STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255328	A. BUILDING _____ B. WING _____	06/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF MARION	6434 A DALE DR MARION, MS 39342

(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 The State Agency (SA) conducted an annual recertification survey from 6/17/19 through 6/20/19. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid requirements of participation. The SA cited F623, F641, F645, F656, F686, F758, and F880. F656 & F686 were cited at s/s of "G" due to harm resulting in an unstageable pressure ulcer. The facility census was 112 and the facility was licensed for 120 beds at the time of survey.	F 000		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623		8/15/19

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

Electronically Signed | 08/07/2019

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 623	Continued From page 1 resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and	F 623		

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F 623	Continued From page 2 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff review, the facility failed to provided written notification of transfer to an acute care hospital for four (4) of five (5) residents reviewed for transfer/hospitalizations, Resident #88, Resident #87, Resident #107, and Resident #73.	F 623	1. Resident #88, Resident #87, Resident #107, and Resident #73 have not been transferred to an acute care hospital since the exit date of the survey. The corrected transfer form is now being used. 2. 15 residents have been transferred to	

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F 623	Continued From page 3 Findings include: Resident #73 A review of the "Written Notice Requirement" for Resident #73, dated 2/25/19, documented a transfer on 2/22/19, without any documentation for the reason of the transfer. The document revealed the purpose of the notice was to make the resident and the resident representatives aware of the facility's bed hold and reserve bed payment policies at the time of the transfer. A review of the physician orders for Resident #73, dated 2/22/19, revealed an order to transfer to another facility. An interview on 06/18/19 at 9:50 AM, with the Administrator (ADM), revealed the only written notification provided to Resident #73 was the "Written Notice Requirement" dated 2/25/19. The ADM said the form would not include the reason for the transfer. The ADM also said the bedhold and notifying the Ombudsmen were the only written reports the facility completed. An interview on 06/19/19 at 2:52 PM, with Registered Nurse (RN) #2, confirmed Resident #73 was sent to the behavioral unit on 2/22/19, related to behaviors and refusing care. RN #2 said the letters were about the bedhold. Resident #87 A review of the "Written Notice Requirement" for Resident #87, dated 2/25/19, revealed the reason for the transfer on 2/23/19, was not included in the documentation. The form revealed the purpose of the document was to make the resident and the resident representatives aware	F 623	an acute hospital setting since the survey and they have the proper notifications on the chart as well as a copy in the Business Office. All residents that are transferred to an acute hospital have the potential to be affected by the identified deficient practice. 3. On 6/28/19, the facility's "Written Notice Requirement" was updated by the Director of Operations to include wording "Reason for Transfer" along with an area provided to be completed when resident is transferred. The Director of Nursing (DON) in-serviced all nurses on the transfer policy on 6/28/19. On 6/28/19, the Administrator in-serviced the Business Office Manager on the transfer letter to be sent to the family. 4. Transfers to the hospital will be reviewed in the Daily Clinical meeting by the Interdisciplinary Team to ensure the proper letters have been mailed. Audits will be reviewed during the monthly Quality Assurance meeting and any corrective action will be addressed.	

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F 623	Continued From page 4 of the facility's bed hold and reserve bed payment policies at the time of the transfer. A review of Resident #87's physician orders, dated 2/23/19, revealed an order for transfer to the emergency room related to a fall. An interview on 06/19/19 at 09:50 AM, with the ADM confirmed the written notification for Resident #87 was not specific to the reason of the transfer and was just related to the bed hold. Resident #107 Review of Resident #107's medical record revealed no documentation of a transfer notice for the resident on 4/26/19. Review of Resident #107's medical record titled, "Interdisciplinary Progress Notes," dated 4/26/2019, revealed that Resident #107 was transferred to the Emergency Room (ER) for evaluation due to Resident #107 complaining of chest pain. Review of Resident #107's medical record titled, "Interdisciplinary Progress Notes," dated 4/29/2019, revealed that Resident #107 was received back from the acute care hospital. Resident #107 returned to the facility with a diagnosis of chest pain, peripheral edema, Atrial fibrillation (A-fib), chronic renal failure, history of Cerebrovascular Accident (CVA), Congestive Heart Failure (CHF), Hypertension (HTN), hypothyroidism, Parkinson Disease, Deep Vein Thrombosis (DVT) prophylaxis. During an interview, on 6/18/2019 at 9:50 AM, the Administrator stated that the facility has not been issuing a written notice of transfer to an Acute	F 623		

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F 641	Continued From page 7 with wound cleanser, pat dry, apply Santyl ointment, cover with gauze, and apply Allevyn heel to heel and secure with Kerlix daily related to progression of wound to Stage 3 pressure injury. Review of Resident #87's care plan, dated 3/25/19, revealed an unstageable pressure injury to the right heel-progression of wound to a Stage 3 pressure injury. 4/30/19 had interventions with wound care and off loading boot to the right lower extremity every shift to keep heel floated at all times. Review of a document titled "Procedure Note", dated 5/9/19, revealed a diagnosis of a right heel ulcer. An interview on 06/19/19 at 10:21 AM, with Registered Nurse (RN) #3, Treatment Nurse, confirmed Resident #87 had a pressure ulcer on her right heel and said the ulcer was facility acquired in March 2019. On 06/19/19 at 3:17 PM, interview with Licensed Practical Nurse (LPN) #3, MDS Nurse, confirmed the MDS with an ARD date of 5/29/19, was incorrectly charted for no pressure ulcers, and the facility needed to file a corrected MDS.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)	F 645		8/15/19

