STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to ensure the specialized call light was accessible for 1 of 1 sampled resident with a breath activated call light. Resident #157. Findings included: Review of the manufacturer's instructions for the Breathcall Series Air Activated Call Light (1/17) documented: "Install clamp on headboard of bed frame so flexible arm projects out and around, pointing toward patient's mouth. Point arm slightly downward so liquid from patient's mouth will not leak into tubing. When treating patient or changing linen, flexible arm may be flipped out of the way. When patient is back in normal position, BreathCall flexible arm can be moved to original position with straw pointing to patient's mouth." Resident #157 was admitted to the facility on 3/29/18 with diagnoses which included: quadriplegia secondary to cervical spine fractures. Review of the Admission MDS (minimum data set) dated 4/5/18 indicated Resident #157 was moderately cognitively intact; required total	F 558	Oak Forest Health and Rehabilitation requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is 5/25/2018. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law. The facility failed to provide education for 100% of employees on the resident's accessibility to a specialized call bell. The staff did not ensure the resident could access the call bell at all times. All residents will be supplied with call bells that accommodate their physical limitations upon admission and if there is any change of condition. A post admission audit is completed to ensure call bell assessments are completed. The facility adjusted the call bell for the resident to ensure accessibility 24/7 immediately. Other residents with sip and	5/25/18

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

Electronically Signed | 05/17/2018

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F 558	Continued From page 1 assistance of two staff for bed mobility and transfers; and had impaired range of motion of both upper and lower extremities. The Care Plan dated 4/9/18 revealed Resident #157 was at risk for falls and fall related injuries due to quadriplegia and was totally dependent for all mobility. Interventions included: check to see that the "Breath" call light was within reach and that it worked appropriately. During an observation and interview on 4/24/18 at 10:41 a.m., Resident #157 was awake in bed with the head of the bed up at approximately a 45 degree angle. The long black flexible arm of the Breathcall call light was observed between the mattress and the foam padded ¼ sized, right side-rail with the straw (mouthpiece) pointing towards the floor, away from the resident. Resident #157 revealed she was unable to move her arms due to fractured vertebrae as a result of an automobile accident. The resident indicated the Breathcall call light had not been accessible for her use since the night before this interview. Resident #157 was noted to be the only occupant of the room. During an interview on 4/25/18 at 11:42 p.m., the Assistant Maintenance Supervisor revealed Resident #157 had a "sip and puff" call light which was special ordered due to her disabilities. He stated that the mouthpiece must be placed on the resident's face near her mouth for access and must be cleaned. On 4/25/18 at 3:45 p.m., Resident #157 was observed asleep in bed. The flexible arm of the Breathcall call light was wrapped around the right side-rail with the mouthpiece facing upright	F 558	puff specialized call bells were assessed for 24/7 accessibility. The facility will provide 100% staff education on all call bell types (push button, pancake, tent, and sip & puff). Any new staff members will be educated in orientation regarding call bells used in the facility. Call bell audit tools will be used to ensure residents have been supplied with calls bells to accommodate their physical limitations for 2 weeks, weekly x 1 month, and monthly x 1 year. The Director of Nursing will present the results of the audit tools to the Monthly QAPI Committee monthly for 1 year. The Director of Nursing, Nurse Managers, and Maintenance Director will implement the above corrective actions.	

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F 558	Continued From page 2	F 558		

(towards the ceiling) at the head of the bed.

On 4/26/18 at 11:06 a.m., Resident #157 was observed asleep in bed. The flexible cord of the Breathcall call light was wrapped around the right side-rail with the straw positioned approximately eight to ten inches from the front of the resident's face.

During an observation on 4/26/18 at 11:42 a.m., Resident #157 was reclining in bed with the head of the bed at a 45 degree angle. The Breathcall call light was approximately eight inches in front of the resident's face with the straw pointed upward. When questioned, the resident responded she was unable to move her head forward.

During an interview on 4/26/18 at 2:51 p.m., NA#4 (nurse aide) indicated she had not worked with Resident#157 until the day of this interview. NA#4 revealed the resident required total assistance with all of her ADL (activities of daily living) care. She stated that the resident required the assistance of two staff for turning and positioning; but required three staff for transfers because one of the three staff was required to hold the resident's head due to her paralysis. NA#4 stated the resident was able to use her call light, but she had not observed the resident use it.

During an interview on 4/27/18 at 8:15 a.m., the Maintenance Supervisor stated that upon admission, he was notified Resident #157 was unable to use the push button call light. The resident informed him she had very limited head and body mobility. He exchanged the push button call light with a pancake call light which the

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F 558	Continued From page 3 resident was able to use against her face. But, the resident's family insisted the resident have the type of call light she had at the hospital which was the "locking breathcall call light ("sip and puff"). He stated that he ordered the specialized call light and upon delivery applied it to the right side-rail of the resident's bed ensuring the "soft-straw" (mouthpiece) was one to two inches from resident's mouth. The Maintenance Supervisor revealed he educated the nurses and nursing assistants (all shifts) on how to keep the specialized call light adjusted to the bed's side-rail, how to change the straw filters, and instructed the staff to ensure the soft-straw remained one to two inches the resident's mouth. He also revealed the straw filters were not re-usable and must be changed two to three times each week. The DON (Director of Nursing) was informed when the staff were educated and indicated the replaceable straws would be kept in the nurse's medication cart. During an interview on 4/27/18 at 2:46 p.m., NA#5 revealed she sometimes worked with Resident #157 since her admission to the facility. She stated that the resident required total assistance with her care, was alert and oriented and able to verbalize her needs. She stated that the resident was able to slightly move her head, only enough to allow the resident to blow into the mouthpiece of the special call light. NA#5 indicated she always ensured the mouthpiece of the call light was close enough to the resident's mouth because it was the only way the resident could communicate her needs, especially due to the resident residing in a private room.	F 558		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		5/25/18

