record review, the facility staff failed to obtain orders for the care and treatment of a colostomy for one of 20 residents, Resident #67.<br><br>Findings were:<br><br>Resident #67 was admitted to the facility with the following diagnoses including but not limited to: diabetes mellitus, hypertension, anxiety, depression, and gastro-esophageal reflux.<br><br>An annual MDS (minimum data set) with an ARD (assessment reference date) of 04/06/2023 assessed Resident #67 as cognitively intact with a summary score of "14".<br><br>On 05/02/2023 at approximately 2:15 p.m., Resident #67 was interviewed regarding life in the facility. During the conversation she stated that she had a colostomy. She stated the facility staff provided all the care for the colostomy. | F 684 | 1. Order obtained for colostomy care for resident #67.<br><br>2. Residents with colostomies charts were audited for orders for colostomy care.<br><br>3. Upon admission and readmission Clinical Coordinators will review physicians orders for residents with colostomies to ensure orders for care and treatment of colostomy are present. Licensed nursing staff will be educated to ensure orders are obtained for colostomy care when appropriate.<br><br>4. Clinical coordinators or designee will review charts of residents with colostomies for orders for care of colostomies weekly x4 then monthly. Then report to DON. DON will report to QAPI monthly. | 6/16/23 |

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| F 684 | Continued From page 7 | F 684 | | |

The clinical record was reviewed at approximately 4:00 p.m. There were no orders observed for the care of Resident #67's colostomy. The care plan was reviewed and included: "Potential for infection/skin breakdown s/t (secondary to) incontinence and colostomy". Interventions included but were not limited to: "Ostomy care as ordered." There were no entries on the care plan or the physician orders for the frequency of flange change, size, brand, etc.

On 05/03/2023 at approximately 9:00 a.m., the MDS coordinator was in the conference room and was asked about orders for Resident #67's colostomy. She printed out the current/active orders for Resident #67 and stated, "I don't see any orders, but the care is being provided... (Name of electronic health record) drops orders off after 365 days...I think that might be what happened."

At approximately 10:10 a.m., RN (registered nurse) #4 who was the unit coordinator was interviewed regarding Resident #67's colostomy. She was asked how the nurses knew when to change the flange, what supplies were needed, etc. She stated, "We don't have a TAR (treatment administration record) we have a task list." She pulled up the task list for Resident #67 and stated, "This says. "Reassess Colostomy RUQ (right upper quadrant) Q (every) shift)....so we look at it every shift." She was asked if there was a task that told the nurses when the flange was due to be changed and how often She stated, "I don't see that...but she has frequent blow outs and we have to change it all the time...her supplies are in her room."

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| F 684 | Continued From page 8<br>A meeting was held with the administrator and the DON (director of nursing) on 05/03/2023 at approximately 11:25 a.m. The above information was discussed. The DON stated she would check and get back to the survey team.<br><br>At 1:20 p.m., the DON came to the conference room. She stated,"I looked and I don't see any orders either...there should have been orders for colostomy care."<br><br>No further information was obtained prior to the exit conference on 05/03/2023. | F 684 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review, and facility document review the facility staff failed to follow infection control practices during the care and treatment of a pressure ulcer for one of 20 residents, Resident #58. | F 686 | 1. Resident has developed no new signs of infection. LPN #2 and RN #4 were re-educated on handwashing between glove changes and care areas.<br><br>2. No other residents identified with same | 6/16/23 |

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| F 686 | Continued From page 9<br><br>Findings were:<br><br>Resident #58 was admitted to the facility with the following diagnoses, including but not limited to: Anemia, protein-calorie malnutrition, dementia, Parkinson's disease, dementia, and sacral Osteomyelitis.<br><br>A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 03/21/2023, assessed Resident #58 as impaired with long and short term memory, as well as daily decision making skills.<br><br>The clinical record was reviewed on 05/02/2023 at approximately 11:00 a.m. and included documentation regarding a pressure injury to her sacrum and an unstageable area to her left hip. The sacral area was measured on 05/01/2023 with the following measurements documented: "8 cm length, 9 cm width and 1.5 cm depth." Treatment orders were: After cleansing with VASH (wound cleanser), then apply Santyl and VASHE to fluffed 4X4 and place in wound bed, cover with abd and secure with tape. Treatment to the left hip was: Clean area with NS then paint left hip eschar well with betadine and allow to air dry.<br><br>On 05/03/2023 at approximately 10:00 a.m., RN (registered nurse) #4 and LPN (licensed practical nurse) #2 were observed providing wound care to Resident #58's sacrum and left hip. Resident #58 was on contact isolation, both RN #4 and LPN #2 donned appropriate PPE (personal protective equipment). RN #4 held Resident #58 over on her right side as LPN #2 provided care to the pressure areas. LPN #2 donned non-sterile | F 686 | problem during care.<br><br>3. Licensed nursing staff will be re-educated on infection control for wound care by Infection Control Practioncioner.<br><br>4. Clinical Coordinator, Infection Control Practitioner, or designee will observe wound care of 50% of residents with pressure ulcers weekly x4 weeks then monthly to ensure infection control practices are followed. Then report to DON weekly. Findings will be reported to QAPI meeting monthly. | |

