STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 2/16/21 through 2/23/21. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# E76111.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted on 2/16/21 through 2/23/21. The facility was found to be not in compliance with 42 CFR §483.80 infection control regulations and had not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# E76111. One of the 2 complaint allegations were substantiated resulting in deficiencies: F583, F658, F686, and F690.	F 000		
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 record reviews, staff interviews, and physician interview, the facility failed to complete an admission skin assessment per facility protocol and failed to enter wound care orders from hospital discharge summary for 1 of 1 resident reviewed for wound care (Resident #1).	F 658	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Director of Health Services provided an all direct care staff with in-service	4/11/21

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

Electronically Signed | 03/12/2021

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F 658	Continued From page 1 Findings included: Resident #1 was admitted to the facility on 7/13/20 was discharged to the hospital on 9/22/20, readmitted to the facility on 10/01/20 and was discharged to the hospital on 11/24/20. The most recent Minimum Data Set dated 10/06/20 revealed Resident #1 was cognitively intact and was coded as extensive assistance for activities of daily living except independent for eating and total dependence for toileting. Review of Resident #1's Nursing Readmission Focused Observation Assessment form dated 10/01/20 and nurses' admission progress note dated 10/01/20 revealed no skin assessment information. Review of Resident #1's hospital discharge summary dated 10/01/20 read in part as follows for wound care: 1. To apply Lac-Hydrin (a prescription lotion) for feet and lower extremities daily. 2. Apply all cotton elastic (ACE) wrap from toes to knees on each shift. 3. Apply Mepilex (an absorbent foam) dressing and change every 3 days or when 80% saturated. An interview on 2/22/21 at 11:21 AM with Nurse #3 revealed she was responsible for Resident #1's readmission on 10/01/20. She further revealed the readmission skin assessment should have been done by the treatment nurse and she didn't know if it was completed or not. Nurse #3 stated the readmission orders should have been entered by the Director of Nursing (DON) or the nurse navigator.	F 658	education on the accepted professional standards and practices concerning skin assessments on each resident in the facility on 3/5/21. This education was provided to all direct care staff that was currently working in the facility on 3/5/21. Any part time or PRN direct care staff that was not working on 3/5/21 will receive the in-service education before working in the facility again. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 2/16/21, the Director of Health Services audited all active resident□s medical records to ensure residents had a current Skin Observation documented. All active residents were found to have a current Skin Observation documented in their medical record. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Skin Observations have now been added to the facility admission/readmission nursing checklist. All Nursing documentation is now reviewed by the Director of Health Services and the Infection Control Nurse during the daily clinical meeting to ensure all admission/readmissions include a Skin Observation. Indicate how the facility plans to monitor	

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F 658	Continued From page 2 An interview on 2/22/21 at 1:14 PM with Nurse #1 revealed he was the treatment nurse at the facility in October He further revealed he was out of the facility on 10/01/20 and did not return to work until 10/05/20. Nurse #1 stated the unit nurse should have completed a skin assessment when Resident #1 returned to the facility on 10/01/20. He stated he did not know why a readmission skin assessment had not been completed for Resident #1. Nurse #1 also stated he performed a routine weekly skin assessment on Resident #1 on 10/07/20 and entered physician orders for wound care based on facility protocols on 10/07/20. Review of the Wound Progress Note dated 10/07/20 at 4:42 PM written by Nurse #1 read in part that Resident #1 had (1) Right lower extremity posterior calf venous stasis ulcer and (2) Left lower extremity large posterior calf venous stasis ulcer. A review of Physician's orders revealed orders dated 10/07/20 for right lower extremity calf venous stasis ulcer care which read to cleanse the wound with normal saline or wound cleanser, apply xeroform (sterile, nonadherent) gauze dressing to ulcer and cover with an occlusive dressing every other day. Further review revealed and order for the left lower extremity posterior calf venous stasis ulcer to be cleansed with normal saline or wound cleanser, apply xeroform (sterile, nonadherent) gauze dressing to ulcer and cover with a kerlix (white gauze) wrap daily. A review of Physician's orders revealed no order for Lac-Hydrin or any prescription lotion for feet. Review of the October 2020 Treatment	F 658	its performance to make sure that solutions are sustained; The Director of Health Services and/or designee will audit all new admission/readmission medical records for resident Skin Observation twice weekly for 4 weeks, then monthly for 3 months. The DHS and/or the Administrator will review the Admission/Readmission Skin Observation Audit monthly to identify patterns/trends and will adjust the audits as necessary to maintain compliance. The DHS and/or the Administrator will review Admission/Readmission Skin Observation Audit during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Include dates when corrective action will be completed: 4/11/21	