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§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

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F 584	Continued From page 5 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews the facility failed to maintain clean floors in residents ' rooms and bathrooms on two of three halls on C Wing and failed to clean a resident ' s fan on one of one ventilator dependent unit. The findings included: Initial tour on 4/23/18 beginning at 6:20 AM and ending at 6:50 AM revealed the following: Room 406 had a brown dried substance on the floor at the entry of the shower and at the baseboard and floor junction; rooms 400, 408, 410, 307 had a brown/black substance at the baseboard and floor junction; rooms 300 and 301 had paper trash and tracheostomy used supplies on the floor behind the mobile supply cart at the resident bedside. In room 300 a stand-up fan had lint build-up on the blades and outer covering. The fan was positioned towards Resident # 3 who was a ventilator dependent resident with a tracheostomy. Follow observations on 4/24/18 at 10: ,19 AM revealed the paper trash in rooms 300 had not been removed. Interview with Resident #30 at the time of the observation in room 301, revealed staff did not move anything in the room to sweep the floor or pick up trash dropped behind the ventilator or cart with supplies. Follow up observations on 4/24/18 at 11:47 AM revealed the paper trash in room 301 had not	F 584	The facility was found to have dirty floors and baseboards, trash on floors, old supplies in room, and lint build up on a resident fan. The facility failed to remove dirty equipment, trash, and clean a dirty fan in a resident's room during daily housekeeping cleanings and staff rounds. All residents' rooms will be safe, clean, comfortable and homelike. The areas cited in the deficiency were cleaned. The fan was also cleaned in the resident room by maintenance. The facility will provide 100% education of all housekeeping staff on the basics of cleaning resident rooms. 100% of all staff will be educated on keeping the facility free of trash and debris around the facility. A Facility Environmental Rounds Tool will be used to ensure resident rooms and common areas will be clean daily for 2 weeks, weekly x 1 month, and monthly x 1 year. The Environmental Service Director will present the results of the audit tools to the Monthly QAPI Committee monthly for 1 year. The Housekeeping Supervisor, Respiratory Manager, and the Administrative Department heads will all implement the above corrective actions.	

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been removed. Interview with Resident #44 at the time of the observation in room 301 revealed staff did not move things to sweep the floor or pick up trash dropped behind the ventilator or cart with supplies.

Follow up observations on 4/24/18 at 12:00 PM revealed rooms 400, 408, 410 and 307 had the dried brown/black substance on the floors near the baseboard and entry of the shower for room 406.

Interview with housekeeper #1 on4/27/18 at 7:57 AM revealed the duties that were performed in each room would include sweep, dust blinds, mop under bed, clean IV (intravenous) poles if dirty, empty trash and clean the bathroom. Further interview revealed she explained she was afraid to move some of the equipment, such as the ventilator and cart with supplies. Continued interview revealed there was trash behind the equipment sometimes. The housekeeper #1 explained the bathroom floors had a build-up that won't come off, and had to be stripped, from years and years of being on it. She continued her explanation the residents on the ventilators can't be in the room when the floors were stripped and deep cleaned. They had to wait until the residents left the room.

Interview on 4/27/18 at 8:39 AM with the Housekeeping Supervisor and the Administrator revealed the trash should be removed from behind the equipment each day. Observations on 4/27/18 at 8:40 AM with the Administrator and Housekeeping Supervisor revealed the paper trash and used tracheostomy supplies were on the floor behind the mobile cart. Further interview with the Housekeeping Supervisor revealed the

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F 584	Continued From page 7 bathroom tile at the baseboard and corners had black substance buildup. She explained a room could be deep cleaned if the residents were discharged, but it would not be possible to deep clean due to the residents would need to be moved, and they had respiratory issues with the cleaning agents. The fan in room 300 had been cleaned as of today. She explained the fan was not on a schedule, it was a personal fan, and maintenance would need to take it apart and clean it.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to assess Resident #215 with contractures on the Minimum Data Set for one of 7 sampled resident with contractures. The findings included: Resident #215 was re-admitted to the facility on 4/12/18 from the hospital with diagnosis of anoxic brain damage, persistent vegetative state, Urinary Tract Infecion, ventilator dependent, and chronic respiratory failure. The Quarterly Minimum Data Set (MDS) dated 2/5/18 indicated Resident #215 had severe impairment with cognition, required total care for activities of daily living and had no impairment with functional range of motion of her extremities.	F 641	The MDS nurse failed to recognize resident contractures as a functional limitation on the MDS assessment. The MDS nurse corrected the MDS assessment. The facility will provide 100% education to the MDS nurses on accuracy regarding functional range of motion for all residents on MDS assessments. The facility will audit 100% of all current residents' MDS assessments for accuracy regarding functional range of motion including residents' care plans. MDS audit tools will be used weekly x 1 month and monthly x 1 year. The Director of Nursing will present the results of the audit tools to the Monthly QAPI	5/25/18