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| F 686 | Continued From page 10 | F 686 | | |

gloves and removed an old soiled dressing from Resident #58's sacrum. She removed her gloves and went to the bathroom to wash her hands. She returned, donned non-sterile gloves and used cleaned the wound using 4X4's and the prescribed wound cleanser. When she completed cleaning she removed her gloves and went to the bathroom to wash her hands. She returned, donned non-sterile gloves and continued care of the sacral pressure ulcer. She changed gloves two more times while completing the treatment, but did not wash her hands after changing her gloves. When she completed care for the sacral ulcer she provided care to the area on Resident #58's left hip, painting the area with betadine. She did not change gloves or wash her hands before going from one area to the next.

After completion of the dressing change RN #4 and LPN #2 were interviewed and asked about hand washing between glove changes. RN #4 stated, "Yeah, I guess she could have used some gel to clean her hands." LPN #2 stated, "I had already cleaned the area so everything was clean that I was doing..." She was asked if she should have washed her hands before going from the sacral area to the left hip. She stated, "Yes, I should have...I could have gotten some hand sanitizer off the cart."

A meeting was held with the administrator and the DON (director of nursing) on 05/03/2023 at approximately 11:25 a.m. The above information was discussed. The DON stated she would review the policy and get back to the survey team.

At 1:20 p.m., the DON came to the conference room. She presented a policy, "Hand

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| COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER | 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 686 | Continued From page 11<br>washing/Hand Hygiene" which contained the following: "...Use an alcohol-based hand run containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:...After removing gloves...the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections." The DON stated, "She should have washed her hands between glove changes and between care of the two areas."<br><br>No further information was obtained prior to the exit conference on 05/03/2023. | F 686 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review, the facility staff failed to administer oxygen at the physician ordered rate for one of twenty residents in the survey sample (Resident #47).<br><br>The findings include: | F 695 | 1. On 5/3/23 residents #47's oxygen saturation was assessed at 97% and no acute distress was noted. Concentrateor was then adjusted to 4L.<br><br>2. Residents with oxygen orders were reviewed for rate and concentrators assess for correctness. | 6/16/23 |

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| F 695 | Continued From page 12<br>Resident #47 was observed with oxygen administered at 2.5 lpm (liters per minute) when a physician's order required an administration rate of 4 lpm.<br><br>Resident #47 was admitted to the facility with diagnoses that included Parkinson's disease, dementia, atrial fibrillation, gout, hypertension, congestive heart failure, arthritis, and depression. The minimum data set (MDS) dated 3/1/23 assessed Resident #47 with moderately impaired cognitive skills.<br><br>On 5/2/23 at 11:18 a.m., Resident #47 was observed in bed with oxygen administered at a rate of 2.5 lpm. Resident #47 was observed again on 5/2/23 at 3:16 p.m. and on 5/3/23 at 8:16 a.m. with oxygen administered at 2.5 lpm.<br><br>Resident #47's clinical record documented a physician's order dated 11/21/22 for continuous oxygen administration via nasal cannula at a rate of 4 lpm.<br><br>Resident #47's plan of care (revised 5/1/23) documented the resident was at risk of edema and complications related to congestive heart failure. Interventions to prevent complications included, "...Oxygen as ordered..."<br><br>On 5/3/23 at 8:18 a.m., the registered nurse (RN #3) caring for Resident #47 was interviewed about Resident #47's oxygen administration rate. RN #3 checked the electronic health record and stated the resident's oxygen was ordered at 4 lpm. On 5/3/23 at 8:21 a.m., accompanied by RN #3, Resident #47's oxygen was observed at 2.5 lpm. RN #3 assessed the resident's oxygen saturation at this time at 97%. RN #3 stated | F 695 | 3. An Epic task will be created for each resident chart that has an oxygen order to assess the rate every shift. Licensed nursing staff will be educated to ensure that oxygen is being delivered at rate ordered by physician.<br><br>4. Clinical coordinators or designees will monitor 50% of residents with oxygen orders twice weekly x4 weeks for correct rate then monthly. Finding will be reported to DON weekly. Then DON will report to QAPI committee monthly. | |

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| F 695 | Continued From page 13<br>again the oxygen order required administration at 4 lpm.<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 5/3/23 at 11:30 a.m. | F 695 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other | F 880 | | 6/16/23 |

