STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 11.24.19 A recertification survey and investigation of Complaint #85657-C completed 10/21/19-10/24/19 resulted in the following deficiencies. Complaint #85657-C was substantiated. See Code of Federal Regulations (42CFR) Part 482, Subpart B-C.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda

TITLE: Director of Nursing

(X6) DATE: 11/18/19

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 578	Continued From page 1 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have accurate advanced directives for 1 of 24 residents reviewed (Resident #141). The facility reported a census of 41. Findings include: The Minimum Data Set completed with an Assessment Reference Date (ARD) of 9/19/19 showed Resident #141 had a Brief Interview for Mental Status score of 15, indicating intact cognition. The resident had diagnoses of type 2 diabetes mellitus with diabetic neuropathy, long term (current) use of insulin, and acquired absence of left leg below the knee, pain. The resident's electronic record indicated a code status of Do Not Resuscitate (DNR)/No Code with an Iowa Physician Order for Scope of Treatment (IPOST) document in place. The paper copy of the IPOST observed in the	F 578		

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F 578	Continued From page 2 resident's paper chart directed Full treatment with Cardiac Pulmonary Resuscitation (CPR)/Attempt Resuscitation dated 6/12/19. The paper chart included a Physician Order form, dated 10/9/19, that indicated DNR. During an interview on 10/22/19 at 1:54 PM Staff O, Registered Nurse (RN), he stated the nurses would look at the resident's chart or the card the facility had in the Medication Cart that indicated the list of full code residents. During an interview on 10/22/19 at 4:35 PM, the Director of Nursing stated she would expect a new IPOST completed when a change of Advance Directives status was updated. She said she believed the resident did wish to be a DNR after her last hospital stay. During an interview on 10/24/19 at 9:20 AM, the resident and her representative stated they did wish for the resident to be a DNR. The Advance Directives/DNRO Log form, dated 2/15 stated to review and update with a change in condition.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits,	F 583		

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F 583	Continued From page 3	F 583		

and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews, the facility failed to provide privacy to a resident while delivering perineal care for 1 of 4 residents reviewed (Resident #41). The facility reported a census of 41.

Findings include:

According to the clinical record Resident #41 admitted to the facility on 10/17/19. The resident had diagnoses of recurrent aspiration pneumonia, malnutrition, and physical deconditioning.

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F 583	Continued From page 4 During an observation on 10/21/19 at 3:45 PM, observed Staff C, Certified Nurses' Aide (CNA), and Staff I, CNA, started to complete perineal care with the resident's curtain open with a school in view of the windows. During an observation on 10/21/19 at 3:54 PM observed Staff E, Registered Nurse (RN) close the curtains. During an interview on 10/23/19 at 3:42 PM, the MDS Nurse, RN, stated she would expect the staff to close the curtains while providing perineal care. The policy labeled, Privacy and Confidentially, with no date provided stated the resident had the right to personal privacy with personal care.	F 583		
F 606 SS=E	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.	F 606		

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F 606	Continued From page 5	F 606		

§483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.
This REQUIREMENT is not met as evidenced by:
Based on personnel file review, staff interview and facility policy review, the facility failed to assure an Iowa criminal background check for 2 of 6 current employees sampled, (Staff I and Staff J), prior to them working in the facility and ensuring staff receive Dependant Adult Abuse education within 6 months of hire for 1 of 6 staff sampled (Staff I). The facility reported a census of 41 residents.

Findings include:

1. The personnel file for Staff I, Certified Nurse Aide (CNA), documented a hire date of 11/08/2018. The file contained a criminal background completed on 12/14/2018, 36 days after hire. Staff I's personnel file lacked a certificate for the mandatory 2 hour Dependant Adult Abuse class.

2. The personnel file for Staff J, CNA, documented a hire date of 6/18/19. The file contained a criminal background completed on 5/09/19, more then 30 days before hire.

The facility's Abuse Prevention, and Reporting Policy, revised 04/17, directed the following:
Employee Screening:
1. Screen all potential employees prior to hire for a history of abuse, neglect, or mistreating resident/patients, exploitation and/or

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F 606	Continued From page 6 misappropriation of resident property during the hiring process. Screening will consist of but not limited to: Criminal background checks In an interview on 10/24/19 at 10:47 AM, the Business Office Manager stated she did not find a certificate for Dependant Adult Abuse training for Staff I in her personnel file.	F 606		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy	F 625		

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F 625	Continued From page 7 described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to complete a bed hold request for 1 of 1 resident reviewed (Resident #141). The facility reported a census of 41. Findings include: The Minimum Data Set completed with an Assessment Reference Date of 9/19/19 showed a Brief Interview for Mental Status score of 15, indicating intact cognition. The resident had diagnoses of type 2 diabetes mellitus with diabetic neuropathy, long term (current) use of insulin, and acquired absence of left leg below the knee and pain. During an interview on 10/21/19 at 3:00 PM, the resident reported she had been in the hospital for Congestive Heart Failure. The resident stated no one offered her or the resident's representative a bed hold. The Progress Note, dated 8/26/19 at 12:28 AM, stated the nurse heard the resident screaming at 10:50 PM and found the resident face down on the floor in front of the chair. The resident was cold and drenched in sweat. A water cup was full on the bedside table. The staff rolled the resident over to assess for injury, none immediately noted. The nurse asked the resident what happened, but no coherent response given - just mumbling. Assessment of the resident's vitals included a pulse of 38, oxygen saturation of 84% on room air and blood sugar of 45 at the time of fall. The resident did not have orders for glucagon. Blood pressure unable to be read at 10:50 PM. When	F 625		

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F 625	Continued From page 8	F 625		

the certified nurses' aide (CNA) arrived, she retook vitals while the nurse called 911. Blood pressure of 158/92 obtained and with a pulse of 68. The resident observed to be in and out of consciousness. Pupils fixed and pinpoint. The nurse applied sternal rub occasionally to maintain consciousness until Emergency Medical Staff (EMS) arrived. The transfer required five staff to assist in getting the resident onto the backboard. The resident transported to the emergency room. The hospital called at 12:05 AM and stated the resident was given fluids and had regained mental status. The hospital reported the family was at the resident's bedside in the hospital. The nurse was unsure of the resident's admission status at that time.

The Progress Note, dated 8/28/19 at 4:40 PM, indicated the resident returned from the hospital.

The Progress Note, dated 10/2/19 at 10:56 AM, stated the resident was lethargic and confused that morning, vital signs within normal limits with a blood sugar of 129, resident appeared pale and clammy. Fax sent to the provider.

The Progress Note, dated 10/2/19 at 1:47 PM, stated the facility received a return fax with orders to check a complete blood count (CBC) with Differential and a Basic Metabolic Panel (BMP). The resident's son was at facility and requested the resident to be seen. The resident was sent to the emergency room by ambulance.

The Progress Note, dated 10/2/19 at 5:57 PM, noted the facility received a call from the emergency room stating the resident was admitted to the hospital for acute pneumonia.

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F 625	Continued From page 9 The Progress Note, dated 10/3/19 at 9:43 AM, indicated a bed hold was sent to the hospital for the Power of Attorney (POA) to sign. Review of resident's paper and electronic chart lacked documentation regarding a bed hold offered for 8/26/19 hospitalization. During an interview, on 10/23/19 at 1:16 PM, the Corporate Nurse, Registered Nurse, stated she was unable to find a bed hold for the resident for the August hospitalization but found an unsigned one for the October hospitalization. She said she would expect the facility to have gotten it signed. The Bed Hold Requirement and Notification policy, with no date provided, stated to complete the bed hold form before transferring resident/patient to the hospital. In cases of an emergency transfer, must provide written notification within twenty-four hours of transfer. Provide a copy of the bed hold form to the resident and place a copy in the medical record.	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	F 655		

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F 655	Continued From page 10 necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to complete a baseline care plan for two of sixteen residents reviewed (Resident #33 and #41) and failed to provide a written summary for review for one of sixteen residents reviewed (Resident #33). The facility reported a census of 41.	F 655		

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F 655	Continued From page 11	F 655		

Findings include:

1. The Minimum Data Set (MDS) completed for Resident #33 with an Assessment Reference Date (ARD) of 9/24/19 showed a Brief Interview for Mental Status score (BIMS) score of 8, indicating moderate cognitive impairment. The resident had diagnoses of unspecified dementia without behavioral disturbance and unspecified mood [affective] disorder. The resident's admission date to the facility was 8/28/19.

A review of the resident's electronic and paper chart showed a lack of the baseline care plan.

During an interview, on 10/22/19 at 4:17 PM, the Director of Nursing (DON) reported the resident did not have a baseline care plan completed. She stated she discovered a lot of the new admissions had not had one completed and she had worked on completing a QAPI plan related to this with a completion date of 10/30/19. She would provide a copy when she finished with the resident's baseline care plan.

2. According to the clinical record Resident #41 admitted to the facility on 10/17/19. The resident had diagnoses of recurrent aspiration pneumonia, malnutrition, and physical deconditioning.

The electronic record showed a started assessment for the baseline care plan dated 10/16/19. The form was not completed and stated in progress.

During an interview on 10/22/19 at 1:45 PM, Staff H, Certified Nurses' Aide (CNA), and Staff Q, CNA, reported the facility had pocket care plans

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F 655	Continued From page 12 for the residents. The CNAs provided a copy, no information was noted for Resident #41 on the paperwork. The CNAs reported they update this themselves but stated the MDS Nurse should update it. They said each room should have a care plan on the door of the closet for each resident. During an observation on 10/23/19 at 8:16 AM, an inspection of the resident's closet and bathroom showed no care plan in the resident's room. The review of the resident's paper and the electronic chart showed a lack of documentation related to a baseline care plan. During an interview on 10/23/19 at 1:31 PM, the Corporate Nurse stated there was no baseline care plan completed for the resident. The form labeled Care Plan Development, dated 8/15, directed the development of an interim care plan within 24 hours of admission. To ensure meeting of the resident's immediate needs, initiation of the care plan by nursing or designee, and developed further as needed until completion of the comprehensive care plan.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §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.	F 657		

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(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 interviews and record reviews, the facility failed to provide a care conference for 1 of 16 residents reviewed, (Resident #141's). The facility reported a census of 41 residents.