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F 641	Continued From page 8 The care plan did not include current problems of contractures. Observations on 4/27/18 at 1:00 PM with Treatment Nurse #1 revealed Resident #215 could not extend her fingers of either hand, the wrist had limitation in movement and the resident kept her hands in a tight fist. The right hand was closed with the thumb underneath the fingers. The Treatment Nurse #1 explained the thumb nail needed to be trimmed, as it was pressing on the resident ' s palm. She further explained the skin was not broken inside the palm. Interview with MDS Nurse #1 on 4/27/18 at 3:24 PM revealed she did not complete the Quarterly MDS. The nurse who completed the assessment was not available for interview. The MDS Nurse #1 explained it must of missed have been missed.	F 641	Committee Monthly for 1 year. The Director of Nursing, Unit Managers, and MDS nurses will all implement the above corrective actions.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders.	F 655		5/25/18

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F 655	Continued From page 9 (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to develop a baseline care plan that addressed limited range of motion and splinting for 1 of 5 sampled residents (Resident #123) with limited range of motion and failed to develop a baseline care plan for one of two sampled residents with contact precaution isolation (Resident #219). Findings included:	F 655	The facility failed to complete a baseline care plan that included contractures and isolation precautions. There was not a section included for contractures and not a specific area for isolation precautions. The facility updated the baseline care plan to include a specific section for contractures and to specify isolation precautions for residents. The two baseline care plans were corrected.	

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F 655	Continued From page 10 1. Resident #123 was admitted to the facility on 3/13/18 with diagnoses that included, in part, hemiplegia, cerebrovascular accident and dementia. A review of the admission comprehensive Minimum Data Set (MDS) assessment dated 3/22/18 revealed Resident #123 had memory impairment and severely impaired daily decision making skills. The MDS assessment further revealed the resident had functional limitation in range of motion impairment on one side of her upper and lower extremity. A review of the baseline care plan dated 3/13/18 revealed no information related to Resident #123's limited range of motion or splint. A review of the North Carolina Medicaid Program Long Term Care Services FL2 (a form that contains a resident's demographic and medical information that is required upon admission to a skilled nursing facility) dated 2/28/18 revealed Resident #123 had contractures to her left side and had a left hand splint that was to be put on at 9 AM and taken off at 2 PM. A review of a physician order dated 3/14/18 revealed, "Apply brace/sling to left arm daily for contractures and remove at night." On 4/25/18 at 1:39 PM an observation of Resident #123 revealed limited range of motion to her left hand with left hand splint in place. On 4/25/18 at 1:40 PM an interview was completed with Nurse #2. She stated Resident #123 wore a left wrist splint because she had a	F 655	The facility will provide 100% education of all nurses on baseline care plans and the requirements necessary for a thorough care plan. 100% audit of all current baseline care plans will be completed to ensure all functional limitations and isolation precautions have been included. All Baseline care plans will be completed by an RN (Case Manager, Unit Manager, or RN Supervisor). The Director of Nursing and Assistant Director of Nursing will audit daily in morning meeting to ensure compliance and review care plans for any areas of concern. Baseline care plan audit will be used daily for 2 weeks, weekly x 1 month, and monthly x 1 year. The Director of Nursing will present the results of the audit tool to the Monthly QAPI Committee monthly for 1 year. The Director of Nursing and Assistant Director of Nursing will implement the above corrective actions.	

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contracture in her left hand.

On 4/27/18 at 11:19 AM an interview was completed with Nurse #1. She stated when there was a new admission, the baseline care plan was completed by the floor nurse within four hours. She said information from the FL2, resident examination, family interview and medical history was included on the baseline care plan. She reported that Resident #123 had a contracture to her left hand upon admission to the facility. Nurse #1 said she used information and the medication list from the FL2 form and called the provider and verified the orders. She stated Resident #123's left hand contracture and splint was not included on the baseline care plan because there wasn't a box to check that addressed contractures or limited range of motion. She further said there was a section marked "other" on the baseline care plan and the information about the contracture and splint should have been added to that section.

On 4/27/18 at 11:31 AM an interview was completed with MDS Nurse #1. She reported the floor nurse completed the baseline care plan upon admission and a MDS Nurse added information to it if needed. She stated Resident #123's contracture and splint should have been included in the baseline care plan.

On 4/27/18 at 11:46 AM an interview was completed with the Director of Nursing (DON). She said the admitting nurse started the baseline care plan and then a registered nurse (RN) reviewed and signed it within 48 hours. The DON stated the contracture and splint should have been included on the baseline care plan.

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F 655	Continued From page 12	F 655		

2. Resident #219 was admitted on 4/23/18 with diagnosis of sepsis, Clostridium difficile (C. diff) and colitis.

Review of the hospital discharge summary dated 4/23/18 indicated Resident #219 was on an antibiotic orally to treat sepsis, colitis, and C. Diff. The medication Vancomycin 125 milligrams (mg)by mouth was ordered in hospital. The summary indicated on discharge to the facility she was to take Vancomycin 50mg/ml (milliliters) by mouth in a dose of 2.5 ml (liquid form) three times a date. The end date for the course of medication was 4/27/18. The Vancomycin was to continue at the same dose, but decrease the frequency. Vancomycin 2.5 ml twice a day until 5/5/18, then 2.5 ml every day until 5/12/18 then 2.5 ml every other day until 5/19/18. The discharge summary included the results of labwork for C. diff dated 4/12/18 as positive for the infection.