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F 641	Continued From page 6 Resident #87. Findings include: Resident #103 During a record review of the Admission MDS for Resident #103, with the Assessment Reference Date (ARD) of 12/14/18, noted under section 16000 a diagnosis of Schizophrenia. This MDS also noted on Section A1500 a Level II Pre-Admission Screening and Resident Review (PASARR) was not indicated. In an interview with Licensed Practical Nurse (LPN) #3 on 6/18/19 at 4:09 PM, she was asked if Section A1500 had a zero (0), would you expect the resident to have a serious mental illness? She responded, "No", and stated if they had a serious mental illness that there should be a number 1. She confirmed the Admission MDS with the ARD of 12/14/18, under section A1500, noted Resident #103 did not currently have a serious mental illness and/or intellectual disability or a related condition. The Admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 12/14/18, noted under section 16000, Resident #103 had a diagnosis of Schizophrenia. Resident #87 Review of the Resident #87's Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 5/29/19, revealed Section M0210 was documented with a zero (0) indicating the resident did not have one (1) or more unhealed pressure ulcers/injuries. Review of Resident #87's physician orders, dated 4/30/19, revealed an order to clean the right heel	F 641	Resident #87 by the Minimum Data Set nurse on 6/20/19. A modified Minimum Data Set (MDS) for Assessment Reference Date (ARD) 12/14/18 was completed on Section A1500, Pre-Admission Screening and Resident Review,(PASRR)by the Minimum Data Set nurse on 8/7/19, for Resident #103. 2. All resident have the potential to be affected by the identified deficient practice. 3. The Director of Nursing In-serviced the Minimum Data Set (MDS) nurses for the accuracy of the Minimum Data Set on 8/6/19 with emphasis on understanding that psychiatric diagnosis indicates the need for a Level II. The Director of Nursing also conducted an in-service on 8/6/19 for training with the Minimum Data Set Nursing staff to communicate with the wound care nurse and review the chart for any wounds and wound assessments. 4. Beginning 8/12/19, MDS will be audited weekly x 4 weeks by the Director of Nursing and results reported monthly to the Quality Assurance team meeting. Audits will be reviewed by the Interdisciplinary team and evaluated for any corrective action that needs to be implemented. Findings will be presented at the Monthly Quality Assurance meeting to ensure the accuracy of the care plans.	

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F 641	Continued From page 7 with wound cleanser, pat dry, apply Santyl ointment, cover with gauze, and apply Allevyn heel to heel and secure with Kerlix daily related to progression of wound to Stage 3 pressure injury. Review of Resident #87's care plan, dated 3/25/19, revealed an unstageable pressure injury to the right heel-progression of wound to a Stage 3 pressure injury. 4/30/19 had interventions with wound care and off loading boot to the right lower extremity every shift to keep heel floated at all times. Review of a document titled "Procedure Note", dated 5/9/19, revealed a diagnosis of a right heel ulcer. An interview on 06/19/19 at 10:21 AM, with Registered Nurse (RN) #3, Treatment Nurse, confirmed Resident #87 had a pressure ulcer on her right heel and said the ulcer was facility acquired in March 2019. On 06/19/19 at 3:17 PM, interview with Licensed Practical Nurse (LPN) #3, MDS Nurse, confirmed the MDS with an ARD date of 5/29/19, was incorrectly charted for no pressure ulcers, and the facility needed to file a corrected MDS.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)	F 645		8/15/19

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F 645	Continued From page 8 (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the	F 645		

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F 645	Continued From page 9 hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to submit a level II PASARR (Preadmission Screening and Resident Review) for residents with a diagnosis of major mental illness for two (2) of six (6) residents reviewed for PASARR, Resident #103 and Resident #46. Findings include: A review of the facility policy titled "Admission Criteria", revised March 2019, revealed all new admissions and readmissions are screened for mental disorders, intellectual disabilities or related disorders per the Medicaid Pre-Admission Screening and Resident Review process. The facility conducts a Level 1 PASSR screen for all potential admissions to determine if the individual	F 645	1. On 7/25/19 a Mississippi Pre-Admission Screening and Resident Review level II change in condition form was completed by the Admissions Coordinator for Resident #46. For Resident #103, the Minimum Data Set nurse completed a modified Minimum Data Set (MDS) for Assessment Reference Date 12/14/18 on 8/6/19 for Section A 1500, which indicates resident has a serious mental illness, for the Mississippi Pre-Admission Screening and Resident Review (PASRR). 2. All residents have the potential to be affected by the identified deficient practice. 3. On 8/6/19, using the Resident Assessment Instrument manual, the	