Findings include:

The Minimum Data Set completed with an Assessment Reference Date of 9/19/19 showed a Brief Interview for Mental Status score of 15, indicating intact cognition. The resident had diagnoses of type 2 diabetes mellitus with diabetic neuropathy, long term (current) use of insulin, and acquired absence of left leg below the knee and pain.

During an interview on 10/21/19 at 2:48 PM, the resident reported she had been here since May

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F 657	Continued From page 14 and never had an invitation to a care conference or been to one. During an interview on 10/21/19 at 2:49 PM, the resident's representative reported no invitation to care conferences. The resident's chart lacked documentation regarding the care conference being completed or offered. During an interview on 10/23/19 at 3:33 PM, the Corporate Nurse, Registered Nurse, reported there was no documentation regarding a care conference completed. During an interview on 10/23/19 at 3:42 PM, the MDS Nurse, RN, reported she did not have a care conference with the resident. She stated she would like to do one following the completion of their MDS. The MDS Nurse stated she was unsure why this resident did not have a care conference. She stated she was following the list from the previous MDS Nurse, and Resident #141 wasn't on the list. The Care Plan Development policy, dated 8/15, indicated the resident's family, legal guardians, or the resident was encouraged to attend care plan meetings. An invitation via the postal service of the date and time of the meeting and schedule times for the care plan meeting which would be held on a specific date and start time as designated by the facility. Accommodations for scheduling made according to the residents, their family, or their legal guardian's availability or needs as necessary. "Attendance" defined as in person or telephonically. In the event the resident did not have a family or legal guardian, the	F 657		

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F 657	Continued From page 15 resident questioned who, if any, that they would prefer to attend. The MDS Nurse was responsible for preparing and distributing the schedule of MDS assessment completion and care plan meetings to the interdisciplinary team.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to complete Physician Orders as ordered for 1 of 16 residents reviewed (Resident #41). The facility reported a census of 41. Findings include: According to the clinical record Resident #41 admitted to the facility on 10/17/19. The resident had diagnoses of recurrent aspiration pneumonia, malnutrition, and physical deconditioning. The hospital Discharge Summary, dated 10/17/19, indicated the resident had a Stage 2 pressure ulcer to the coccyx. The order stated to apply Z-guard to the wound to treat and protect along with repositioning. A review of the resident's chart showed no further orders related to dressing change. According to Resident #41's clinical record, the	F 658		

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F 658	Continued From page 16 resident had an order to check blood sugars four times daily, dated 10/19/19. The resident's electronic record showed the following blood sugar results: 10/22/2019 12:15 563.0 milligram (mg) 10/21/2019 23:13 425.0 mg 10/20/2019 23:06 340.0 mg 10/20/2019 10:43 325.0 mg 10/20/2019 01:08 394.0 mg During an interview on 10/23/19 at 2:23 PM, the Corporate Nurse, RN, stated she would expect blood sugars to be done as ordered. She also reported she was unable to find an order for a dressing change, only an order dated 10/21/19 to clarify if the facility should continue a dressing change. The Progress Note dated 10/22/19 at 3:21 PM, noted the resident had an order for Amoxicillin-Pot Clavulanate Suspension Reconstituted 400-57 milligrams (mg)/5 milliliter (ML) for a total dose of 875mL twice a day for eight days. The order was noted on 10/17/19. The medication was not available for administration. A call placed to Omnicare on the 10/22/19 billing issue resolved, and the prescription should arrive on 10/22. First dosing requested. Head to toe assessment completed, lung sounds clear but diminished in lower lobes, and the resident has been afebrile since admission. Primary Care Physician updated and recommendations requested. The Progress Note dated 10/22/19 at 4:09 PM, noted a call out to the provider for clarification, asked him if it was ok to start antibiotic today as ordered before. The provider elected not to	F 658		

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participate. The Director of Nursing (DON) to contact the original physician that ordered the prescription.

During an interview on 10/22/19 at 4:35 PM, the DON stated she provided education to the nurses, to re-educate the staff to call and determine why the pharmacy did not provide the medications for an order. She said the drug would not be available in the emergency kit (E-Kit) due to it being a liquid suspension medication. She stated the nurse was to notify the pharmacy and make sure it is coming and they could not ignore it. She stated they were to notify their supervisor if the medication wasn't available. The DON reported she did an audit on all of the residents on antibiotics and found no other concerns. She stated the resident had been assessed and was not running any fevers. She reported the facility notified the provider of the missed dose.

During an interview on 10/23/19 at 11:02 AM, the facility's primary pharmacy for Medicare and Medicaid patients reported the facility sent the orders to the pharmacy at 3:17 PM. At 6:06 PM, the pharmacy called to clarify a prescription and was told by the nurse the resident was going to private pay for his medications through a different pharmacy, even though the resident was skilled. The Pharmacist stated Augmentin was not on the resident's profile.

During an interview on 10/23/19 at 11:07 AM, the facility's primary pharmacy for private pay residents reported the resident was not even in the system. They said they received information on 10/22/19, but they did not provide his services. The Pharmacist stated they have a pharmacist on-call 24 hours per day for emergencies. The

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Pharmacist reported they do not keep an E-Kit in the building as the facility could not have two different pharmacy kits in the building.

During an interview on 10/23/19 at 11:22 AM, the MDS Nurse, Registered Nurse, reported she was speaking to the pharmacy at the time and was on hold. She stated she was looking for the resident's antibiotic. She said she had searched the entire facility, and it was not anywhere. The MDS Nurse stated if the medication were available to be given on 10/20/19 or 10/21/19, there would still be medication in the building.

During an interview on 10/23/19 at 4:24 PM, the Corporate Nurse said the physician stated to not start the antibiotic until after he saw the resident at his visit on 10/24/19.

During an interview on 10/24/19 at 08:42 AM, the resident's representative stated the physician stopped to see the resident today. She said that he would be changing his medications as the resident's oxygen saturation was only 85% upon assessment. She stated the resident did not have fevers and it was too difficult to determine an infection as the resident always had a gurgling sound.

The Physician's Progress Notes Orders, dated 10/24/19, directed to start Cefdinir 600 mg per the jejunostomy (j)-tube daily for seven days.

The Medication Administration policy, with a revision date of 8/21/19, stated the purpose was to administer the medication according to the principles of medication administration, including the right medication, to the right resident/patient at the right time, and in the right dose and route.

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide consistent treatment and cares to prevent the development or decline of a pressure ulcer for 2 of 5 residents reviewed (Resident #17 and #41). Resident #17 resulted in a deterioration of the pressure ulcer. The facility reported a census of 41. Findings include: 1. The Minimum Data Set (MDS) completed with an Assessment Reference Date of 8/22/19 showed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. The resident had diagnoses of Diabetes Mellitus Type II, pressure ulcer of left buttock, stage two, and pressure ulcer caused by a device. The MDS indicated the resident was at risk for the development of pressure ulcers. The resident required extensive assistance of at least two staff with bed mobility	F 686		

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and total assistance of at least two staff with transfers during the seven day lookback period.

The Medication Administration record indicated the resident had an order for Optifoam with a start date of 9/10/19 to the left buttock ulcer to be changed once every three days and as needed for saturation.

The Medication Administration record indicated the resident had an order with a start date of 10/12/19 to cover the left buttocks with Aquacel or optical AG and foam dressing to be changed three times a week and as needed for wound care.

The Medication Administration record indicated the resident had an order with a start date of 10/11/19 to cover the right side buttocks with a foam dressing or use barrier ointment with care every shift for wound care.

The Medication Administration record indicated the resident had an order dated 10/11/19 to follow up with the resident's wound care appointment in the facility on 10/22/19 unless the wound got worse, then call the wound care nurse for instructions.

During an observation on 10/23/19 at 07:54 AM, observed the resident's dressing to have a bowel movement (BM) on the dressing.

During an interview on 10/23/19 at 9:25 AM, Staff B, Licensed Practical Nurse (LPN), stated she had not yet completed the resident's dressing change and it wouldn't probably be for hours. Staff B said the wife liked the resident to be up and laid down at certain times. She stated the

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dressing change completion would probably after lunch.

During an interview on 10/23/19 at 9:42 AM, the resident's representative stated she would have preferred the staff not to get the resident up until the dressing was changed. She said now that the resident was up, she would prefer for him not to lay back down until he went down for his nap after lunch because it is too difficult for the resident and the staff with the mechanical lift. She stated sometimes the facility doesn't have the right dressing for the treatment, but they just needed to reorder it. She said they have different dressings they use at that time until they get new bandages in. She stated sometimes he would get BM on his dressing but they would always change it if it did have a BM on it.

During an observation on 10/23/19 at 12:46 PM, observed Staff B remove her toothpick from her mouth and placed it on the medication cart. Staff B then walked into the resident's room without hand hygiene and applied gloves. Staff B prepped the supplies on the nightstand. Staff B removed the dressing, without a documented date, from the resident's coccyx. Serous drainage observed to the dressing. Observed two wounds to the resident, one approximately nickel size to the left buttock and a smaller open area to the right side of the buttock. Staff B sprayed the prepared gauze with wound cleanser and cleansed the wound. Staff B applied a cream to the wound as the wife helped to hold buttocks and applied dressing to cover both wounds with the one dressing. Staff M, Certified Nurses' Aide (CNA) placed a body pillow under the resident's right side to keep the resident off his bottom.