Review of the admission orders dated 4/24/18 included contact enteric precautions related to C. diff.

Review of the 48 hour baseline care plan revealed no mention of the infection C. diff or use of contact precautions.

The nurses note dated 4/23/18 indicated Resident had liquid stools.

Interview on 4/25/18 at 11:24 AM with Nurse #3 reported Resident #219 stools were still loose.

Interview with the Nurse Case Manager on 04/25/18 01:36 PM revealed she reviewed the baseline care plans. Resident #219 was admitted

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F 655	Continued From page 13 on Monday and the baseline care plan was completed by the floor nurse. Review of the baseline care plan revealed the Unit Manager #2 had signed the care plan was complete. Usually, the Admission Nurse reviewed the baseline care plans, ensured there were goals, approaches and met with the resident and/or family to go over the care plan. Interview with the Director of Nursing (DON) on 4/26/18 at 9:03 AM revealed she would expect the contact isolation to be on the baseline care plan. She explained it (contact isolation) may not have been included since nursing staff were not sure if she should be on contact precautions on admission. The resident had treatment for the C. diff and had formed stools per the hospital. On admission she did have some loose stools, and the isolation precautions were initiated. The baseline care plan was completed on admission. Interview with the Nurse Case Manager on 4/27/18 at 3:21 PM revealed she missed the C. diff and isolation precautions. She usually looked at the medications to guide her for any type of infections.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		5/25/18

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F 657	Continued From page 14 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to update a care plan for 2 of 31 residents. 1. The care plan for Resident #44 was not updated to resolve an infection with use of intravenous antibiotics and 2. The care plan for Resident #53 was not updated to include the application of lymphedema pumps and wraps to reduce swelling of the lower extremities. The findings included: 1. Resident #44 was readmitted to the facility on 2/14/18 with diagnosis of quadriplegia, ventilator dependency with tracheostomy and bacteremia. Review of the care plan dated 2/16/18 included a problem of "PICC line" (percutaneous inserted	F 657	The MDS nurse failed to update care plans after a routine assessment. The MDS nurse corrected the care plans. The facility will provide 100% education of all MDS nurses to update care plans after each assessment. 100% audit will be completed of all current resident care plans to ensure they accurately reflect the current treatments and care necessary for resident care. Care Plan audit tools will be completed weekly x 4 weeks and monthly x 1 year. MDS nurses will present the results of the audit tool to the Monthly QAPI Committee monthly for 1 year. The Director of Nursing, Assistant	

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F 657	Continued From page 15 central catheter), and "recent hospitalization for bacteremia - completing course of IV antibiotics." Review of the medical record revealed the infection had resolved and the PICC line was removed on 2/27/18. Interview on 4/26/18 at 1:26 PM with MDS Nurse #1 revealed the care plan was not updated. The MDS nurse responsible for the care plan was not available for interview. The MDS Nurse #1 explained the care plan should have been updated. 2. Resident #53 was admitted to the facility on 6/2/17 with diagnoses which included: multiple sclerosis, congestive heart failure, and lymphedema. The Physician's Order dated 1/5/18 documented staff were to apply lymphedema pumps to Resident #53's legs for one hour, remove the sleeves then apply ace wraps to her legs. When the application was completed, the staff were to sign the log posted in the resident's room. Only staff trained were to perform this application process. Review of the quarterly Minimum Data Set (MDS) dated 2/9/18 indicated Resident #53 was cognitively intact, required extensive assistance of two staff with bed mobility and transfers, and had no range of motion impairments. Resident #53's Care Plan was not updated to include the application of the lymphedema pumps and the ace wraps to the resident's legs. Review of the Weekly Sign off Sheets of	F 657	Director of Nursing, and MDS nurses will implement the above corrective actions.	

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F 657	Continued From page 16	F 657		

Tasks/Concerns posted in Resident #53's room on 4/8/18 through 4/28/18 indicated the lymphedema pumps and the wraps were frequently not applied to the resident's legs as ordered.

Review of the April 2018 MAR (medication administration record) revealed the lymphedema pumps and wraps were not applied to Resident #53's legs on 4/3/18, 4/4/18, 4/5/18, 4/6/18, 4/7/18, 4/9/18, 4/11/18, 4/14/18, 4/15/18, 4/16/18, 4/17/18, 4/20/18, 4/23/18, 4/24/18, and 4/25/18. The nursing staff documented "nurses not trained" or no reason was given (especially during the evening shift) why the lymphedema pumps and wraps were not applied to the resident's legs as ordered.

During an interview on 4/27/18 at 3:39 p.m., MDS Coordinator#1 and the DON (Director of Nursing) stated that not documenting the application process of the lymphedema pumps and the wraps on Resident #53's Care Plan was an oversight; but the care was given and documented on the MAR (medication administration record).