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F 645	Continued From page 10 meets the criteria for a mental disorder, intellectual disorder or related disorders. If the screen indicates the individual may meet the criteria, he/she would be referred for a Level II. Resident #103 Record review of the Level 1 PASARR, with the assessment date of 2/8/19, indicated a Level II screening was not indicated for Resident #103, even though Resident #103 had a diagnosis which included Schizophrenia. Review of the Admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 12/14/18, noted under section 16000, a diagnosis of Schizophrenia. Interview with the Admissions Personnel, on 6/18/19 at 3:07 PM, confirmed Resident #103 required a Level II screening because she was admitted with a diagnosis of Schizophrenia and was later completed on 2/13/19. The Admissions Personnel confirmed the Level I screen on 2/8/19, noted a Level II is not indicated for Resident #103. She confirmed the Admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 12/14/18, under section A1500, noted Resident #103 did not currently have a serious mental illness and/or intellectual disability or a related condition. When asked if Section A1500 had a zero (0), would you expect the resident to have a serious mental illness? She responded, "No". Stated if they had a serious mental illness that there should be a number 1. Resident #46 A review of Resident #46's Pre-Admission Screening (PAS) dated 9/26/16, revealed the facility documented "No" for major mental illness	F 645	Director of Nurses in-serviced the Minimum Data Set nurses with emphasis on understanding psychiatric diagnosis indicates the need for a Level II. Beginning 8/11/19, Section A 1500 of the Minimum Data System will be audited weekly x 4 weeks by the Director of Nursing. 4. The Director of Nursing will report Audit findings monthly to the Quality Assurance committee for review and further action as needed.	

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F 645	Continued From page 11 and history of taking psychotropic mediations. A review of a Resident # 46's progress note, dated 9/21/16, provided by the facility, revealed a diagnosis of Schizophrenia. Resident #46 was taking the medications Imipramine (an antidepressant), and Perphenazine (an antipsychotic). A review of the MDS dated 8/16/19, revealed Section A1500's PASARR review was documented "0" which indicated "No", and Section A1510 was blank for the questions of serious mental illness. An interview on 06/18/19 at 3:09 PM, with Admission/Marketing Personnel, revealed she did not do a Level II referral on Resident #46, because she was admitted in 2016, prior to the regulation changes in 2017. She confirmed the PAS was filled out incorrectly concerning the serious mental illness and Resident #46 should have been referred on admission for a Level II. The Admission/Marketing Personnel said the Level II's were all kept in a binder in her office when they were sent back from Ascend. The Admission/Marketing Personnel also said she did not show the Minimum Data Set (MDS) nurses the results of the Level II. An interview on 6/18/19 at 3:12 PM with the Administrator revealed Resident #46 did not have a Level II done because the facility thought it was not required, because Resident #46 was admitted in 2016, prior to the regulation changes in 2017. An interview on 06/18/19 at 3:55 PM with Licensed Practical Nurse (LPN) #3, revealed she had been doing MDS's for 3.5 years. LPN #3	F 645		

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F 645	Continued From page 12 said she looked on the chart for the Level II and if it wasn't there, she would ask the Coordinator. LPN #3 said she did not know the Level II's would be in a binder in the admission office.	F 645		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		8/15/19

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F 656	Continued From page 13 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to develop and implement the care plan for weekly skin assessments related to risk of pressure ulcers; and, the resident removing devices for prevention, for one (1) of three (3) wound care care plans reviewed, Resident #87. The resident was identified with an acquired unstageable pressure ulcer on 3/24/19. Findings include: A review of a facility policy titled "Care Plans-Comprehensive", revised March 2017, revealed an individualized person centered care plan that includes measurable objectives and timetables to meet the resident's needs is developed for each resident. The care plan team develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. The care plan aides in preventing or reducing declines in the resident's functional status and/or functional levels. A review of a facility policy titled "Prevention of Pressure Ulcers", revised October 2010, revealed to assess the resident's skin, according to facility	F 656	1. Resident #87 skin audit was completed by assigned licensed practical nurse on 6/20/19. Wound to right heal improving and no new skin issues noted. 6/27/19 skin audit revealed no changes. No required changes to care plan for 6/20/19 and 6/27/19 skin audits. The audits will continue weekly thereafter. The comprehensive care plan has been updated by the Minimum Data Set nurse to reflect weekly body audits and resident removing own protective devices on 8/6/19. 2. All resident with pressure ulcers and /or at risk for skin breakdown have the potential to be affected by the identified deficient practice. There are currently 10 residents with pressure ulcers. Care plans updated to reflect current interventions. 3. Director of Nursing began in-servicing nurses on 8/7/19 and will complete in-servicing all nurses by 8/15/19 on up-dating care plans for proper use of protective devices and weekly skin audits. Director of Nursing began reviewing care plans on 6/20/19. Director of Nursing will monitor the care plans weekly beginning 8/9/19 to ensure weekly body audits and	