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F 686	Continued From page 22 During an observation on 10/23/19 at 12:46 PM, the resident's representative reported the wound was definitely worse. She stated its the worst it's ever looked. During an observation on 10/23/19 at 12:46 PM Staff B, reported she felt the resident needed another treatment but the wound nurse would be here on Friday. During a follow-up interview on 10/23/19 at 1:01 PM, Staff B stated she would not notify the wound nurse because she'll be here anyways on Friday to assess him. The resident's current Care Plan stated the resident had impaired skin integrity related to incontinence, decreased mobility, self-care deficits, and type two diabetes. The resident had excoriation to his coccyx. The goal stated the coccyx would show improvement and would have no new areas of skin breakdown. The interventions included: 1. The Wound Nurse (WOCN), had discontinued services as the resident's area to the coccyx is nearly healed. Notify the WOCN of worsening or any new areas. 2. Air mattress on the bed. 3. Barrier cream to peri area twice daily and with incontinence. 4. Complete a Braden assessment on admit, quarterly, and as needed (PRN). 5. Linens to be kept clean, dry, and wrinkle-free. Linens to be changed weekly and PRN. 6. Lotion PRN to treat dry skin. 7. Pressure-relieving cushion on the chair. The resident did bring a cushion from home, WOCN was aware.	F 686		

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8. Refer to Registered Dietitian as needed.
9. See current WOCN orders for treatment in Treatment Administration Record (TAR). Foam dressing and Venelex twice daily (BID) to the coccyx.
10. Skin checks completed BID by CNAs and any new or worsening areas reported to charge nurse to assess.
11. Turn and reposition routinely throughout the day and night.
12. Weekly skin checks by the nurse. Report any new or worsening areas to MD/WOCN.

The Progress Note dated 8/28/19 at 11:40 AM, labeled Nutrition, noted the Dietitian's quarterly assessment. The resident's weight 262 pounds (#), up 1.5% in 30 days, which is not a significant weight change. The resident consumed a regular diet and was assisted with meals as needed. Intake equal to 50-75%. Takes Arginaid for skin healing, note sore to buttocks healed, but the skin is fragile. Will keep supplements in place. The resident took folic acid, vitamin B complex, and Multi-Vitamin supplements. The resident's overall nutrition needs met at present. Care Plan goal met. The Dietitian would continue with plans and monitor ongoing.

The Wound Assessment completed on 9/10/19 by the WOCN indicated the resident had an open area to the sacrum. The history of the present illness (HPI) stated the resident was seen per the resident's representative's request. The resident continued to use an air mattress on the bed and cushions placed in his seating. The wound measurements indicated the right side of the buttock and the sacral area was pink and intact with no open areas. The left side of the patient's buttock had a small opening measuring 0.5 by 0.4

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by 1 with the edges attached surrounding tissue was pink. The plan was to discontinue the wound care to the right buttock and cover the left buttock with a foam dressing to be changed three times a week and as needed.

The Wound Assessment completed on 9/17/19 by the WOCN ,indicated the resident had an open area to the sacrum. The history of the present illness (HPI) stated the resident was sitting in his recliner for the exam and the WOCN was unable to examine the resident's sacral ulcer. The resident representative reported the wound had not gotten any worse.

The Wound Assessment completed on 10/11/19 by the WOCN, indicated the resident had an open area to the sacrum. The history of present illness (HPI) stated the resident was seen for follow-up on the resident's sacral coccyx ulcers related to pressure. The resident continued to use air mattresses on the bed, wheelchair and the recliner for offloading. The resident continued to get a protein supplement for nutrition. The facility placed foam dressing with border on for treatment as well to provide extra cushion. The wound measurements indicated the right side revealed intact pink tissue with no compromised skin, while the left side showed a very small area measuring 0.5 by 0.4 by 0.1 that was open and pink with moist edges and surrounding tissue was intact and pink.

The Pressure Injury Weekly Assessment - Version 4 dated 9/10/19 at 9:52 PM, indicated the resident had a facility acquired pressure injury to the left buttock that measured 1 cm by 1cm by 0 at stage II. The wound had no exudate drainage and no odor. The surrounding skin color was pink

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and intact, well approximated surrounding tissue/wound edges and a pink wound bed. The area under interventions noted the wound was showing improvement as the treatment was effective with the care plan interventions to reposition and follow treatment orders.

The Pressure Injury Weekly Assessment - Version 4 dated 9/12/19 at 3:27 PM, indicated the resident had a facility acquired pressure injury to the left buttock that measured one by one by 0 at stage II. The wound had no exudate drainage and no odor. The surrounding skin color was pink with intact, well approximated surrounding tissue/wound edges and a pink wound bed. The area under interventions noted the wound was showing improvement as the treatment was effective with the care plan interventions to reposition and follow treatment orders.

The Pressure Injury Weekly Assessment - Version 4 dated 9/19/19 at 8:46 PM, was started but not complete as the form was blank.

The Pressure Injury Weekly Assessment - Version 4 dated 9/26/19 at 1:32 PM, indicated the resident had a facility acquired pressure injury to the left buttock that measured one by one at stage II. The wound had a scant amount of exudate drainage and no odor. The surrounding skin color was pink with intact surrounding tissue/wound edges. The area under interventions noted the wound was showing improvement as the treatment was effective and to continue care plan interventions.

The Pressure Injury Weekly Assessment - Version 4 dated 10/2/19 at 1:19 PM, indicated the resident had a facility acquired pressure injury to

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the left buttock that measured 0.75 by 0.25 at a stage I. The wound had a scant amount of clear exudate drainage and no odor. The surrounding skin color was pink with intact surrounding tissue/wound edges and a red wound bed appearance. The area under interventions noted the wound was showing improvement as the treatment was effective and to continue care plan interventions.

The Pressure Injury Weekly Assessment - Version 4 dated 10/9/19 at 1:46 PM indicated the resident had a facility acquired pressure injury to the left buttock that measured one by one at stage II. The wound had a scant amount of exudate drainage and no odor. The surrounding skin color was pink with intact surrounding tissue/wound edges. The area under interventions noted the wound was showing improvement as the treatment was effective and to continue care plan interventions.

The Pressure Injury Weekly Assessment - Version 4 dated 10/16/19 at 3:42 PM indicated the resident had a facility acquired pressure injury to the left buttock that measured one by one at stage II. The wound had a scant amount of exudate drainage and no odor. The surrounding skin color was pink with intact surrounding tissue/wound edges. The area under interventions noted the wound was showing improvement as the treatment was effective and to continue care plan interventions.

The Pressure Injury Weekly Assessment - Version 4 dated 10/23/19 at 11:04 AM indicated the resident had a facility acquired pressure injury to the left buttock that measured one by one at stage II. The wound had a scant amount of

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exudate drainage and no odor. The surrounding skin color was pink with intact surrounding tissue/wound edges. The area under interventions noted the wound was showing improvement as the treatment was effective and to continue care plan interventions.

The resident's chart lacked an assessment regarding the right pressure ulcer on the right buttock area noted by the WOCN.

During an interview on 10/23/19 at 10:15 AM, the Wound Nurse, Advanced Registered Nurse Practitioner (ARNP), stated she would typically write an order for supplementation per the Dietitian. She said she would schedule her visits based on if the resident were stable, then WOCN would come every two weeks, and if the resident was not stable, she would come every week. She stated she would expect the facility to contact her sooner if the wound worsened. She reported the facility never notified her if the wound had worsened to make her aware. She said she had not seen a decline in the residents she was following in the facility. The Wound Nurse reported she did all of her assessments on the residents and did not even look at the facility assessments. She stated she would always write an order to do the dressing change as needed for saturation of stool or urine. The Wound Nurse said most of the time, when she came to the facility, she could not find a nurse and would frequently only have one nurse for the entire building. She stated the facility took very complicated patients; they did not have the staff to care for them. The Wound Nurse stated there was always new staff, so no one knows what is going on.

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During an interview on 10/23/19 at 3:45 PM, when asked about the Pressure Injury Weekly Assessment completed at 11:04 a.m. before the dressing change had been completed at 12:46 p.m. on 10/23/19, the Corporate Nurse stated she would expect the staff to not document an assessment without completing an assessment on the resident.

2. According to the clinical record Resident #41 admitted to the facility on 10/17/19. The resident had diagnoses of recurrent aspiration pneumonia, malnutrition, and physical deconditioning.

The hospital Discharge Summary, dated 10/17/19, indicated the resident had a Stage 2 pressure ulcer to the coccyx. The order stated to apply Z-guard to the wound to treat and protect along with repositioning.

The Progress Note dated 10/17/19 at 9:58 AM, noted the resident admitted to the facility by ambulance. The resident was alert and oriented to name and place with a low voice tone. The resident has upper and bottom dentures and no hearing aids. Rales noted in the bi-lateral right and left, anterior, and posterior lung fields upon inspiration when auscultated with a stethoscope. Skin warm and dry, pressure wound noted on the coccyx, no drainage or odor noted at this time. Small wounds noted on the right, second, and third toes, the left foot, the second toe beside the great toe. The resident has a gastrostomy-jejunostomy (G-J) tube noted in the middle abdomen. Resident continues on Jevity 1.5 calorie (cal) @ 75 milliliter (ml)/hour (hr). Abdomen soft and non-distended with bowel sounds present in all four quadrants. The resident

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had a medium loose brown stool noted in brief. Redness noted to the scrotum and the perineal area. Clean and dried the resident as well as applied protective ointment. Resident unable to stand at this time. The resident required three-person assistance. Head of the bed elevated. Bed in the lowest position and the call light within reach.

During an interview on 10/21/19 at 2:11 PM, the resident's representative reported the resident would slide down in the chair to get off the bedsore on his bottom.