During an observation and interview on 4/24/18 at 3:41 p.m., Resident #53 was sitting in her wheelchair in her room. Both of the resident's legs were wrapped in ace bandages covered with non-skid knee socks. The resident revealed she had a history of lymphedema. The resident stated that she previously met with the Physician and Unit Supervisor#2 concerning staff not receiving training on how to apply the lymphedema pumps and the lymphedema wraps to her legs. She revealed Unit Supervisor#2 instructed RNA#1 (restorative nurse aide) to accompany her

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F 657	Continued From page 17 (resident) to the Lymphedema Clinic to learn how to correctly wrap her legs, which she did for a while.	F 657		
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to follow the care plan to place floor mats at bedside for fall prevention for 1 of 2 residents (Resident #16) reviewed for falls. Findings included: Resident #16 was admitted to the facility on 3/15/17 with diagnoses that included, in part, hypertension, pneumonia and anxiety disorder. Resident #16 discharged to the hospital on 12/27/17 and was re-admitted to the facility on 1/3/18. A review of the comprehensive Minimum Data Set (MDS) assessment dated 1/12/18 revealed Resident #16 had severe cognitive impairment. She required extensive assistance with transfers and did not walk. A review of the care plan revealed Resident #16 was at high risk for falls. A care plan intervention dated 12/12/17 after the resident fell out of bed	F 659	Staff failed to follow the resident care plan to ensure all fall interventions were in place. On several occasions, the floor mats were not at bedside for a resident. The mats were immediately placed at bedside. Staff will recognize and respond to all directives regarding resident care as laid out in the resident care plan. The Certified Nursing Assistant in question was relatively new to the facility (<90 days). She had been told in report that the roommate had a fall earlier in the week so she assumed the floor mats were for the other resident in the room. Although she verbally stated she should have looked at the care card, she did not. Her records were reviewed and she has completed a CNA Skills Checklist in orientation that included care cards. She was immediately re-educated. The staff involved (including the CNA and the facility IC nurse) knew the location of	5/25/18

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F 659	Continued From page 18 revealed, "Mats to floor at bedside." A review of a fall report dated 12/12/17 revealed Resident #16 was found on the floor next to her bed at approximately 3:51 AM. Nursing staff completed a head to toe assessment and determined there was no injury. The care plan was updated after the fall and floor mats were provided at bedside. On 4/26/18 at 9:25 AM an observation was made of Resident #16's room. The resident was in her bed, eating breakfast. One side of her bed was up against the wall. The fall mat was not on the floor beside the other side of her bed. On 4/26/18 at 9:46 AM an observation of Resident #16's room revealed the resident was in bed and the fall mat was not on the floor beside her bed. On 4/26/18 at 9:47 AM an interview was completed with Unit Supervisor #1. She stated Resident #16 needed two staff members to help with transferring and used a mechanical lift for transfers. She said the resident had sustained multiple falls in recent months because she had dementia and thought she still had the ability to walk. The Unit Supervisor stated one of the interventions to prevent injury from falls was that a floor mat was placed beside Resident #16's bed. On 4/26/18 at 10:04 AM an observation of Resident #16's room and interview with the Unit Supervisor and Nurse Aide (NA) #1 was completed. An observation of the room revealed the floor mat was not beside Resident #16's bed. An interview with both the Unit Supervisor and NA	F 659	the care cards and their responsibility to follow them. They admitted they simply did not follow the care card. Education/disciplinary action was given where warranted. All staff were re-educated on the facility expectations to follow the care cards. The facility will educate 100% of all nursing staff on the care plan purpose and expectation of the facility for following interventions on the care plan. The facility will provide qualified staff to follow each resident care plan. The facility will audit 100% of all current care cards. Care Card Intervention Audit tools will be completed daily x 2 weeks, weekly x 1 month, and monthly x 1 year. The Director of Nursing will present the results of the audit tool to the Monthly QAPI Committee monthly for 1 year. The nurse management team consisting of Unit Managers, Shift Supervisors, Director of Nursing, and Assistant Director of Nursing will implement the above corrective actions.	

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F 659	Continued From page 19 #1 revealed they did not know why the floor mat was not beside Resident #16's bed. An interview with NA #1 revealed fall prevention interventions were located on the care card inside the resident's closet door. The Unit Supervisor stated she would educate staff on fall prevention interventions for Resident #16. On 4/26/18 at 10:10 AM an interview was completed with the Staff Facilitator/Infection Control Nurse. She reported she had set up the breakfast tray for Resident #16 that morning. She stated she had not seen the fall mat beside the resident's bed when she delivered the tray. She further stated she did not put the floor mat in place beside Resident #16's bed because she did not know it was supposed to be there. She said fall prevention interventions were listed on the care plan. On 4/27/18 at 10:50 AM an observation of Resident #16's room revealed the resident was in bed and the fall mat was not on the floor beside her bed. On 4/27/18 at 11:50 AM an interview was completed with the Director of Nursing (DON). She stated she expected that staff would follow the care plan and implement interventions, including the fall mat, and said the staff were educated the day before regarding the placement of the fall mat.	F 659		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		5/25/18