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F 656	Continued From page 14 protocol and review the care plan to assess for any special needs of the resident. During an interview on 6/20/19 at 10:20 AM, The DON said the care plan should address the Care Area Assessment's and Braden score to determine the resident's risk for pressure ulcers. The DON said the facility policy was to complete weekly skin checks. Review of a care plan, dated 3/6/19, revealed Resident #87 had a risk for skin breakdown related to the increased need for mobility. The care plan was revised on 3/6/19 for positioning and cleaning related to a recent hip fracture. There were no interventions for weekly skin audits. A review of Resident #87's "Event Tracking Report" dated 3/6/19, revealed a care plan problem "At risk for skin breakdown related to increased need for mobility positioning and right hip fracture." A review of the Resident #87's care plan, dated 3/25/19, revealed an unstageable pressure injury to right heel-progression of wound to Stage 3 pressure injury 4/30/19. The care plan had interventions with wound care and off loading boot to right lower extremities every shift to keep heel floated at all times. Resident #87's care plan did not list any concerns of the resident removing her off loading boot and staff having to replace it often during the day. The care plan also did not include weekly skin evaluations. A review of the Resident #87's Braden scale dated 2/26/19, completed by RN #2, with a score of "16", indicated a "moderate risk" for skin	F 656	residents who remove protective devices are identified on the care plan. 4. Director of Nursing will report audit findings monthly to the Quality Assurance (QA) committee for review and further action as needed.	

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F 656	Continued From page 15 breakdowns. Review of skin audits revealed no documentation related to the right heel on the skin audit that was completed on 2/26/19, upon hospital return. There was no further documentation of a skin assessment until 3/19/19, and the audit revealed no skin problems. A review of Resident #87's Care Area Assessments (CAA's) section, on the MDS, dated 3/5/19, indicated the care area Pressure ulcer was triggered and the decision to care plan was marked to proceed related to Resident #87's declined mobility and continent status . Review of nurses notes dated 3/21/19, revealed Resident #87 became agitated and aggressive when staff attempted to perform daily care. Review of nurses notes dated 3/24/19 at 5:07 PM, revealed Licensed Practical Nurse (LPN) #5 was called to Resident #87's room and noted a pressure ulcer to the resident's right heel with some blackness noted around the area and the charge nurse then assessed Resident #87. A review of the weekly wound assessment, dated 3/25/19, revealed a "new" pressure ulcer, unstageable with slough/eschar, that measured 2.8 centimeters (cm) in length, by 5.3 cm width, by 0 cm depth, identified on 3/24/19, and signed by RN #3. A review of Resident # 87's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/26/19, revealed Section M0210, was documented "1" and Section M0300, F, was documented "1" indicating one (1) unstageable	F 656		

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F 656	Continued From page 16 wound with slough and or eschar. A review of Resident #87's physician's orders revealed an order, dated 4/30/19, to clean the right heel with wound cleanser, pat dry, apply Santyl ointment, cover with gauze and apply Allevyn heel to heel, and secure with Kerlix daily related to progression of wound to Stage 3 pressure injury. An interview on 06/19/19 at 10:21 AM with Registered Nurse (RN) #3, Treatment Nurse, confirmed Resident #87 had a pressure ulcer on her right heel and said the ulcer was facility acquired in March 2019. An interview on 06/19/19 at 11:16 AM, with RN #2, confirmed Resident #87's weekly skin audit was completed on 3/19/19, and the documentation revealed no skin problems. RN #2 stated the documentation indicated eschar on the wound care assessment completed on 3/25/19, by RN #3. She also confirmed the previous skin assessment was completed on 2/26/19, on the form "Nursing Admission History and Physical Assessment" on hospital return and said skin conditions would only be documented if there was a problem. RN #2 confirmed there was no documentation related to the right heel. An observation of Resident #87's wound care, provided by RN #3, on 06/19/19 at 1:32 PM, revealed the resident had a right heel ulcer. An interview on 06/19/19 at 1:36 PM, with RN #3, revealed Resident #87 did remove her boot, and she had to put the boot back on very often during the day.	F 656		

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F 656	Continued From page 17 An interview on 06/20/19 at 10:21 AM with RN #3, Treatment Nurse, revealed the prevention measures would include a weekly body audit that was done by the licensed practical nurses (LPN's). RN #3 considered Resident #87 would be at risk for skin breakdown related to the recent right hip fracture. RN #3 confirmed the wound was eschar with a blister when she evaluated the wound on Monday 3/25/19, which was first identified on the previous day, 3/24/19. An interview on 6/20/19 at 10:20 AM, with Director of Nursing (DON), revealed she would expect Resident #87 to be at risk for pressure ulcers after the right hip surgery related to her limited range of motion. The DON said the care plan should address the CAA's and Braden score to determine the resident's at risk. The DON said the facility policy was to complete weekly skin checks by the LPN's, but the nurses had only completed a weekly skin check on 3/19/19, since Resident #87's 2/26/19 hospital return. An interview on 06/20/19 at 11:03 AM, with Resident #87's Medical Doctor (MD) revealed the facility had policies for preventive measures for wounds but would have to review Resident #87's chart and call back. The MD never returned the call. An interview on 06/20/19 at 11:09 AM, with LPN #4, MDS Nurse, revealed residents were evaluated for at risk of skin breakdowns by the Braden scale and the Care Area Assessments (CAA's) would trigger the care plan to be completed. An interview on 06/20/19 at 1:09 PM, with the DON revealed the "16" on the Braden scale	F 656		