During an observation on 10/21/19 at 3:54 PM, Staff I wiped the resident's backside and noted stool on the resident's dressing. Staff E left the room to get the dressing supplies. Staff E returned and applied gloves without hand hygiene and removed the dressing and cleansed the wound with damp gauze. Staff E then applied a cream to areas around the wound and applied a bandage to each side of the resident's buttock. Once completed, Staff E left the room without completing hand hygiene.

A review of the electronic and paper record showed no order for the treatment of the dressing to the pressure ulcers on the coccyx.

The Skin Care and Wound Management policy dated 6/15, stated to obtain a physician's order for the identified protocol or treatment order. The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds. The interdisciplinary team works with the resident/patient and family/responsible party to identify and implement interventions to prevent

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and treat potential skin integrity issues. The interdisciplinary teams evaluate and documents identified skin impairments and pre-existing signs to determine the type of impairment, underlying condition contributing to it, and description of impairment to determine the appropriate treatment. Components of the skincare and wound management program include, but are not limited to, the following:
1. Identification of residents at risk of developing pressure ulcers.
2. Implementation of prevention strategies to minimize the potential for developing pressure ulcers and skin integrity issues.
3. Weekly monitoring of resident/patient skin status.
4. Daily monitoring of existing wounds.
5. Application of treatment protocols based on clinical "best practice" standards for the promotion of wound healing.
6. Interdisciplinary review of identified skin impairments.
7. Monitoring for consistent implementation of interventions and the effectiveness of interventions.
8. Review and modification of treatment plans, as applicable.
9. Analysis of facility pressure ulcer data for quality improvement opportunities.
The policy defined a pressure as a localized injury to the skin and underlying tissue usually over a bony prominence, as a result of stress or pressure in combination with shear and friction.

During an interview on 10/23/19 at 4:10 PM, the Registered Dietitian (RD) stated she would look at the resident oral intake to check for the need for supplementation. She said if the weight were stable, she would supplement with Arginaid to not

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F 686	Continued From page 31 add the excess calories. The RD stated if the resident needed to gain weight, she would do a supplement like Boost. If the resident had trouble with sugar or a Diabetic, she would do something like glucerna. The RD stated it was sometimes a hit or miss with notifications of pressure ulcers. She said she would typically ask the staff or review the chart to determine if an increase in visits is needed. She reported she would like to try to increase the number of visits if able. The RD stated the facility used to hold skin and weight meetings in the past, but the facility was not doing them currently that she was aware of but would be welcome to do them. During an interview on 10/24/19 at 11:43 AM, the Corporate Nurse, RN, stated the facility was not doing their weekly skin and weight meeting.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide proper supervision to prevent accidents for one of one resident reviewed (Resident #41). The facility reported a census of 41 residents. Findings include:	F 689		

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According to the clinical record Resident #41 admitted to the facility on 10/17/19. The resident had diagnoses of recurrent aspiration pneumonia, malnutrition, and physical deconditioning.

During an interview on 10/21/19 at 2:27 PM, the resident's representative reported the resident fell three times on the day he admitted to the facility due to the bed being too small. She stated when she walked into the room, the resident was on the floor on his knees as he slid out of bed. She said the staff told her that was the third time it had occurred.

The chart showed a lack of documentation related to a fall.

The Progress Note dated 10/22/19 noted Resident #41's family had brought in bed from private home. Family stated that resident is most comfortable in this bed and request that facility to not order a longer bed at this time.

During an interview on 10/22/19 at 4:57 PM, the Director of Nursing (DON) stated if the resident was seen on his knees on the floor, that would be a fall because it would be a change in plane. She stated the nurse should have done an assessment related to the fall. The Social Worker reported they were not told the bed was changed due to the resident falling out of it.

During a follow-up interview on 10/24/19 at 8:45 AM, the resident's representative stated the resident was half on the bed and half off the bed when she entered the room, but he was not decent, so she left the room to give him privacy. She stated later in the same night the resident

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F 689	Continued From page 33 was on the floor and her brother picked him up by the shoulders with the staff in the room. The Fall Risk Reduction & Management policy, with a revision date of 12/15, stated post-fall management included appropriate resident care, evaluation, and revision of existing interventions and investigation into potential factors to determine areas of improvement. The policy directed staff to revise the care plan to indicate changes in interventions with each fall and as indicated. Modify, document goals, and interventions with each fall and as indicated. Notify the Fall Action Team if a resident experiences a fall.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §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	F 690		

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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 clinical record review, observation, facility policy review and staff interview, the facility failed to provide incontinence and catheter care to minimize the risk of cross-contamination and infection for 3 of 4 residents observed for incontinence care (Residents #16, #33, and #41). The facility reported a census of 41 residents.

Findings include:

1. A review of Resident # 16 Minimum Data Set (MDS) revealed diagnoses of Sequelae of cerebral infarction, senile degeneration of the brain and type 2 Diabetes Mellitus. The resident required extensive assist with bed mobility, transfer and toileting.

Resident #16's Care Plan with a target date of 12/6/19, noted a focus for potential for alteration in skin integrity r/t (related to) bowel and bladder incontinence, age related skin changes and decreased mobility with intervention of skin barrier cream to peri area with incontinence

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F 690	Continued From page 35 episodes. During observation on 10/22/19 at 10:00 AM, Staff H, Certified Nurse Aid (CNA) and Staff K, CNA, arrived and placed Resident #16 in bed to change a wet brief. Staff H and Staff K donned gloves, pulled down Resident #16's slacks, opened the brief and found it wet with urine. Staff H handed Staff K a cleansing cloth and Staff K proceeded to wash in an up/down motion to the frontal area then with same wipe washed buttocks area. Staff K failed to cleanse hip area that had been in contact of urine in the brief. Staff H squeezed Remedy Phytopley cream into Staff K's gloved hand to smear on resident's buttock. Staff H and Staff K proceeded to put on a clean brief and pull up the resident's slacks. Staff K placed the dirty brief/wipes in waste basket and Staff H and Staff K removed their gloves to wash their hands. Staff K picked up the waste bag and took it to dirty utility room to dispose of. A review of the facility Nursing Procedure Manual: Perineal Care revised date 4/13 revealed: Female: Purpose: To promote cleanliness and prevent infection Procedure: 4. wash hands and apply gloves 9. Separate the labia with one hand and wash with the other, using gentle downward strokes form the front to the back of the perineum. Remove gloves, wash hands and apply clean gloves if original gloves were visibly soiled. 12. Clean, rinse and dry the anal area, starting at the posterior vaginal opening and wiping from front to back. 13. Remove gloves, wash hands and apply clean gloves.	F 690		

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F 690	Continued From page 36 14. Apply ordered creams or ointments and/or skin barrier cream to prevent breakdown as needed. Remove gloves, perform hand hygiene and apply clean gloves. 2. The MDS completed for Resident #33 with an Assessment Reference Date (ARD) of 9/24/19 showed a Brief Interview for Mental Status score (BIMS) score of 8, indicating moderate cognitive impairment. The resident had diagnoses of unspecified dementia without behavioral disturbance, the urgency of urination and unspecified mood [affective] disorder. During an observation on 10/22/19 at 9:04 AM, observed the resident requesting to urinate despite catheter. During an observation on 10/22/19 at 9:05 AM, observed Staff L, Certified Nurses' Aide (CNA), wash her hands then placed a gait belt on the resident. Staff L removed her gloves and puts on new gloves without hand hygiene. Staff L then lifted the resident's foot pedals of the wheelchair and moved the resident closer to the commode. Staff L gave the resident the walker and assisted the resident to stand and walk to the commode. The resident reported she was completed and was unable to urinate. Staff L got wipes and took out wipes from the package. Staff L placed the unused open wipes on the back of the commode. Staff L had the resident stand up and provided perineal care from the backside of the resident using the wipes from the back of the commode. She then had the resident sit down. Staff L	F 690		

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removed her gloves and washed her hands. The resident reported she was afraid to stand. Staff L had the resident sit down and left to get another CNA, Staff M. Both CNAs washed their hands and applied gloves, then assisted the resident to her bed. Staff L took the commode to the bathroom and rinsed it out. Staff L then took the wipes and washed BM off the commode bucket then washed the bottom of the commode seat before washing the top of the commode seat with the same wipe. Staff L took the garbage bag from the garbage can and put the commode bucket into the bag and placed the bagged bucket into the commode frame.

3. According to the clinical record Resident #41 admitted to the facility on 10/17/19. The resident had diagnoses recurrent aspiration pneumonia, malnutrition, and physical deconditioning.

During an observation on 10/21/19 at 3:43 PM, with the curtains to the window open, Staff A pulled down the resident's pants and brief to preform perineal care. With two wipes together, Staff A wiped the resident's front and pulled back the foreskin. Staff A wiped multiple times in multiple areas of the resident's perineal area without changing the wipe. Staff E left to get the resident's cream to apply after the perineal care. Due to the resident's treatment cream, Staff A requested washcloths to finish wiping the resident's perineal area. Staff I left the resident's room with gloves on to get towels. At 3:54 PM, Staff E returned to the resident's room and closed the resident's window curtains. Staff I returned to the room with washcloths. Staff I dropped one washcloth on the floor and then picked up the washcloth. Staff I placed the dropped washcloth with the other clean washcloths on to the counter.

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Staff I filled the sink and placed the wash clothes into the sink to get them wet. Once wet, Staff I handed the wash clothes to Staff A. Staff A washed the resident's front side with two separate washcloths then dried the area with one washcloth. Staff E then applied gloves without hand hygiene and applied the cream to the front of the resident's perineum. Staff I and Staff A then rolled the resident to the left side and Staff E provided perineal care to the resident's backside. With wipes, Staff E wiped the resident's backside and noted stool on the resident's dressing. Staff E left the room to get the dressing supplies. Staff I and Staff A finished the perineal care and placed the dirty linens on the counter next to the clean linens. Staff I removed her gloves to expose another layer of gloves. Staff I left this pair of gloves on without providing any hand hygiene. Staff E returned and applied gloves without hand hygiene and removed the dressing and cleansed the wound with damp gauze. Staff E then applied a cream to areas around the wound and applied a bandage to each side of the resident's buttock. Once completed, Staff A placed the dirty cloths on the counter with the other dirty linen. Staff E left the room without completing hand hygiene. Staff I picked up the dirty linen and garbage then walked out of room.