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F 677	Continued From page 20 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide showers and bed baths for 2 of 7 dependent residents on the ventilator unit. (Residents #31 and 215) The findings included: 1. Resident #31 was originally admitted to the facility on 1/24/18 with diagnoses including stroke, diabetes, respiratory failure with ventilator dependency and pressure ulcers. The Admission Minimum Data Set (MDS) dated 1/31/18 indicated Resident #1 had severe impairment with long and short-term memory and decision-making abilities. He required total assistance of two staff with bed mobility, transfers, personal hygiene and bathing. The MDS indicated he had an indwelling urinary catheter and was always incontinent of bowel. Review of the care plan dated 2/5/18 included a problem of impaired mobility and activities of daily living and scheduled care task with approaches for the nursing assistants (NA ' s) to provide a bath on Monday and Wednesday by first shift, provide personal hygiene, incontinence care for bowel movements and assure that resident is clean, neat appearance and odor free. Observations on 4/23/18 at 11:15 AM revealed Resident #31 received a bed bath. Review of the documentation by the NA ' s for the timeframe of 3/27/18 to 4/26/18 revealed Resident #31 had received one shower, during	F 677	The facility failed to provide regular showers and bed baths. The facility provided showers and bed baths to the residents cited in the deficiency. All residents who are unable to carry out ADLs will receive the necessary services to maintain personal hygiene by following shower schedules. The facility will provide 100% education of all nursing staff on the facility policy to offer all residents a shower twice weekly and a bed bath daily. The facility will provide 100% education to all supervisors and unit managers on appropriate allocation of staff to ensure there are sufficient aides to provide scheduled showers. Shower audit tools will be used facility wide daily x 2 weeks, weekly x 1 month, and monthly x 1 year. The Director of Nursing will present the results of the audit tool to the Monthly QAPI Committee monthly for 1 year. Unit Managers, Director of Nursing, and Assistant Director of Nursing will implement the above corrective actions.	

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F 677	Continued From page 21	F 677		

the week of the survey. During that timeframe he had received 19 bed baths in 5 weeks, with one bath as "refused."

Interview with NA#2 on 4/26/18 at 10:06 AM revealed when one aide was scheduled to work on the ventilator unit, showers could not be given to the residents. She explained two staff were needed to transfer Resident #31 and provide the shower.

Interview with Nurse # 6 revealed there were times she worked with one NA on the ventilator unit. She explained the aides would provide bed baths, but could not give showers. During the interview she explained showers had not been given on the weekends since she had been working due to the lack of a second NA.

Interview with the Director of Nursing on 4/27/18 at 1:46 PM revealed the staffing on the ventilator unit was with 2 nurses and 2 aides. The staff would be able to complete the showers and bed baths. An explanation for the lack of showers was not provided.

2. Resident #215 was originally admitted to the facility on 9/26/14 with diagnoses including respiratory failure, ventilator dependency, diabetes and anoxic brain injury.

The most recent Minimum Data Set (MDS) a quarterly, dated 2/8/18 indicated Resident #215 was in a persistent vegetative state, required total assistance of 2 staff for turning, transfers, personal hygiene, and bathing. The resident had an indwelling urinary catheter and was always incontinent of bowel.

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F 677	Continued From page 22	F 677		

The care plan dated 2/15/18 included a problem of requiring total care due to persistent vegetative state as well as a left below the knee amputation. The approach included bed baths on non-shower days to be provided by nursing.

Review of the documentation by the nursing assistants (NA) for the time frame of 3/27/18 to 4/26/18 indicated Resident #215 had received no showers in 5 weeks. Resident #215 had received a total of 47 bed baths and 2 sponge baths.

Review of the bath schedule posted on the ventilator unit revealed it was by room number and bed A or bed B. Resident #215 was supposed to have showers on Saturday on first shift, according to this schedule.

Interview with NA#3 on 4/26/18 at 10:06 AM revealed when one aide was scheduled to work on the ventilator unit, showers could not be given to the residents. She explained two staff were needed to transfer Resident #215 and provide the shower. Further interview revealed each shift was to provide a bed bath for the residents on the unit.

Interview with Nurse # 6 revealed there were times she worked with one NA on the ventilator unit. She explained the aides would provide bed baths, but could not give showers. During the interview she explained showers had not been given on the weekends since she had been working due to the lack of a second NA.

Interview with the Director of Nursing on 4/27/18 at 1:46 PM revealed the staffing on the ventilator unit was with 2 nurses and 2 aides. The staff would be able to complete the showers and bed

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F 677	Continued From page 23 baths. An explanation for the lack of showers was not provided.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to apply the lymphedema pumps and ace wraps to the lower extremities of 1 of 1 sampled resident as ordered by the Physician. Resident #53 Findings included: Resident #53 was admitted to the facility on 6/2/17 with diagnoses which included: multiple sclerosis, congestive heart failure, and lymphedema. The Physician's Order dated 1/5/18 documented staff were to apply lymphedema pumps to Resident #53's legs for one hour, remove the sleeves then apply ace wraps to her legs. When the application was completed, the staff were to sign the log posted in the resident's room. Only staff trained were to perform this application process.	F 684	The facility failed to train all nurse and med aides to apply lymphedema pumps twice daily for a resident. The facility initiated education to all appropriate staff immediately. There are no other residents ordered lymphedema pumps in the facility. The facility will provide 100% of all nurses and medication aides on the application of a lymphedema pump and leg wraps. The facility will use an audit tool to ensure compliance daily x 2 weeks, weekly x 1 month, and monthly x 1 year. The Director of Nursing will present the results of the audit tool to the Monthly QAPI Committee monthly for 1 year. The C Wing Unit Manager will implement the above corrective actions.	5/25/18

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Review of the quarterly Minimum Data Set (MDS) dated 2/9/18 indicated Resident #53 was cognitively intact, required extensive assistance of two staff with bed mobility and transfers, and had no range of motion impairments.

Review of the Weekly Sign off Sheets of Tasks/Concerns posted in Resident #53's room on 4/8/18 through 4/28/18 indicated the lymphedema pumps and the wraps were frequently not applied to the resident's legs as ordered.