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| F 880 | Continued From page 14<br>persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review, and facility document review the facility staff failed to follow their infection control | F 880 | 1. a. On 5/3/23 RN #4 and LPN #2 were educated on handwashing between glove changes and between care of 2 areas. | |

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| F 880 | Continued From page 15<br>policy for hand washing during the care and treatment of a pressure ulcer for one of 20 residents, Resident #58, and failed to follow infection control practices during a medication pass on Unit 1.<br><br>Findings were:<br><br>1. Resident #58 was admitted to the facility with the following diagnoses, including but not limited to: Anemia, protein-calorie malnutrition, dementia, Parkinson's disease, dementia, and sacral Osteomyelitis.<br><br>A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 03/21/2023, assessed Resident #58 as impaired with long and short term memory, as well as daily decision making skills.<br><br>The clinical record was reviewed on 05/02/2023 at approximately 11:00 a.m. and included documentation regarding a pressure injury to her sacrum and an unstageable area to her left hip.<br><br>On 05/03/2023 at approximately 10:00 a.m., RN (registered nurse) #4 and LPN (licensed practical nurse) #2 were observed providing wound care to Resident #58's sacrum and left hip. Resident #58 was on contact isolation, both RN #4 and LPN #2 donned appropriate PPE (personal protective equipment). RN #4 held Resident #58 over on her right side as LPN #2 provided care to the pressure areas. LPN #2 donned non-sterile gloves and removed an old soiled dressing from Resident #58's sacrum. She removed her gloves and went to the bathroom to wash her hands. She returned, donned non-sterile gloves and used cleaned the wound using 4X4's and the | F 880 | b. On 5/2/23 LPN #1 was educated not to dispense medications that have been touched with bare hands or that has been dropped on a surface.<br><br>2. Nursing staff will be monitored periodically when providing wound care and medication pass for these infection control practices.<br><br>3. Licensed nursing staff will be educated on infection control practices during wound care and medication administration by Infection Control Practitioner.<br><br>4. Clinical Coordinators, Infection Control Practitioner or designees will observe 50% of residents having wound care weekly x4 weeks and will complete a med pass audit twice weekly x 4 weeks for infection control practices and then monthly. Then report to DON weekly. DON will report to QAPI committee monthly. | |

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| F 880 | Continued From page 16 | F 880 | | |

prescribed wound cleanser. When she completed cleaning she removed her gloves and went to the bathroom to wash her hands. She returned, donned non-sterile gloves and continued care of the sacral pressure ulcer. She changed gloves two more times while completing the treatment, but did not wash her hands after changing her gloves. When she completed care for the sacral ulcer she provided care to the area on Resident #58's left hip, painting the area with betadine. She did not change gloves or wash her hands before going from one area (sacrum) to the next (hip).

After completion of the dressing change RN #4 and LPN #2 were interviewed and asked about hand washing between glove changes. RN #4 stated, "Yeah, I guess she could have used some gel to clean her hands." LPN #2 stated, "I had already cleaned the area so everything was clean that I was doing..." She was asked if she should have washed her hands before going from the sacral area to the left hip. She stated, "Yes, I should have...I could have gotten some hand sanitizer off the cart."

A meeting was held with the administrator and the DON (director of nursing) on 05/03/2023 at approximately 11:25 a.m. The above information was discussed. The DON stated she would review the policy and get back to the survey team.

At 1:20 p.m., the DON came to the conference room. She presented a policy, "Hand washing/Hand Hygiene" which contained the following: "...Use an alcohol-based hand run containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:...After removing

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| F 880 | Continued From page 17 | F 880 | | |

gloves...the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections." The DON stated, "She should have washed her hands between glove changes and between care of the two areas."

No further information was obtained prior to the exit conference on 05/03/2023.

2. On 5/02/23 at 8:38 AM during a medication pass and pour, license practical nurse (LPN #1) was dispensing medications to Resident #18. While removing medications from the packets, LPN #1 dropped a tablet (Magnesium 400 milligrams) on the medication cart, picked the medication up with bare hand, placed it in the medication cup, and gave it to Resident #18.

Prior to the observation LPN #1 had went into Resident #18's room to obtain vital signs, was observed reaching into her pocket to retrieve a marker, and had not cleaned off the medication cart where the medication landed.

After the medication pass was completed the above information was presented to LPN #1, LPN #1 nodded her head in understanding, but did not respond.

On 5/03/23 at 10:41 AM the DON (director of nursing) was informed of the above finding. The DON verbalized that LPN #1 should have disposed of the medication.

A facility policy titled "Administering Prepared Medication" read in part "Don't place tablets or capsules in your hands [...]"

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| F 880 | Continued From page 18<br><br>On 5/03/23 at 11:24 AM the above information was presented to the DON and administrator. No other information was presented prior to exit conference on 5/3/23. | F 880 | | |