During an interview on 10/23/19 at 3:42 PM, the MDS Nurse, RN, stated she would expect staff not to wear two pairs of gloves unless the Doctor ordered it. She said she expected the staff to wash their hands. The MDS Nurse stated she would expect the staff to wipe only once and then throw the wipe before taking a new wipe when doing incontinent care. She also said she would not expect staff to put dirty linen with clean linen.

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F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, the facility failed to notify the resident's primary Physician regarding the request of treatment for use related to the resident's pressure ulcer for one of one resident reviewed (Resident #41). The facility reported a census of 41. Findings include: According to the clinical record Resident #41 admitted to the facility on 10/17/19. The resident had diagnoses of recurrent aspiration pneumonia, malnutrition, and physical deconditioning. During an interview on 10/21/19 at 2:11 PM, the	F 710		

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F 710	Continued From page 40	F 710		

resident's representative reported the resident would slide down in the chair to get off bedsore on his bottom.

The discharge instructions dated 10/16/19 at 2:19 PM stated the resident had a stage two pressure ulcer to the coccyx that was present on admission to the hospital. The surrounding tissue was noted to be red and slow to blanch. The patient was incontinent of bowel and bladder. On 10/15/19, the wound was noted to be slightly smaller, use Zguard to treat, and protect along with repositioning.

The Progress Note dated 10/17/19 at 9:58 AM, noted the resident admitted to the facility by ambulance. The resident was alert and oriented to name and place with a low voice tone. The resident has upper and bottom dentures and no hearing aids. Rales noted in the bi-lateral right and left, anterior, and posterior lung fields upon inspiration when auscultated with a stethoscope. Skin warm and dry, pressure wound noted on the coccyx, no drainage or odor noted at this time. Small wounds noted on the right, second, and third toes, the left foot, the second toe beside the great toe. The resident has a gastrostomy-jejunostomy (G-J) tube noted in the medial abdomen. Resident continues on Jevity 1.5 calorie (cal) @ 75 milliliter (ml)/hour (hr). Abdomen soft and non-distended with bowel sounds present in all four quadrants. The resident had a medium loose brown stool noted in brief. Redness noted to the scrotum and the perineal area. Clean and dried the resident as well as an applied protective ointment. Resident unable to stand at this time. The resident requires three-person assistance. Head of the bed elevated. Bed in the lowest position and the call

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F 710	Continued From page 41 light within reach. During an observation on 10/21/19 at 3:54 PM, Staff I wiped the resident's backside and noted stool on the resident's dressing. Staff E left the room to get the dressing supplies. Staff E returned and applied gloves without hand hygiene then removed the dressing and cleansed the wound with damp gauze. Staff E then applied a cream to areas around the wound and applied a bandage to each side of the resident's buttock. Once completed, Staff E left the room without completing hand hygiene. A review of the electronic and paper record showed no order for the dressing on the pressure ulcers on the coccyx. Per the chart review, the first documented notification regarding the resident and treatment orders noted in the chart to be on 10/21/19. The facility questioned the need to continue the optifoam dressing daily and how often. The Physician responded on 10/22/19 to address at the nursing home on Thursday. The Physician's Progress Notes orders dated 10/24/19, directed the resident to have Optifoam dressing to the coccyx, change every three days, or if saturated. The Skin Care and Wound Management policy, dated 6/15, stated to obtain a physician's order for the identified protocol or treatment order.	F 710		
F 729 SS=E	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification.	F 729		

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F 729	Continued From page 42 Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on personnel file reviews and staff interview, the facility failed to obtain registry verification of a certified nurse assistant (CNA) prior to hire for 3 of 3 currently employed CNA's. The facility reported a census of 41 residents.	F 729		

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F 729	Continued From page 43 Findings include: The personnel file for Staff H, CNA, documented a hire date of 2/27/19. The file contained a direct care worker (DCW) registry check completed after hire on 10/22//19. The personnel file for Staff J, CNA, documented a hire date of 06/18/19. The file contained a direct care worker (DCW) registry check completed after hire on 10/22/19. The personnel file for Staff P, CNA, documented a hire date of 06/18/19. The file contained a direct care worker (DCW) registry check completed after hire on 6/20/19. During an interview on 10/23/19 at 2:11 PM, the Nurse Consultant confirmed all the records, the dates of hire and dates CNA direct Care Worker check. The Nurse Consultant confirmed the Direct Care Worker Check needs to be completed prior to hire to confirm they are active.	F 729		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to develop a care plan with measurable goals and interventions to address the care and treatment for a resident with	F 744		

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F 744	Continued From page 44 dementia for 1 of 3 residents reviewed (Resident #33). The facility reported a census of 41 residents. Findings include: The Minimum Data Set completed with an Assessment Reference Date of 9/24/19 showed a Brief Interview for Mental Status score of 8, indicating moderate cognitive impairment. The resident had diagnoses unspecified dementia without behavioral disturbance and unspecified mood [affective] disorder. A review of the resident's Care Plan lacked information regarding the resident's dementia. During an interview on 10/23/19 at 11:22 AM, the MDS Nurse reported she had not written an area in the Care Plan related to dementia. She stated she was still in the learning process of how her current facility wants the Care Plans done.	F 744		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either	F 801		

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F 801	Continued From page 45	F 801		

full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations

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F 801	Continued From page 46 after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on records review and interviews, the facility failed to ensure that the dietary service manager had the required qualification. The facility identified a census of 41 residents. Findings include: During an interview on 10/22/19 at 7:20 AM Staff G, Dietary Service Manager (DSM) stated she did not have any training for her position but was signed up for a class that she probably won't be taking. In an interview on 10/22/19 at 2:32 PM the Business Office Manager said Staff G, Dietary Manager, had not handed in a written resignation and it was understood that she was staying on as manager until we hired a new person.	F 801		

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F 801	Continued From page 47 A review of Staff G's personnel file lacked a resignation letter. The file lacked certificate for a Dietary Manager as per regulations. A review of the Dietary Services Supervisor Job Description, dated 1/13, described the DSM's Minimum Skills/Experience/Education: Be a graduate of an accredited course in dietetic training approved by the American Dietetic Association. During an interview on 10/23/19 at 4:11 PM the Dietary Consultant confirmed Staff G did not get any training due to she never seemed to be available for me to train.	F 801		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's	F 803		

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F 803	Continued From page 48 dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to follow the menu for 1 resident on pureed diet and 2 residents on mechanical soft diets,(Residents #5, #16 and #39). The facility reported a census of 41. Findings include: 1. A review of Resident #16's medical record noted diagnoses of senile degeneration of brain, type 2 diabetes mellitus and alzheimer's. The resident had a physician order dated 8/28/19, for pureed diet and honey thicken fluids. During observation of breakfast meal service on 10/22/19 at 8:10 AM Staff G, Dietary Service Manager (DMS), placed oatmeal into a bowl, added water and placed in the microwave. Staff G put the oatmeal in Robot Coup to puree. Staff G placed the oatmeal in a bowl for Resident #16. In an interview on 10/22/19 at 8:15 AM, Staff G explained the staff said Resident #16 only gets oatmeal for breakfast. Staff G confirmed she hadn't asked the resident or family for food preference. The general noon menu for Tuesday 10/22/19 included ham, mashed potatoes, and baked beans.	F 803		

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F 803	Continued From page 49 Observation on 10/22/19 at noon, Staff G placed 2 servings of ham, 2 servings of mash potatoes and 2 servings of baked beans in the Robot Coupe and pureed this all together. Staff G did not measure this mixture and proceed to place 3/4 of mixture in a bowl for Resident #16. Resident # 16 did not get a piece of pie with her pureed diet as noted on the general diet. 2. A review of Resident #5's medical record noted diagnoses of alzheimer and anemia. The record included a Physician order dated 8/2/19 for Mechanical Soft diet. The general noon menu for Tuesday 10/22/19 included ham, mashed potatoes, and baked beans. Observation on 10/22/19 at noon, Staff G placed 2 servings of ham, 2 servings of mash potatoes and 2 servings of baked beans in the Robot Coupe and Pureed this all together. Staff B did not measure this mixture and proceed to place the left over 1/4 on a plate with an extra serving of mashed potatoes and piece of pie for Resident #5. 3. A review of Resident #39's medical record noted diagnoses of muscular dystrophy, anemia, type 2 diabetes mellitus and depression. The record included a Physician order dated 8/2/19 for Mechanical Soft diet. The general noon menu for Tuesday 10/22/19 included ham, mashed potatoes, baked beans and pie. During observation on 10/22/19 at noon, Resident #39 received a piece of ham approximately 4 x 4,	F 803		

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F 803	Continued From page 50 this was not ground as per his diet order for mechanical soft diet. During an interview on 10/22/19 at 7:20 AM Staff G, Dietary Service Manager (DSM) stated all the residents receive a general diet, only the consistency may differ. Staff G confirmed there was only 1 resident with a pureed diet and 2 residents with mechanical soft diets, so their meat is ground. During an interview on 10/22/19 at 12:30 p.m. the Staff G, DSM, stated Resident #39 hasn't ever gotten ground meat and Resident #5 eats pureed meals better, isn't it better the resident eats. Staff G confirmed she did not puree the pie so Resident #16 did not get a piece of pie. During an interview on 10/22/19 at 2:35 PM the Director of Nursing confirmed it would be her expectation the dietary staff would follow the diet order the physician ordered. A review of the Dietary Services Supervisor Job Description dated 1/13 described the DSM's Essential duties and responsibilities: Review therapeutic and regular diet plans and menus to assure they are in compliance with the physician's orders. Visit residents periodically to evaluate the quality of meals served, likes and dislikes, etc. During an interview on 10/23/19 at 4:11 PM, the Dietary Consultant stated it would be her expectation for the staff to follow the menu and the resident ordered diet.	F 803		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2)	F 808		

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F 808	Continued From page 51 §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to develop and evaluate therapeutic diets, including texture of foods and liquids, to meet the specialized needs for 3 residents with orders for therapeutic diets (Residents #5, #16, and 39). The facility reported a census of 41. Findings include: A review of Resident #5's medical record included a Physician order dated 8/2/19 for Mechanical Soft diet. A review of Resident #16's medical record included a physician order dated 8/28/19 for pureed diet and honey thicken fluids. A review of Resident #39's medical record included a Physician order dated 8/2/19 for Mechanical Soft diet. A review of the week at a glance menu for week two, 10/20/19 through 10/26/19 revealed only a general diet menu. The dietary staff lacked a therapeutic menu for the pureed and mechanical diets.	F 808		

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Observation on 10/21/19 at 8:30 AM noted the kitchens only menu for the staff was a general diet menu. Staff F, Dietary Cook, said that was the only menu they had and wasn't sure what a therapeutic menu was.