Review of the April 2018 MAR (medication administration record) revealed the lymphedema pumps and wraps were not applied to Resident #53's legs on 4/3/18, 4/4/18, 4/5/18, 4/6/18, 4/7/18, 4/9/18, 4/11/18, 4/14/18, 4/15/18, 4/16/18, 4/17/18, 4/20/18, 4/23/18, 4/24/18, and 4/25/18. The nursing staff documented "nurses not trained" or no reason was given (especially during the evening shift) why the lymphedema pumps and wraps were not applied to the resident's legs as ordered.

During an interview on 4/27/18 at 3:39 p.m., MDS Coordinator#1 and the DON (Director of Nursing) stated that not documenting the application process of the lymphedema pumps and the wraps on Resident #53's Care Plan was an oversight; but the care was given and documented on the MAR (medication administration record).

During an observation and interview on 4/24/18 at 3:41 p.m., Resident #53 was sitting in her wheelchair in her room. Both of the resident's legs were wrapped in ace bandages covered with

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non-skid knee socks. The resident revealed she had a history of lymphedema. The resident stated that she previously met with the Physician and Unit Supervisor#2 concerning staff not receiving training on how to apply the lymphedema pumps and the lymphedema wraps to her legs. She revealed Unit Supervisor#2 instructed RNA#1 (restorative nurse aide) to accompany her (resident) to the Lymphedema Clinic to learn how to correctly wrap her legs, which she did for a while.

On 4/26/18 at 2:45 p.m., Nurse#3 was observed leaving Resident #53's room. She stated she had just applied the lymphedema pumps to the resident's legs. She stated the pumps were to be applied twice each day for one hour (day shift and evening). When the timer on the pumps signaled the hour of application was complete, Nurse#3 would remove the pumps and apply cocobutter cream to the resident's legs. Nurse#3 stated she would then apply edema wraps to each leg and cover the resident's feet with non-skid socks.

During an interview on 4/27/18 at 1:15 p.m., Unit Supervisor#2 revealed several weeks prior, the Ombudsman and Resident#53 met with the facility's Administration with a list of concerns. A list of these concerns were given to her (Unit Supervisor#2) and she created a weekly sign-off sheet of tasks/concerns for the nurses and the resident to initial as tasks were completed. This was also documented on the monthly MAR. Unit Supervisor#2 stated that she began training several nurses on 3/30/18 on how to apply the lymphedema pumps and compression wraps; but she did not document the training or have the nurses sign attendance sheets. She stated that the resident had a history of lymphedema and

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F 684	Continued From page 26 use to be a patient at the lymphedema clinic prior to her admission to the facility. While a resident at the facility, the resident began going back to the Lymphedema Clinic (not ordered by facility's Physician). The Lymphedema Clinic wrote a consult on 1/10/18 recommending facility staff apply the pumps and wraps twice each day. RNA#1 was sent to the clinic with the resident where she also received training on the application of the wraps and pumps. During an interview on 4/27/18 at 3:08 p.m., RNA#1 stated the Assistant Director of Nursing/Restorative Supervisor sent her to the Lymphedema Clinic with Resident #53 in February 2018 to learn how to apply the lymphedema pumps and the compression wraps. RNA#1 indicated she was to train the other nursing assistants on how to apply the pumps and wraps. But, the facility made the decision for only the nurses were to do the applications.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		5/25/18

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F 686	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to apply a multi-podus boot and failed to apply bunny boots (both used for heel protection to prevent pressure ulcers) for 2 of 31 residents (Resident #365 and Resident #102) sampled. Findings included: 1. Resident #365 was readmitted to the facility on 3/26/18 with diagnoses, in part, of right sided hemiplegia following a stroke, peripheral vascular disease, diabetes mellitus type 2 and a right below the knee amputation. A review of the quarterly Minimum Data Set (MDS) assessment dated 3/30/18 revealed Resident #365 had impaired cognition, required extensive to total assistance for his activities of daily living (ADLs), was non-ambulatory, incontinent of bowel and bladder and was at risk for developing pressure ulcers. Resident #365 did not have current pressure ulcers. A review of the care plan dated 6/1/16 and most recently updated on 4/2/18 reflected a healed stage IV pressure ulcer to the resident's heel. The care plan indicated a problem that resident remained a high risk for pressure ulcers with a goal that Resident #365 would not develop pressure ulcers over the next 90 days. A review of the physician orders for April 2018 revealed an order dated 3/27/18 for Resident #365 to wear multi-podus boot on left foot to protect heel at all times, may remove for bathing and ADL's.	F 686	The facility failed to maintain bunny boots and multipodus boots as ordered to promote healing and prevention of pressure sores. After interviewing staff, the multi-podus boot had become soiled. The staff appropriately sent the boot to the laundry. They failed to replace the boot or provide an alternate intervention while the boot was being laundered. The nurse failed to reflect this on the Medication Record. The facility has since ordered additional boots to have sufficient on hand for replacements. The staff also failed to read the care card for the resident with bunny boots. The staff interviewed all stated they knew the location of the care card and their purpose. They verbalized understanding of facility expectations but failed to follow the care plan. Re-education and disciplinary action was given as warranted. The facility will provide 100% education to all nursing staff on the importance of following pressure reduction measures. The facility will complete a 100% audit of all ordered preventative measures to prevent new ulcers to ensure measures are in place and care planned. The facility will use a pressure ulcer intervention tool to ensure compliance daily x 2 weeks, weekly x 1 month, and monthly x year. The Director of Nursing will present the results of the audit tool to the Monthly QAPI Committee monthly for 1 year.	