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F 658	Continued From page 3 Administration Record (TAR) revealed the order for the right lower extremity venous stasis ulcer dressing change was first initialed as completed on 10/09/20. Further review revealed the left lower extremity venous stasis ulcer dressing change was first initialed as completed on 10/09/20. An interview on 2/22/21 at 10:40 AM with the Physician revealed he was notified of Resident #1's bilateral venous stasis ulcers and did not have any concerns related to his wound care. An interview on 2/22/21 at 2:45 PM with the Director of Nursing (DON) revealed Resident #1 should have had a readmission skin assessment when he returned to the facility. She stated it was just missed and the nurse who performed the skin assessment should have entered the wound care orders. The DON stated it was a 'cascade' where the skin assessment didn't get done, so the wound orders didn't get entered and the resident did not receive wound care until 10/07/20. An interview on 2/16/21 at 3:04 PM with the Administrator revealed he was unaware that Resident #1 had not had a readmission skin assessment within 24 hours of his return to the facility. He stated residents should receive wound care in a timely manner.	F 658		
F 686 SS=E	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-	F 686		4/11/21

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F 686	Continued From page 4 (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 record reviews, staff and physician interviews, the facility failed to complete an admission skin assessment, identify and provide treatment to the right ischium (buttock) for 1 of 1 resident (Resident #1) reviewed for pressure ulcers. Findings included: Resident #1 was admitted to the facility on 7/13/20, was discharged to the hospital on 9/22/20, readmitted to the facility on 10/01/20 and was discharged to the hospital on 11/24/20. He had diagnoses which included diabetes mellitus and hypertension. The most recent Minimum Data Set dated 10/06/20 revealed Resident #1 was cognitively intact and was coded as extensive assistance for activities of daily living except independent for eating and total dependence for toileting. Review of Resident #1's Nursing Readmission Focused Observation Assessment form dated 10/01/20 and nurses' admission progress note dated 10/01/20 revealed no skin assessment information.	F 686	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Director of Health Services provided an all Nursing staff with in-service education on the accepted professional standards and practices concerning wound treatments/care in the facility on 3/5/21. This education was provided to all Nursing staff that was currently working in the facility on 3/5/21. Any part time or PRN direct care staff that was not working on 3/5/21 will receive the in-service education before working in the facility again. All residents with wounds were assessed by the wound care nurse week ending ,2/20/21, to ensure they were receiving the appropriate wound treatment. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 2/16/21, the Director of Health	

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F 686	Continued From page 5 Review of Resident #1's wound observation history dated 10/07/20 at 4:43 PM by Nurse #1 revealed the resident had a right ischium pressure ulcer which measured 3 centimeters (cm) wide by 4 cm long and 0.1 cm deep. An interview on 2/22/21 at 11:21 AM with Nurse #3 revealed she was responsible for Resident #1's readmission on 10/01/20. She further revealed the readmission skin assessment should have been done by the treatment nurse and she didn't know if it was completed or not. Nurse #3 stated the readmission orders should have been entered by the Director of Nursing (DON) or the nurse navigator. An interview on 2/22/21 at 1:14 PM with Nurse #1 revealed he was the treatment nurse at the facility in October He further revealed he was out of the facility on 10/01/20 and did not return to work until 10/05/20. Nurse #1 stated the unit nurse should have completed a skin assessment when Resident #1 returned to the facility on 10/01/20. He stated he did not know why a readmission skin assessment had not been completed for Resident #1. Nurse #1 also stated he performed a routine weekly skin assessment on Resident #1 on 10/07/20 and found a right ischium (buttock) pressure ulcer. He further stated when he assessed Resident #1 on 10/07/20 he was unaware he had a pressure ulcer and there was no dressing on it. Nurse #1 stated he notified the Physician and entered physician orders for wound care based on facility protocols on 10/07/20. A review of Physician's orders revealed orders dated 10/07/20 for right ischium pressure ulcer wound care which read to cleanse with normal	F 686	Services audited all active resident□s medical records to ensure residents with wounds identified on the current Skin Observation also had wound treatment orders. All active residents with wounds identified on the current Skin Observation did have wound treatment orders documented in their medical record. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Wound Treatment Orders will be added to the facility admission/readmission nursing checklist list. All new skin observations will be reviewed during the daily clinical meeting. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Health Services and/or designee will audit medical records for residents identified with wounds on the current Skin Observation for wound treatment orders twice weekly for 4 weeks, then monthly for 3 months. The DHS and/or the Administrator will review the Wound Treatment Order Audit monthly to identify patterns/trends and will adjust the audits as necessary to maintain compliance. The DHS and/or the Administrator will review the Wound Treatment Order Audit during the monthly QAPI meeting and the audits will continue at the discretion of the	