In an interview on 10/22/19 at 7:20 AM, Staff G stated there is no therapeutic menu, all the residents are on a general diet. The pureed and mechanical soft ordered diets would get everything on the general menu only it would be grounded or pureed.

The definition of "Therapeutic Diet" per regulations:
a diet ordered by a physician or delegated registered or licensed dietitian as part of treatment for a disease or clinical condition, or to eliminate or decrease specific nutrients in the diet, (e.g., sodium) or to increase specific nutrients in the diet (e.g., potassium), or to provide food the resident is able to eat (e.g., a mechanically altered diet).

"Mechanically altered diet" per regulations:
one in which the texture of a diet is altered. When the texture is modified, the type of texture modification must be specific and part of the physicians' or delegated registered or licensed dietitian order.

In an interview on 10/23/19 at 4:11 PM the Dietary Consultant stated she was not aware mechanical soft and pureed diets were considered therapeutic diets. The Dietary Consultant stated she would fix this as they were going to the Martin Brothers menus.

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F 812	Continued From page 53	F 812		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews the facility failed to document the temperatures of the meals prior serving, handle food safely to prevent food-borne illness and consistently monitor the internal temperature of their refrigerators and freezers. The facility reported a census of 41. Findings include: 1. Observation on 10/21/19 at 9:17 AM during the initial walk through noted documents of temperatures taped to the fridge and freezer doors. These documents had days not filled in with the temperature.	F 812		

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F 812	Continued From page 54 The milk fridge October document lacked a temperature recorded on the PM shift for the 1, 4-10, 15 - 21. The white refrigerator October document lacked a temperature recorded on the AM shift for the 8, 9, 10, 15 -18, and 21 and the PM shift for October 9, 10, 15 - 19. The refrigerator October documentation lacked a temperature recorded on the AM shift on the 17, 18, 20. For the 4 - 16 a line placed with documentation of "range 32-40 and the PM shift for October 1, 4, 7 - 10, 13 - 21. The freezer in back documentation lacked a temperature recorded on the AM and PM shifts on the October 4th through the 18th. A review of the Dietary Services Supervisor Job Description dated 1/13 described the DSM's Equipment and Supply Functions: Make periodic rounds to check equipment and to assure that necessary equipment is available and working properly. Review of Nutrition Services Manual: Sanitation dated 6/15 Refrigerator/Freezer Temperature Log Purpose To record temperatures of all refrigeration/freezers units located in the kitchen area. Responsible person(s) / When Morning cook upon arrival and evening cook before closing department for the evening. Instructions: 3. Record temperature in the AM column when unit first opened for the day. 4. Record temperature in the PM column prior to closing for the day	F 812		

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F 812	Continued From page 55 During an interview on 10/22/19 at 1:30 PM Staff G, DSM, stated she didn't know why the temperatures aren't marked. Staff G said it is important because the freezer in the back is watched closely because we have found it above freezing before. During an interview on 10/23/19 at 4:11 PM the Dietary Consultant stated the freezers and refrigerator temperatures need to be checked in AM and PM because we aware of the freezer not always working properly. 2. Observation on 10/21/19 at 9:17 AM during the initial walk through noted a document recording of temperatures taped the cupboard titled Food Temps In Warmer. October dates that lacked temperatures recorded were: Breakfast, 1, 2, 4, 9 - 18. Dinner 1, 2, 9 - 18. Supper 1, 4, 5, 7 - 10, 14, 15 - 18. A review of the Nutrition Services Manual; Sanitation and Food Production dated 6/15: Temperatures: Food temperatures are taken during preparation, cooking, meal service and storage. 6. Record temperatures on the menu spreadsheet for each meal, noting all temperatures including alternates and special orders. During an interview on 10/22/19 at 1:30 PM Staff G, DSM, stated she didn't know why the temperatures were not documented, guess the staff just didn't do it. During an interview on 10/23/19 at 4:11 PM the Dietary Consultant stated it would be her	F 812		

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F 812	Continued From page 56	F 812		

expectation the meal temperatures would be taken prior to serving.

3. On 10/22/19 at 7:30 AM Staff G, DSM, dons oven mitts and removes the Egg Bake for Breakfast, dons a pair of gloves, opened the milk refrigerator and removes milk/juice glasses from the fridge and placed on counter. Staff G pushed coffee cart into the Dinning Room and moves to the steam table for serving breakfast. Staff G, picked up a knife and proceeded to cut the egg bake into pieces approximately 4 inch square (menu stated required #18 scoop).
At this time placed the food on the plate, reached back and grabbed milk/juice glasses by the top and placed on the tray. A resident requested toast, Staff G, walked to the bread cabinet, opened the door removed a loaf of bread, opened the wrapper and pulled out a piece of bread to place in toaster. Staff G continued to serve breakfast, when toast was done grabbed the toast, buttered it and placed on plate. Staff G walked to the refrigerator, removed a piece of cheese and placed on toast. At this time Staff G removed her gloves and donned a new pair.

At 7:50 AM, Staff G wearing gloves left steam table, grabbed an apple from a bowl, washed it in the sink, cut up into pieces and placed on tray for the resident, Staff G then changed gloves.

At 8:10 AM Staff G wearing gloves filled a bowl with oatmeal, placed in micro-wave, placed the oatmeal in Robot coup to puree. Staff G request Staff N, Dietary Cook, to help with the Robot Coupe Blades. Staff N entered the kitchen from Dinning Room, with bare hands picked up blades, adjusted the Robot coupe and placed blades in the machine. When the meal is pureed, Staff N

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F 812	Continued From page 57 removed blades with bare hands and took blades to the sink. A review of Nutrition Services Manual: Sanitation dated 06/15 noted: Procedure: 3. Change Gloves: with each new task A review of Infection control Manual revised date 02/17 Handwashing: Overview: ...The facility requires personnel to wash hands thoroughly to remove dirt, organic material and transient microorganisms...Hands must be washed after the following, including, but not limited to: Contact with contaminated items or surfaces Removal of gloves During an interview on 10/23/19 at 4:11 PM, the Dietary Consultant stated it would be her expectations for the dietary staff to change gloves after touching contaminated items and wash their hands. During an observation on 10/21/19 at 12:13 PM, observed Staff A, Certified Nurses' Aide (CNA) picking her chin and her ear then without hand hygiene continued to assist the resident with the resident's meal. During an observation on 10/21/19 at 12:15 PM, observed Staff A continued to assist the resident with her meal. Staff A picked her fingers, then rubbed her lips. During an interview on 10/24/19 at 10:08 AM, the Corporate Nurse, Registered Nurse, stated she would expect staff to wash their hands while	F 812		

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F 812	Continued From page 58 assisting residents with their meal, and it would not be appropriate to help a resident eat following touching their face, ears or lips.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		

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F 880	Continued From page 59 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide appropriate infection prevention and control procedures for 3 of 16 residents reviewed (Resident #141,# 33, #41). The facility reported a census of 41.	F 880		

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F 880	Continued From page 60 Findings include: 1. The Minimum Data Set (MDS) completed for Resident #141 with an Assessment Reference Date (ARD) of 9/19/19 showed a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. The resident had diagnoses of type 2 diabetes mellitus with diabetic neuropathy, long term (current) use of insulin and acquired absence of left leg below the knee, pain. The resident had injections for seven of the seven days of the lookback period. During an observation on 10/23/19 at 7:40 AM, Staff B, Licensed Practical Nurse (LPN), prepared 25 units of Novolin N 100 units per milliliter (u/ml). Staff B then walked from the medication cart in the dining room to the resident's room. Staff B knocked on the resident's door and explained the process to the resident and set down the diabetic tray on the counter, without a barrier. Staff B walked over to the resident with the same gloves and injected insulin into the resident's abdomen using one hand to stabilize the stomach. Staff B picked up the tray off the counter and exited the resident's room with the same gloves still on. 2. The MDS completed for Resident #33 with an ARD of 9/24/19 showed a BIMS score of 8, indicating moderate cognitive impairment. The resident had diagnoses of unspecified dementia without behavioral disturbance, the urgency of urination and mood [affective] disorder. During an observation on 10/22/19 at 9:04 AM, the resident requested to urinate despite catheter. During an observation on 10/22/19 at 9:05 AM, Staff L, Certified Nurses' Aide (CNA), washed her	F 880		

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hands and placed a gait belt on the resident. Staff L then removed her gloves and put on new gloves without hand hygiene. Staff L lifted the resident's foot pedals of the wheelchair and moved the resident closer to the commode. Staff L gave the resident the walker and assisted the resident to stand. The resident walked to the commode. The resident reported she was completed and was unable to urinate. Staff L got a package of wipes and took out wipes from the package. Staff L placed the unused open wipes on the back of the commode. Staff L had the resident stand up and provided perineal care from the backside of the resident using the wipes from the back of the commode. She then had the resident sit down. Staff L removed her gloves and washed her hands. The resident reported she was afraid to stand. Staff L had the resident sit down and left to get another CNA, Staff M. Both CNAs washed their hands and applied gloves and assisted the resident in her bed. Staff L took the commode to the bathroom and rinsed it out. Staff L took the wipes and washed the BM off the commode bucket then washed the bottom of the commode seat before washing the top of the commode seat with the same wipe. Staff L took garbage bag from the garbage can and put the commode bucket into the bag and placed the bagged bucket into the commode frame.