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F 656	Continued From page 18 indicated Resident #87 was at risk for skin breakdowns. An interview on 06/20/19 at 1:41 PM, with DON, revealed the care plans for prevention of pressure ulcers were completed for Resident #87 that focused on immobility and incontinence. The DON said once the care plan was completed, the expectation was the staff to follow the interventions. She said the care plan for Resident #87 was updated on 5/29/19, and the computer system removed the at risk for breakdown when the care plan was updated to an actual pressure ulcer.	F 656		
F 686 SS=G	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 observation, staff interview, record review, and facility policy review, the facility failed to prevent a resident from developing a heel pressure ulcer, as evidenced by failure to perform weekly assessments, and failure to ensure	F 686	1. Resident #87 skin audit was completed by assigned licensed practical nurse on 6/20/19. Wound to right heal improving and no new skin issues noted. 6/27/19 skin audit revealed no changes from	8/15/19

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F 686	Continued From page 19 interventions were provided to prevent the pressure ulcer, for Resident #87, a resident who was at risk of a pressure ulcer, related to immobility and recent surgery. This affected one (1) of three (3) residents observed with pressure sores, resulting in actual harm for Resident #87. Findings include: A review of a facility policy titled, "Prevention of Pressure Ulcers", revised October 2010, revealed to assess the resident's skin, according to facility protocol. Interview with the Director of Nursing (DON) on 6/20/19 at 10:20 AM, revealed the policy was to perform skin assessments weekly. An observation on 6/17/19 at 4:57 PM, revealed Resident #87 was up in wheelchair with a padded boot on the right foot. Review of an assessment, upon return from the hospital on 2/26/19, on the form "Nursing Admission History and Physical Assessment", revealed skin conditions would only be documented if there was a problem. There was no documentation of skin issues to Resident #87's right heel. The assessment revealed documentation of "dry" skin/island dressing intact to right hip and bruise to left foot, right hand and wrist, bilateral arms. The lower extremities were documented "not applicable".There were no weekly skin assessments documented from 2/26/19 until 3/19/19, and again no issues were identified on the assessment. A review of the Resident #87's Braden scale dated 2/26/19, completed by RN #2, revealed a score of "16", which indicated a "moderate risk"	F 686	previous week. No required changes to care plan for 6/20/19 and 6/27/19 skin audits. Resident Care Coordinators will audits weekly thereafter. 2. All resident with pressure ulcers and /or at risk for skin breakdown have the potential to be affected by the identified deficient practice. There are currently 10 residents with pressure ulcers. Resident Care Coordinator has been monitoring body audits since 6/20/19 and no other residents with pressure areas have had any missed body audits. 3. Director of Nursing began in-servicing nurses on 8/7/19 and will complete in-servicing all nurses by 8/15/19 on up-dating care plans for proper use of protective devices and weekly skin audits. Review of body audits began on 6/20/19 by Resident Care Coordinator. All residents with pressure ulcers will be monitored weekly by Resident Care Coordinators and/or Treatment nurse. 4. Resident Care Coordinators will report audit findings monthly to the Quality Assurance (QA) committee for review and further action as needed.	

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F 686	Continued From page 20 for skin breakdowns. A review of Resident #87's Care Area Assessments (CAA's) section on the Minimum Data Set (MDS), dated 3/5/19, indicated the care area Pressure Ulcer was triggered, and the decision to care plan was marked to proceed, related to Resident #87's declined mobility and continent status . A review of Resident #87's "Even Tracking Report" dated 3/6/19 revealed a care plan problem "at risk for skin breakdown related to increased need for mobility positioning and right hip fracture." There were no interventions for skin assessments and/or interventions for prevention of heel breakdown. Review of Nurse's Notes, dated 3/21/19, revealed Resident #87 became agitated and aggressive when staff attempted to perform daily care. Review of Nurse's Notes, dated 3/24/19 at 5:07 PM, revealed Licensed Practical Nurse (LPN) #5 was called to Resident #87's room and noted a pressure ulcer to the resident's right heel with some blackness noted around the area and the Charge Nurse then assessed Resident #87. A review of Resident #87's "Incident Case Report", dated 3/24/19 at 4:47 PM, revealed a noted pressure ulcer to the right heel with some blackness noted. The documentation on the incident report revealed the Nurse Practitioner was notified, footwear was on; the resident used a wheelchair and required assistance. A review of the Resident #87's care plan with a problem, dated 3/25/19, revealed an unstageable	F 686		

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F 686	Continued From page 21	F 686		

pressure injury to right heel-progression of wound to stage 3 pressure injury 4/30/19. The care plan had interventions with wound care, and off loading boot to right lower extremities every shift to keep heel floated at all times.

A review of Resident #87's "Initial Wound Assessment", dated 3/24/29, revealed the wound was new and located on the right heel. The wound assessment also listed the etiology was "other, unstageable" with "slough/eschar" that measured 3 centimeters (cm) length by 4.6 cm width.

A review of the Resident #87's "Weekly Wound Assessment" dated 3/25/19, revealed a "new" pressure ulcer with unstageable with slough/eschar that measured 2.8 cm length by 5.3 cm width by 0 cm depth, identified on 3/24/19, and signed by RN #3.