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F 686	Continued From page 6 saline or wound cleanser, apply an antimicrobial dressing and cover with an occlusive dressing every other day. Review of the October 2020 Treatment Administration Record (TAR) revealed the order for the right ischium pressure ulcer dressing change was first initialed as completed on 10/09/20. An interview on 2/22/21 at 10:40 AM with the Physician revealed he was notified of Resident #1's right ischium pressure ulcer and did not have any concerns related to his wound care. He also revealed he was aware the resident's wound had continued to deteriorate while he was at the facility and stated he felt it was 'inevitable due to the resident's comorbidities.' An interview on 2/22/21 at 2:45 PM with the Director of Nursing (DON) revealed Resident #1 should have had a readmission skin assessment when he returned to the facility. She stated it was just missed and the nurse who performed the skin assessment should have entered the wound care orders. The DON stated it was a 'cascade' where the skin assessment didn't get done, so the wound orders didn't get entered and the resident did not receive wound care until 10/07/20. An interview on 2/16/21 at 3:04 PM with the Administrator revealed he was unaware that Resident #1 had not had a readmission skin assessment within 24 hours of his return to the facility. He stated residents should receive wound care in a timely manner.	F 686	QAPI committee. Include dates when corrective action will be completed: 4/11/21	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690		4/11/21

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F 690	Continued From page 7 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 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 observations, record reviews, and staff	F 690	Address how corrective action will be	

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F 690	Continued From page 8 interviews, the facility failed to secure the catheter tubing for 1 of 1 resident reviewed for urinary catheter care (Resident #2). Findings included: Resident #2 was admitted to the facility on 12/30/20 and with diagnoses which included diabetes mellitus and sacral ulcer. The admission Minimum Data Set dated 1/20/21 revealed Resident #2 had severe cognitive impairment and was coded for indwelling catheter. An observation on 2/16/21 at 10:45 AM of Resident #2's catheter revealed there was no catheter tube securing device on the resident. Review of Resident #2's Physician Orders revealed an order dated 1/15/21 which read in part for a catheter with a leg device to be checked daily. Review of the January 2021 Treatment Administration Record (TAR) revealed the order for daily catheter with leg device to be checked daily was signed as completed from 1/15/21 through 1/31/21. Review of the February 20201 TAR revealed the order for daily catheter with leg device to be checked daily was signed as completed from 2/01/21 through 2/23/21. An interview on 2/16/21 at 10:51 AM with Nurse #1 revealed he was the treatment nurse at the facility and responsible for ensuring Resident #2 had a catheter securement device in place. Nurse	F 690	accomplished for those residents found to have been affected by the deficient practice; The Director of Health Services provided all direct Nursing care staff with in-service education on the accepted professional standards and practices concerning Catheter Care in the facility on 3/5/21. This education was provided to all direct Nursing care staff that was currently working in the facility on 3/5/21. Any part time or PRN direct care staff that was not working on 3/5/21 will receive the in-service education before working in the facility again. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 2/16/21, the Director of Health Services assessed all active residents with foley catheter to ensure that a catheter securement device is appropriately in place. All active residents with foley catheter were found to have a securement device appropriately in place. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Nursing will confirm that foley securement device is appropriately in place when providing daily catheter care. CNA will notify nursing if foley securement device dislodges during direct care.	