3. According to the clinical record Resident #41 admitted to the facility on 10/17/19. The resident had diagnosed recurrent aspiration pneumonia, malnutrition, and physical deconditioning.

During an observation on 10/21/19 at 3:26 PM Staff A, Certified Nurses' Aide (CNA), and Staff I, CNA, entered the resident's room to assist the resident. Both CNA's applied gloves, then stood

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F 880	Continued From page 62	F 880		

and waited for the nurse to help as the resident required three staff to assist.

During an observation on 10/21/19 at 3:28 PM, Staff A left the room to look for the nurse with gloves on. At 3:32 PM, Staff I left the room to look for help with gloves on. At 3:38 PM, Staff I and Staff E, Registered Nurse (RN), returned to the resident's room and waited for Staff A to return. At 3:43 PM, Staff A returned to the room and applied gloves without hand hygiene. The three staff rolled the resident to the left side to reposition the mechanical lift sling. In the process, the feeding tube disconnected from the resident. The nurse attached the tube, without cleansing to the tube coming out of the resident. The staff then lifted the resident up with the mechanical lift and moved the resident to the bed. The nurse disconnected the feeding tube and placed the tube over the pole without covering the end of the feeding tube. The two CNAs put the resident into the bed. The nurse reconnected the feeding tube to the resident without cleansing the end. With the curtains to the window open, Staff A pulled down the resident's pants and brief to preform perineal care. With two wipes together, Staff A wiped the resident's front and pulled back the foreskin. Staff A wiped multiple times in multiple areas of the resident's perineal area without changing the wipe. Staff E left to get the resident's cream to apply after the perineal care. Due to the resident's treatment cream, Staff A requested washcloths to finish wiping the resident's perineal area. Staff I left the resident's room with gloves on to get towels. At 3:54 PM, Staff E returned to the resident's room and closed the resident's window curtains. Staff I returned to the room with washcloths. Staff I dropped one washcloth on the floor and then picked up the

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washcloth. Staff I placed the dropped washcloth with the other clean washcloths on to the counter. Staff I filled the sink and set the wash clothes into the sink to get them wet. Once wet, Staff I handed the washcloths to Staff A. Staff A washed the resident's front side with two separate washcloths then dried the area with one washcloth. Staff E applied gloves without hand hygiene and applied the cream to the front of the resident's perineum. Staff I and Staff A then rolled the resident to the left side and Staff E provided perineal care to the resident's backside. With wipes, Staff I wiped the resident's backside and noted stool on the resident's dressing. Staff E left the room to get the dressing supplies. Staff I and Staff A finished the perineal care and placed the dirty linens on the counter next to the clean linens. Staff I removed her gloves to expose another layer of gloves. Staff I left this pair of gloves on without providing any hand hygiene. Staff E returned and applied gloves without hand hygiene andremoved the dressing and cleansed the wound with damp gauze. Staff E applied a cream to areas around the wound and applied a bandage to each side of the resident's buttock. Staff E left the room without completing hand hygiene. Staff I picked up the dirty linen and garbage then walked out of the room.

During an interview on 10/23/19 at 3:42 PM, the MDS Nurse, RN, stated she would expect staff not to wear two pairs of gloves unless the Doctor ordered it. She said she expected the staff to wash their hands. The MDS Nurse stated she would expect the staff to wipe only once and then throw the wipe before taking a new wipe when doing incontinent care. She also said that she would not expect staff to put dirty linen with clean linen.

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F 880	Continued From page 64 During an observation on 10/23/19 at 11:35 AM, the MDS Nurse, RN, placed the Accu check monitor on the counter, then wiped Resident #41's finger with an alcohol wipe. The MDS Nurse then poked the resident's finger with the lancet and wiped the first blood with a cotton ball. The finger poke resulted in no further blood. The MDS Nurse removed her gloves and with no hand hygiene went to med cart to get new lancet. The MDS Nurse put on new gloves without hand hygiene and used the same alcohol wipe to cleanse the resident's finger. The MDS Nurse then poked the resident's finger and wiped the initial blood with a cotton ball, then checked the resident's blood sugar. The MDS Nurse removed gloves and washed her hands. Without gloves, the MDS Nurse picked up the Accu check monitor and used lancet and took them to the medication cart. The MDS Nurse got a wipe out of the medication cart and wiped the machine front and back for ten seconds, then placed onto the medication cart. During an interview on 10/23/19 at 11:35 AM, the MDS Nurse reported a three minute kill time for the wipe used to clean the Accu check machine. During an interview on 10/23/19 at 4:35 PM, the Corporate Nurse, Registered Nurse (RN), stated she would expect the staff to follow the procedure to clean the Accu check machine. During an interview on 10/23/19 at 5:06 PM, the Corporate Nurse reported that each resident had their Accu check machine. She had the Business Office Manager clarify this. The form labeled Glucometer Cleaning and	F 880		

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F 880	Continued From page 65 Disinfecting with no date provided stated to wipe down with Sani-cloths (purple top) - Contact time for purple top wipes is two minutes. The policy said that glucometers cleaned after each patient's use, in between patients, and after contact with blood or body fluids. The form stated to change gloves between patients and perform hand hygiene. Always perform hand hygiene before putting on gloves. The staff was to perform hand hygiene immediately after removal of gloves and before touching other medical supplies intended for multi-patient use, including glucometers. The policy stated that supplies and medication for fingerstick monitor or insulin administration not be placed on potentially contaminated environment surfaces e.g., bed. The packet given by the facility for cleaning of the Accu check labeled Micro-Kill Bleach germicidal bleach wipes stated to apply pre-saturated towelette and wipe the desired surface to be disinfected. A 30 second contact time is required to kill all of the bacteria and viruses on the label except a one minute contact time is required to kill Candida albicans and Trichophyton mentagrophytes and a three minute contact time are required to kill Clostridium difficile spores. Reapply as necessary to ensure that the surface remains wet for the entire contact time.	F 880		

578 Advanced Directives

1. IPOST for identified resident #141 was updated on 10/30/2019 with POA and PCP signature to change resident to DNR.
2. Audit was completed by DON on current residents in the facility to verify IPOST matches order in PCC and care plan. Completed by 11/5/2019.
3. Education provided by DON to Licensed Nursing Staff by 11/17/2019 on Advanced Directives requirements and expectations.
4. DON or Designee will audit IPOST monthly for 3 months to ensure that orders match PCC and Care Plan. DON or Designee will audit new admissions to ensure that IPOST is completed accurately and PCC order and care plan state same as IPOST. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of Compliance 11/24/19

583 Privacy

1. Resident #41 was discharged from the facility on 10/29/19.
2. CNA competencies completed by DON or designee regarding resident privacy while providing personal cares by 10/17/2019.
3. Education provided by DON or designee to Nursing staff on or before 11/24/2019 regarding the requirements of maintaining privacy while providing cares.
4. DON or Designee will audit by random observation 5x/week for 4 weeks and 3x/week for 8 weeks to verify privacy continues to be provided during nursing cares. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed
5. Date of Compliance: 11/24/19

606 – Criminal background check

1. CNA I's background check was completed on 12/14/18. CNA I was removed from the schedule on 11/6/2019 by the DON until mandatory 2 hours Dependent Adult Abuse class can be completed.
2. BOM will audit new employee files in the past 60 days by 10/28/2019 to determine if any other employees background checks were completed past 30 days of hire.
3. Education provided by Administrator to Business Office Manager on or before 11/6/19 regarding background check completion timely requirements and expectations. DON was educated by Regional Nurse Consultant on or before 11/6/19 related to CNA requirements of completing 2 hours of Dependent Adult Abuse class.
4. Administrator or designee will audit upon prior to hire date that background check was completed prior to 30 days from hire date for 3 months. The Administrator or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of compliance: 11/6/19

625 Bed Hold

1. The nurse that discharged resident #141 will be re-educated by DON before returning to work, related to the requirements of providing the bed hold
2. DON or designee will audit hospital transfers by 11/24/2019 on current residents in the past 30 days to ensure bed hold forms were completed with transfer as required.
3. Education provided by DON to Licensed Nursing Staff on or before 11/24/2019 regarding requirements related to providing bed hold forms when resident is transferred to hospital, including completing documentations.
4. DON or Designee will audit hospital transfer during morning meeting, times 12 weeks to ensure bed hold forms continue to be provided with transfer to the hospital. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of Compliance: 11/24/19

655- Baseline Care Plan

1. Baseline care plan for resident #33 was completed by 11/11/2019 by a Licensed nurse. Provided written summary for review for resident #33 by 11/11/2019. Resident #41 was discharged from the facility on 10/29/19.
2. Audit was completed by DON or designee by 11/24/2019 for current residents admitted in the past 30 days to verify that baseline care plans were completed and a copy of the summary provided to the resident and/or resident representative, any that are found to be out of compliance will be completed.
3. Education provided by DON to Licensed Nursing Staff by 11/24/2019 regarding baseline care plan completion requirements and expectations.
4. DON or Designee will audit baseline care plans weekly for 4 weeks and months for 2 months to ensure baseline care plans continue to be completed within 48 hours after admission as required. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of Compliance: 11/24/19