Review of the Treatment Administration Record (TAR) for June 2019, revealed Off Loading Boot to right lower extremity every shift to keep heel floated at all times, initiated 3/25/19.

An interview on 06/19/19 at 1:36 PM, with RN #3, revealed Resident #87 did remove her boot, and she had to put the boot back on very often during the day.

A review of Resident #87's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/26/19, revealed Section M0210 was documented "1" and Section M0300, F, was documented "1" indicating one (1) unstageable wound with slough and/or eschar.

A review of Resident #87's physician's orders

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F 686	Continued From page 22	F 686		

revealed an order, with a date of 4/30/19, clean right heel with wound cleanser, pat dry, apply Santyl ointment, cover with gauze and apply Allevyn heel to heel, and secure with Kerlix daily related to progression of wound to Stage 3 pressure injury.

Review of a "Procedure Note", dated 5/9/19, by the Wound Doctor, revealed the pre-operation diagnosis was right heel ulcer and the procedure performed was selective debridement of right heel ulcer including non-viable slough and exudate with 2.4 x 1.5 cm debrided.

A review of a facility statement dated 6/19/19, signed by the DON, revealed the facility believed that Resident #87's right heel wound was clinically unavoidable related to impaired mobility due to fracture, lab levels, weight loss, and refusal of care, however there were no documented interventions for the refusal of care by Resident #87.

An interview on 06/19/19 at 10:21 AM, with Registered Nurse (RN) #3/Treatment Nurse, confirmed Resident #87 had a pressure ulcer on her right heel and said the ulcer was facility acquired in March 2019. She said it was found on a weekly skin check over a weekend. RN #3 said Resident #87's ulcer started as a blister and quickly developed into a Stage 3. She stated the resident was able to move extremities freely but not able to walk. RN #3 said Resident #87 used her feet to "scoot" herself in the wheelchair. RN #3 also said the resident had not been going to the wound clinic, but the Wound Doctor had seen and debrided the wound.

An interview on 06/19/19 at 11:16 AM, with RN

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F 686	Continued From page 23	F 686		

#2, confirmed Resident #87's weekly skin audit was completed on 3/19/19, and the documentation revealed no skin problems. RN #2 stated the documentation indicated it was eschar on the wound care assessment completed on 3/25/19, by RN #3. She also confirmed the last prior skin assessment was completed on 2/26/19, on the form "Nursing Admission History and Physical Assessment" upon hospital return, which documented skin conditions would only be documented if there was a problem. RN #2 confirmed there was no documentation related to the right heel on the assessment. RN #2 confirmed there were no documented weekly assessments from 2/26/19 until 3/19/19.

During an interview on 06/19/19 at 1:26 PM, Certified Nursing Assistant (CNA) #2 said she did not remember seeing a skin problem with Resident #87 before they found the ulcer on her heel. She said the resident wore tennis shoes and sandals before she went out to the hospital. She said when Resident #87 would walk, it was on the side of her foot. CNA #2 said the resident's sandals did not cover her heel. CNA #2 also said Resident #87 moved her own legs and positioned them independently.

An observation of Resident #87's wound care on 06/19/19 at 1:32 PM, provided by Registered Nurse (RN) #3, revealed the resident had a right heel ulcer, which measured 1.2 cm length by 1.3 cm width by 1.4 cm depth. The wound was located above the back of the heel about 0.5 inch from the bottom of the foot. The wound was round with distinct edges, pink and no discharge.

An interview on 06/20/19 at 9:50 AM, with CNA #3, Bath Aide, revealed Resident #87 had always

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had a covering on her heel since she started bathing her. CNA #3 stated Resident #87 would complain of pain, but it was related to the right hip fracture. CNA #3 said the policy was to do a complete body check during the bath and to notify her nurse if any problems were noted.

On 06/20/19 at 10:21 AM, an interview and observation with the DON and RN #3/Treatment Nurse, revealed one (1) pair of Resident #87's tennis shoes was a pink, size 7.5 with a stiff back that was indented halfway down the heel and had shoe laces. The DON placed the tennis shoe on Resident #87 and confirmed it would hit the area of the breakdown if she was wearing the shoes prior to the breakdown. RN #3, said the prevention measures should included a weekly body audit that was done by the LPN's, and Resident #87 would be at risk for breakdown from the recent hip fracture. RN #3 said once the wound was found, the boot was applied, weekly checks were performed by the RN Wound Care Nurse, and an air mattress was applied to the bed. RN #3 said the resident did not wear any shoes on the right foot since the wound was found. RN #3 confirmed it was eschar with a blister when she evaluated Resident #87's heel wound on Monday 3/25/19, which was originally found on 3/24/19. The DON said she would expect Resident #87 to be at risk for pressure ulcers after the surgery, related to her limited range of motion (ROM), and the care plan should address the CAA's and Braden score to determine if the resident's at risk. The DON said the facility policy was to complete weekly skin checks by the LPN's, but the nurses had only completed a weekly skin check on 3/19/19, since Resident #87's 2/26/19 hospital return. The DON then stated an investigation was completed by

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her on 6/19/19, with the review of the Resident #87's medical record. The DON did not have a reason as to why the investigation was done at this time, and did not provide a policy for the investigation.