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F 690	Continued From page 9 #1 stated there were no catheter securing devices in the facility. He further stated he had asked the supply Associate to order them and they were back ordered. Nurse #1 also stated he had informed management that there were no catheter securing devices and they were back ordered. An interview on 2/16/21 at 11:13 AM with Nursing Assistant (NA) #2 revealed she often provided care for Resident #2 and provided care for her today. She stated that she had notified Nurse #1 earlier today that Resident #2 did not have a catheter securement device. An interview on 2/16/21 at 12:01 PM with the Supply Associate revealed she was responsible for ordering supplies for the facility. She also revealed the facility had Velcro leg straps for catheter securement in stock at the facility. She further stated she was unaware of any recent orders for catheter securing devices and had none on backorder. An interview on 2/16/21 at 2:46 PM with the Director of Nursing (DON) revealed Resident #2 should have had catheter securement device in place and she did not know why it was not. An interview on 2/16/21 at 3:04 PM with the Administrator revealed he was unaware that Resident #2 did not have a catheter securement device in place and stated he expected the nurses to follow physician's orders and facility policy for catheter securement devices.	F 690	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Health Services and/or designee will audit all residents with foley catheter for appropriate use of foley catheter securement device twice weekly for 4 weeks, then monthly for 3 months. The DHS and/or the Administrator will review the Foley Catheter Securement Device Audit monthly to identify patterns/trends and will adjust the audits as necessary to maintain compliance. The DHS and/or the Administrator will review the Foley Catheter Securement Device Audit during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Include dates when corrective action will be completed: Corrective action to be completed by 4/11/21	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		4/11/21

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F 842	Continued From page 10 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

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F 842	Continued From page 11 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to protect the private health information by leaving confidential medical information in an area accessible to the public on the covered back porch outside the facility. Findings included: An observation on 2/16/21 at 8:08 AM revealed stacks of boxes sitting outside the facility dining room on a back-porch area. No staff were observed outside.	F 842	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Director of Health Services provided an in-service with education on the accepted professional standards and practices concerning maintaining medical records on each resident in the facility on 3/5/21. This education was provided to all staff that was currently working in the facility on 3/5/21. Any part time or PRN	

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F 842	Continued From page 12 An observation on 2/16/21 at 8:22 AM with the Director of Nursing (DON) revealed there were approximately 35 boxes stacked 3 or 4 high on the porch outside the facility dining room. Some boxes had resident names written in black on the outside of the box. Examination of two of the top boxes revealed the contents contained folders with resident names. The folders contained resident medical information. A large empty, unlocked and open metal file cabinet was sitting on the porch beside the boxes. There was also a box containing some plastic devices sitting on top of a stack. One of the stacks of boxes was propped against the empty metal file cabinet with pieces of wood. The bottom boxes in a couple of the stacks appeared to be wet and slightly crumpled. An interview during the observation on 2/16/21 at 8:22 AM with the DON revealed she did not realize the boxes which contained confidential medical information were outside. She confirmed that the information was not secured and was accessible by anyone who walked around the building or unauthorized staff. An interview on 2/22/21 at 2:40 PM with the Medical Records Manager revealed the boxes were moved out on the back porch to make room for the 2nd Coronavirus Disease 2019 (COVID-19) vaccine clinic which was held on 2/02/21. She stated she did not move them and was aware they contained resident confidential medical information which should be kept in a locked, secure area. An interview on 2/16/21 at 3:04 PM with the Administrator revealed the resident medical records had been moved out of an office to make	F 842	staff that was not working on 3/5/21 will receive the in-service education before working in the facility again. All boxes were removed from the covered patio area on 2/16/21 and immediately transported to an offsite storage unit and was stored under lock and key. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Administrator searched inside the facility and outside for any remaining boxes marked for medical records and boxes that were not marked for medical records, to determine if any medical records were improperly stored. No additional medical records were found to be unsecured or stored anywhere in the facility or outside the facility on 2/16/21 and again on 2/17/21. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The facility Medical Records Manager was educated by the Administrator on 3/11/21 to ensure that no medical records will be left unsecured anywhere inside or outside the facility. All medical records will be properly identified and marked, by the Medical Records Manager moving forward and with the correct date so the medical records can be properly identified and then transported to the offsite Medical Records Storage Unit and secured under	

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F 842	Continued From page 13 room for the vaccine clinic. An interview on 2/23/21 at 11:38 AM with the Administrator revealed he had inventoried the boxes and he stated that only 5 or 6 of the boxes contained resident medical information and the rest contained facility forms which were being moved to an offsite storage location. He stated he did not know when the boxes had been moved outside.	F 842	lock and key. The Medical Records Manager will also make weekly rounds in the facility to ensure no Medical Records are unsecured or improperly stored beginning 3/15/21. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Medical Records Manager will audit inside/outside the facility for unsecured/improperly stored medical records weekly x2 for 4 weeks, then monthly for 3 months. The DHS and/or the Administrator will review the audits monthly to identify patterns/trends and will adjust the audits as necessary to maintain compliance. The DHS and/or the Administrator will review Medical Records audits by the Medical Records Manager during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Include dates when corrective action will be completed: 4/11/21	
F 880 SS=E	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	F 880		4/11/21

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F 880	Continued From page 14	F 880		

development and transmission of communicable diseases and infections.