657 Care Conferences

1. Care conference for resident #141 will be held by 11/17/2019 the Interdisciplinary Team (IDT) and family
2. Audit was completed by DON or designee of current residents admitted to facility in the past 60 days to ensure care conferences were held as required, if the care conference was not held the care conference will be held by the IDT on or before 11/17/2019.
3. Education provided by Regional MDS Consultant (RMDS) to MDS Coordinator and DON related to requirements and expectations of care conference schedules by 11/17/2019.
4. DON or Designee will audit weekly for 12 weeks to ensure residents are receiving care conferences as required. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of Compliance: 11/24/19

658 Nursing standards

1. Resident #41 was discharged from the facility on 10/29/19.
2. Audit completed by DON on or before 11/24/2019 for residents receiving ABT in the past 30 days to ensure medication was given per physician's orders. Audit completed by DON on or before 11/24/19 for current resident who require accu checks in the past 30 days to ensure accu check was completed per physician order. Audit completed by DON on or before 11/24/2019 for current residents who require treatments in the past 30 days to ensure treatments are provided per physician's orders.
3. Education provided by DON to Licensed Nursing staff on or before 11/24/2019 related to physician notification when medication is not available and following physician orders including accu checks and treatment orders.
4. DON or Designee will audit 5x/week for 4 weeks and 3x/week for 8 weeks to ensure physician notified when a medication is not available. DON or designee will audit 5x/week for 4 weeks and 3x/week for 8 weeks to ensure physician orders continue to be followed with accu checks and treatments. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of Compliance: 11/24/19

686 Pressure Ulcers

1. For resident #17 wound assessment was completed on 10/23/19, Wound Care Nurse assessed wound on 10/24/2019. Resident #41 was discharged from the facility on 10/29/19.
2. The DON or designee will complete an audit to determine current residents who have pressure ulcers and who are at moderate to high risk for developing pressure ulcers to verify preventative measures are in place for treatment and prevention by 11/1/2019.
3. The DON and or designee will provide education by 11/17/2019 to License Nurses and CNA's related to the requirements and expectations of providing care and treatment for pressure ulcers, promote healing and prevention.
4. The DON or designee will audit weekly for 12 weeks residents with pressure ulcers and are moderate/high risk for developing pressure ulcers to ensure preventative measures continue to be in place as required. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of Compliance: 11/24/19

689 – Accident Falls

1. Resident #41 was discharged from the facility on 10/29/19.
2. Audit completed by DON or designee by 11/24/2019 on resident who are moderate/high risk for falls to ensure interventions are in place as required.
3. Education provided by DON or designee to Nursing Staff on or before 11/24/2019 regarding accident/fall prevention, assessment completion and documentation requirements.
4. DON or Designee will audit 5 residents/week for 4 weeks and 3 residents/week for 8 weeks to verify prevention interventions continue to be in place per care plan. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of Compliance: 11/24/19

690 – Incontinent Care

1. Resident #16 was assessed for signs and symptoms of urinary tract infection on 11/15/2019 by licensed nurse.
   Resident #33 was assessed for signs and symptoms of urinary tract infection on 11/15/2019 by licensed nurse.
   Resident #41 was discharged form the facility on 10/29/19.
2. Peri care competencies completed by DON or designee to ensure infection control is maintained while providing peri care on or before 11/24/2019.
3. Education provided by DON or designee to Nursing Staff by 11/24/2019 related to the requirements and expectations for incontinence care in.
4. DON or Designee will complete peri-care observations on random staff 5 staff/week for 4 weeks and 3 staff/week for 8 weeks. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of Compliance: 11/24/19

710 – Notification to Physician

1. For resident #41 a treatment order was obtained from PCP on 10/24/19 by the licensed nurse.
2. An audit will be completed by DON or designee by 11/17/2019 to identify residents receiving dressing changes and verify physician's orders match dressing change provided.
3. Education provided by DON to Licensed Nursing staff by 11/17/2019 related to the requirements of obtaining physician orders prior to starting a dressing change.
4. DON or Designee will audit one time weekly for 4 weeks then monthly for 2 months physician's orders continue to be obtained prior to starting dressing changes. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of Compliance: 11/24/19

729 CNA Registry Check

1. For Staff Member H and J direct care worker registry check was completed on 10/22/2019. For Staff Member P direct care worker registry check was completed on 6/20/2019.
2. Audit completed by Director of Nursing on new hires in the past 60 days by 11/24/2019 to identify if registry check was completed prior to hire.
3. Education provided by Regional Nurse Consultant to Director of Nursing by 11/24/2019 related to the requirements of checking direct care worker registry prior to hire.
4. BOM or designee will audit new hire weekly for 4 weeks and monthly for 2 months to ensure registry check continues to be completed prior to hire. The BOM or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of Compliance: 11/24/19

744 – Dementia care plan.

1. Resident #33 care plan will be updated by the MDS coordinator to include measurable goals and interventions for dementia diagnosis on or before 11/24/2019.
2. Audit was completed by DON or designee on or before 11/24/2019to identify residents with a dementia diagnosis to verify care plan interventions and measurable goals are implemented as required.
3. Education provided to MDS coordinator by DON on or before 11/24/2019 related to the requirements of including dementia focus interventions and measurable goals on care plan if a resident has a diagnosis of dementia.
4. DON or Designee will review care plans weekly for 4 weeks and monthly for 2 months for new admissions upon initial full care conference to verify Dementia diagnoses care plans continue to be implemented as required. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of Compliance: 11/24/19

801— Dietary Manager

1. Staff G - Dietary service manager resigned on11/1/2019.
2. A replacement has been hired and will sign up for Dietary Services Manager Training on or before 11/24/19 at DMACC and the Dietitian has agreed to mentor employee.
3. Dietary Consultant is training new employee and employee available for training starting 11/4/2019. Education provided by Regional Director of Operation or designee to Administrator by 11/24/2019 on requirements for hiring a certified Dietary Service Manager.
4. Administrator or Designee will review dietary manager training monthly for 3 months. The Administrator or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of Compliance: 11/24/19

803 – Menus meet resident needs

1. Resident #16 was provided diet as ordered by the physician per scheduled menu with each pureed food served separately as required on 10/23/2019.
   Resident #5 was provided diet as ordered by the physician per scheduled menu with each pureed food served separately as required on 10/23/2019.
   Resident # 39 was provided diet as ordered by the physician on 10/23/2019.
2. Admin/Designee will complete observational audit of all 3 meals on or before 11/24/19 to ensure diets are served per physician orders and pureed foods are served separately as required.
3. Education was provided to Dietary Manager by Administrator/designee on or before 11/24/19 related to the requirement of provided diets per physician's order, per scheduled menu including serving pureed foods separately as required.
4. Administrator or Designee will complete observational audits 3 times a week for 4 weeks and weekly for 2 months to ensure meals continue to be served per physician's order and pureed foods are served separately as required. The Administrator or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of Compliance: 11/24/19

808 – Therapeutic diet

1. Therapeutic diet menu for pureed and mechanical diets were provided to the dietary staff by Administrator on 10/23/2019.
2. An audit will be completed by Dietary Manager by 11/24/2019 to ensure therapeutic menus are available to dietary staff as required.
3. Dietary Staff was educated by Administrator or designee on or before 11/24/19 related to the requirements of providing mechanical altered and pureed diets per physician order.
4. Administrator or Designee will complete observational audits weekly for 4 weeks and monthly for 2 months to ensure mechanically altered and pureed diet menus continue to be provided as required. The Administrator or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of Compliance: 11/24/19

812 – Kitchen infection control

1. Refrigerator and Freezer temperatures were confirmed on or before11/24/19 by Dietary Consultant or designee to ensure temperatures meet food safety requirements. Food temperatures were confirmed on or before 11/24/19 by Dietary Consultant or designee to ensure food temperatures meet food safety as required. Dietary staff G was educated by Dietary Consultant or designee on or before 11/24/19 related to food safety requirements, including hand hygiene requirements.
2. An audit was completed by Administrator or designee on or before 11/24/19 to ensure Refrigerator, Freezer and food temperatures are completed as required. An observational audit was completed by Administrator or designee on or before 11/24/19 to ensure food safety guidelines are maintained including hand hygiene.
3. Dietary Consultant was educated by Administrator or designee on or before 11/24/19 related to monitoring refrigerator, freezer and food temperatures as required. The Dietary staff was educated by the Dietary Consultant or designee on or before 11/24/19 related to monitoring refrigerator, freezer, food temperatures and maintaining food safety guidelines including hygiene as required.
4. Administrator or Designee will complete observational audits weekly for 4 weeks and monthly for 2 months to ensure monitoring refrigerator, freezer, food temperatures and maintaining food safety guidelines including hygiene continue to be completed as required. The Administrator or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of Compliance: 11/24/19

880 – infection Control

1. Resident #141 was assessed for signs and symptoms of infection (s/s) on 11/15/2019 by the licensed nurse with no s/s of infection noted.
   Resident #33 was assessed for signs and symptoms of infection (s/s) on 11/15/2019 by the licensed nurse with no s/s of infection noted.
2. Observational audits were completed by DON or designee on or before 11/24/2019 to infection control is maintained while providing injection, peri care and catheter care.
3. DON or designee will provide education to nursing staff by 11/24/2019 regarding infection control requirements including hand hygiene, insulin injection procedure, glove changing, incontinent care, catheter care and accu check procedures.
4. The DON or Designee will complete observational audit 5x/week for 4 weeks and 3x/week for 8 weeks to ensure infection control continues to be maintained including hand hygiene, insulin injection procedure, glove changing, incontinent care, catheter care and accu check procedures. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.
5. Date of Compliance: 11/24/19