An interview on 06/20/19 at 11:03 AM, with Resident #87's Medical Doctor (MD) revealed the facility had policies for preventive measures for wounds, but would have to review Resident #87's chart and call back. MD never returned the call.

An interview on 06/20/19 at 11:09 AM, with Licensed Practical Nurse (LPN) #4/MDS Nurse, revealed residents were evaluated for risk of skin breakdowns by the Braden scale, and the Care Area Assessments (CAA's) would trigger the care plan to be completed, with interventions to prevent breakdown.

On 06/20/19 at 11:31 AM, an interview with LPN #5 confirmed she was working the day the pressure ulcer was found on Resident #87's right heel. LPN #5 said she had been here about five (5) months and was one (1) of the nurses that took care of Resident #87. LPN #5 said CNA #4 called her to the resident's room, during the 3-11 shift, because Resident #87's "sock was soiled". LPN #5 said the drainage was brown tinted. She said Resident #87 would previously walk on the outside of her heels because her sandals were too small and had to get new shoes prior to the wound being found. LPN #5 said Resident #87 never complained of pain with right ankle/foot. LPN #5 said she notified the Charge Nurse and completed the incident report.

An interview on 06/20/19 at 2:30 PM, with CNA #4, revealed she had been working in the facility

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F 686	Continued From page 26 since February of 2019. CNA #4 stated she was working the day the ulcer was found on Resident #87's right heel. CNA #4 said the resident had on the gray tennis shoes when she put her to bed that afternoon on 3/24/19. CNA #4 stated she took off Resident #87's shoes and the inside of the right shoe was wet and the sock was wet around the heel with a brown discharge stain. CNA #4 said she then notified LPN #5. CNA #4 said the facility policy was to check the skin every time you assist a resident and report to the supervisor any abnormal findings. An interview on 06/20/19 at 1:09 PM, with the DON, revealed the "16" on the Braden scale indicated the resident was at risk for skin breakdowns. The DON also said with the CAA's and the Braden scale, Resident #87 should have a care plan related to the risk of skin breakdown, with interventions in place. On 06/20/19 at 1:16 PM, an attempt was made to interview the Wound Doctor, but he was out of town and not available at his office.	F 686		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		8/15/19

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F 758	Continued From page 27 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure Resident #47	F 758	1. Psychiatric Nurse Practitioner assessed Resident #47 on 6/19/19 and	

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F 758	Continued From page 28 was free from unnecessary pychotropic medications, and without dose reduction, for one (1) of five (5) residents reviewed for unnecessary medications. Findings include: Review of a physician order, dated 1/26/19, revealed Resident #47 was ordered Risperidone 0.5 milligram (mg) one (1) by mouth at bedtime for Dementia with Behaviors. During an interview on 06/17/19 at 2:29 PM, Resident #47's wife stated he always sleeps now, but staff told her his medication had not changed since February. She stated it all started after he came into the room with her, about a month ago. Resident #47 was observed asleep in bed. Resident was admitted on 9/11/18, and Observation on 06/18/19 at 4:33 PM, revealed Resident #47 is in bed asleep. His wife stated he sleeps about 20 of 24 hours of every day. Record review revealed no changes had been made to the dose of the Risperidone 0.5 mg since the order date. In an interview on 06/18/19 at 5:11 PM, RN #5 stated initially Resident #47 came into the facility and he slept a lot, but later had some behaviors that staff was unable to redirect him, and he was placed on Risperidone. RN #5 stated the resident had not had any further problems but he does sleep a lot. When asked if the resident slept that much, would you expect to see a dose reduction? She responded, "Yes". She stated that the resident should have already had a dose	F 758	ordered a dose reduction from 0.5 milligrams to 0.25 milligrams of Risperidone. The dose reduction was implemented on 6/20/19 and Risperidone was discontinued on 7/23/19, with no noted adverse effects. 2. All residents receiving psychotropic medications have potential to be affected for this deficient practice. There are currently 24 residents on psychotropic medications. 3. The Director of Nursing and Resident Care Coordinators will do a 100% audit of residents on psychotropic medications by 8/15/19, to ensure that that documentation of target behaviors and/or side effects are being monitored by direct care nurses. The Interdisciplinary Team will review any new behaviors or any new psychotropic orders to ensure behavior monitoring is in place in the weekly psychotropic meetings. Beginning 8/12/15 and monthly, thereafter, the Director of Nursing and Resident Care Coordinators will review the Psychotropic med log for the last gradual dose reduction. 4. Audit findings will be reported by the Resident Care Coordinators to the monthly Quality Assurance meeting for review and further action as needed. The plan of correction will be integrated into the monthly Quality Assurance meeting.	