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

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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F 880	Continued From page 15 (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, record review, and staff interviews, the facility failed to ensure residents were offered or provided hand hygiene when 3 of 3 Nursing Assistants (NA) delivered meal trays to 5 of 5 residents (Residents # 3, #4, #5, #6, #7) observed for infection control practices. This failure occurred during a COVID-19 pandemic. Findings included: A continuous observation was made on 2/16/21 from 8:38 AM to 8:50 AM of the breakfast trays being delivered to residents' rooms. Nursing Assistant (NA) #3 was observed to enter Resident #4's room, deliver the resident's meal tray, and depart the resident's room. NA #3 did not offer or provide hand hygiene for the resident.	F 880	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Director of Health Services provided an in-service with education on the accepted professional standards and practices concerning hand hygiene per company policy in the facility on 3/5/21. This education was provided to all staff that was currently working in the facility on 3/5/21. Any part time or PRN staff that was not working on 3/5/21 will receive the in-service education before working in the facility again. All staff were required to view the CDC	

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F 880	Continued From page 16 NA #4 was observed to enter Resident #5's room, deliver the resident's meal tray, and depart the resident's room. NA #4 did not offer or provide hand hygiene for the resident. NA #5 was observed to enter Resident #3's room, deliver the resident's meal tray, and depart the resident's room. NA #5 did not offer or provide hand hygiene for the resident. An interview on 2/16/21 at 2:31 PM with NA #3 revealed she had received hand hygiene training and was aware she was supposed to offer or provide hand hygiene to all residents before each meal. She stated she had not offered or provided hand hygiene to the residents this morning with the breakfast trays because she 'just wasn't thinking'. An interview on 2/16/21 at 2:27 PM with NA #4 revealed she had received hand hygiene training and was aware she was supposed to offer or provide hand hygiene to all residents before each meal. She stated she had not offered or provided hand hygiene to the residents this morning with the breakfast trays because being observed had made her nervous. NA #5 was not available for interview during the investigation. An interview on 2/16/21 at 11:22 AM with the Infection Control Nurse revealed she did not know why the residents had not been offered or provided hand hygiene this morning and affirmed that all staff had been trained to offer or provide hand hygiene to all residents before each meal. An interview on 2/16/21 at 2:46 PM with the Director of Nursing (DON) revealed all staff had	F 880	sponsored video CLEAN HANDS: COMBAT COVID-19! Staff were required to sign an attestation letter as documentation when completed. This was required to be completed 3/19/21. All new employees will be required to watch the video as part of the new hire orientation. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 2/16/21, the Director of Health Services audited every resident room to ensure hand sanitizer was available for resident use before meals and snacks. All resident rooms were found to have adequate hand sanitizer available for resident use. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Beginning on 3/19/21, the facility will implement a new protocol of providing individual hand sanitizing wipes on alert and oriented resident□s meal trays to make it available to direct care Nursing staff to offer hand hygiene. In addition, nursing staff will offer hand hygiene to non-oriented residents at bedside. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;	

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F 880	Continued From page 17 been trained to provide hand hygiene to residents before meals and she did not know why they had not done so this morning when the delivered breakfast trays. An interview on 2/16/21 at 3:04 PM with the Administrator revealed all residents should be offered or provided hand hygiene before meals.	F 880	The Director of Health Services and/or designee will perform audits of direct care staff providing proper hand hygiene to all residents with meals/snacks provided. Audits will be done three times weekly for 4 weeks, then monthly for 3 months. The DHS and/or the Administrator will review the audits monthly to identify patterns/trends and will adjust the audits as necessary to maintain compliance. The DHS and/or the Administrator will review Resident Hand Hygiene audits during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Include dates when corrective action will be completed: 4/11/21	