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F 758	Continued From page 29 reduction. During an interview on 06/18/19 at 5:22 PM, RN #2 stated Resident #47 was admitted on Risperidone 0.25 mg one (1) by mouth twice daily. RN #2 was unable to stated what behaviors the resident had for the medication. During an interview on 06/18/19 at 5:25 PM, RN #4 stated Resident #47 had not had any behaviors to indicate continuing Risperidone. RN #4 confirmed a dose reduction had not been attempted, just changed from 0.25 mg twice daily to 0.5 mg at bedtime. RN #4 confirmed Resident #47 slept a lot. RN #4 was unable to say what behaviors the resident exhibited. On 06/18/19 at 5:42 PM, an attempt was made to call the Nurse Practitioner (NP) for Geri-Psyche, who was responsible for ordering and continuing Resident #47's Risperidone. There was no answer at this time.	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		8/15/19

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F 880	Continued From page 30 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (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.	F 880		

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F 880	Continued From page 31 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to ensure the possible spread of infection for one (1) of (6) six medication administration observations; and the facility failed to follow the manufacturer's instruction for the facility's dryer for one (1) of two (2) laundry room observations. Findings include: Review of the facility's policy titled, "Administering Medications," dated 12/2017, revealed that it is the policy of this facility that medications shall be administered in a safe and timely manner, and as prescribed. The policy states that the facility's staff shall follow established facility infection control procedures (handwashing, antiseptic technique, gloves, isolation precautions) when these apply to the administration of medications. During an observation, on 06/20/2019 at 9:16 AM, of a medication administration, by Licensed Practical Nurse (LPN) #1, it was observed that LPN #1 dispensed the medication from the bubble packaging into her ungloved right palm,	F 880	1. On 6/20/19, LPN who did the deficient practice was educated by the RN supervisor on proper administration of medication. In-services for all nurses began on 8/7/19 by the Director of Nursing on proper medication to prevent the spread of infection and will be completed by 8/15/19. The lint trapped was cleaned on 6/19/19, by the assigned laundry personnel. The Director of Maintenance in-serviced the assigned laundry personnel on 6/19/19 about cleaning the lint trap and completing the lint trap cleaning log. 2. All residents have the potential to be affected for this same deficient practice. 3. Beginning on 8/7/19, the Director of Nurses will in-service all nurses on policy and procedures for infection control concerning medication administration to prevent the spread of infection and will be completed by 8/15/19. Observation of med pass will be conducted weekly x 4 weeks on each shift by Resident Care Coordinators or unit managers to ensure	

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F 880	Continued From page 32 and then placed the medication into the medication cup. LPN #1 administered the medication from the medication cup to the resident. During an interview, on 6/20/2019 at 9:20 AM, with Licensed Practical Nurse (LPN) #1, it was confirmed that she had dispensed a medication into her bare hand and then placed it into the medication cup. LPN #1 stated that she should have held the medication card over the cup and popped it directly into the medication cup. LPN #1 stated that putting the medication into her bare hand to dispense the medication was an infection control concern. During an interview, on 6/20/2019 at 9:29 AM, with Registered Nurse (RN) #1/Unit Manager, it was revealed that when administering medications to residents, if you place the medications into your bare hands it is an infection control concern. During an interview, on 6/20/2019 at 9:55 AM, the Director of Nursing (DON) confirmed that it is an infection control issue, if you put a medication into your bare hand, and then administer the medication to a resident. Record Review of the Fire Safety and Prevention Policy revealed all personnel must learn methods of fire prevention and must report conditions that could result in a potential fire hazard. Clean filters on heating systems, dryers, etc., on a regular basis. During a tour on 06/19/2019 at 3:12 PM, of the laundry room with the Maintenance Director, revealed a large amount of lint hanging from the	F 880	proper dispersion of medication to prevent the spread of infection. On 6/19/19, the Director of Maintenance in-serviced all laundry staff about Fire Safety and cleaning the lint trap. The Director of Maintenance and the Administrator will monitor the cleaning of the lint traps as well as monitoring the cleaning log weekly X 4 weeks. 4. The Resident Care Coordinators will bring the results of the med pass observations to the monthly Quality Assurance (QA) meeting for review and further action as needed. The Director of Maintenance will bring the results of the audits of the dryer lint cleaning log to be reviewed at the monthly Quality Assurance meeting and further action as needed.	

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F 880	Continued From page 33 lint tray on both dryers. During an interview on 06/18/19 at 3:18 PM, with Housekeeper #1, revealed she had changed the filters at 1:00 PM. Housekeeper #1 was asked for the dryer cleaning logs. Housekeeper #1 stated it was not updated. Record Review of the Dryer Cleaning Schedule Log revealed all dryer lent traps will be cleaned every two (2) hours or every two (2) loads to prevent lint build up; once done sign in appropriate box. Record Review of the Dryer Cleaning schedule revealed the last time the log was documented was dated 12/8/2018. Record Review of the in-service training, dated 10/4/2018, revealed Housekeeper #1 (Laundry worker) was trained to clean dryer lint screens according to the schedule and log in book. During an interview on 06/19/19 at 1:21 PM, the maintenance Director confirmed the lint tray had a large amount of lint hanging from the tray. The Maintenance Director said the tray could not have been dumped at 1:00 PM. The Maintenance Director said it was too much lint in the trays. The Maintenance Director said Housekeeper #1 had worked at the facility for approximately a year. The Maintenance Director stated that staff was in-serviced once a year on how to handle laundry equipment. The Maintenance Director also confirmed the dryer cleaning logs were not updated.	F 880		

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 08/09/2019

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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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 6/19/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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