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F 686	Continued From page 28 On 4/24/18 at 10:03 AM, Resident #365 was observed lying in bed without a multi-podus boot on. On 4/24/18 at 2:15 PM, Resident #365 was observed lying in bed without a multi podus boot on. On 4/25/18 at 10:50 AM, Resident #365 was observed lying in bed without a multi podus boot on. On 4/25/18 at 2:24 PM, Resident #365 was observed lying in bed without a multi podus boot on. On 4/26/18 10:14 AM, Resident #365 was observed lying in bed without a multi podus boot on. On 4/25/18 at 11:25 AM, an observation of wound care was done to a sheared area to Resident #365's right knee. Treatment nurse #2 revealed the resident had a previous pressure ulcer to his left heel and they were wrapping it every three days for protection. Treatment nurse #2 further revealed the resident was supposed to wear a multi-podus boot and was observed looking around the room for it, but was unable to find it. On 04/27/18 at 10:22 AM, an interview with NA #3 who was assigned to the resident, revealed restorative puts multipodus boots on. On 04/27/18 at 10:41 AM, an interview with Unit Manager #1 revealed she didn't know who is responsible for applying the multi podus boot, but she would find out.	F 686	The Director of Nursing, Assistant Director of Nursing, and Unit Managers will implement the above corrective actions.	

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On 04/27/18 11:17 AM, an interview was conducted with Treatment nurse #1. She revealed the floor staff was responsible for making sure the multi podus boot was applied and that when they went in the room to do wound care, they would make sure it was on. She further revealed it could have been sent to the laundry, but could not say why the multi podus boot was not on the resident for the last 3 days.

On 4/27/18 at 5:15 PM, an interview with the Director of Nursing was conducted. She revealed it was her expectation that physician orders be carried out.

2. Resident #102 was admitted to the facility on 7/28/14 with diagnoses, in part, of dementia, type 2 diabetes mellitus and functional quadriplegia.

The most recent Minimum Data Set (MDS) assessment dated 3/7/18 revealed the resident had severe cognitive impairment, was dependent on staff for all activities of daily living (ADL's), incontinent of bowel and bladder and at risk for skin breakdown. The resident did not have any current skin breakdown.

A review of the care plan dated 3/19/19 revealed a problem of risk for skin breakdown with a goal to have no new pressure ulcers over the next 90 days.

A review of the physician orders for April 2018 revealed an order dated 7/18/16 for the resident to wear bunny boots while in bed.

On 4/25/18 at 4:15 PM, the resident was observed lying in bed without bunny boots on.

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F 686	Continued From page 30 On 4/26/18 at 8:27 AM, the resident was observed lying in bed without bunny boots on. On 4/27/18 at 10:22 AM, an interview with NA #3, who was assigned to the resident, revealed the nursing assistants apply the bunny boots and could not say why they were not on. On 04/27/18 11:17 AM, an interview was conducted with Treatment nurse #1. She revealed the floor staff was responsible for making sure the bunny boots were applied and that when they went in the room to do wound care, they would make sure it was on. She further revealed they could have been sent to the laundry, but could not say why the bunny boots were not on the resident for the last 3 days. On 4/27/18 at 5:15 PM, an interview with the Director of Nursing was conducted. She revealed it was her expectation that physician orders be carried out.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		5/25/18

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F 688	Continued From page 31 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide range of motion or splint application services for 2 of 7 dependent residents with contractures on the ventilator unit. (Residents #31 and 215) The findings included: 1. Resident #215 was originally admitted to the facility on 9/26/14 with diagnoses including respiratory failure, ventilator dependency, diabetes and anoxic brain injury. Review of the care plan updated on 4/24/17 indicated a problem of at risk for contracture. Approaches included restorative nursing to provide gentle stretching of her hands prior to splint application. This update included restorative nursing was discontinued on 10/4/17 due to current treatment by therapy. The occupational therapy (OT) discharge note dated 11/21/17 indicated the resident was seen due to contractures in both hands and use of splinting to prevent further contractures. The discharge instructions indicated the resident was discharged to "LTC" (long term care). The most recent Minimum Data Set (MDS) a quarterly, dated 2/8/18 indicated Resident #215 was in a persistent vegetative state, required total	F 688	The facility failed to provide splinting orders after residents' multiple hospitalizations. Therapy screened both residents to indicate a referral for therapy. The facility will education the Restorative Nurse Manager and Rehab Manager on improving communication between departments on providing treatment and services that is appropriate eliminating further decrease in range of motion. The facility will provide 100% audit of all residents on restorative and therapy caseloads over the past 6 months to ensure continuity of care between the services. Weekly meetings will be held to review residents on caseload and those with change in status (discharges and significant change) to communicate needs for changes between services. The Restorative Nurse Manager will present any variances to the Monthly QAPI Committee monthly for 1 year. The Restorative Nurse Manager and Rehabilitation Manager will implement the above corrective actions.	

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assistance of 2 staff for turning, transfers, personal hygiene, and bathing. This MDS did not assess the resident as having functional limitation in movement of the upper or lower extremities.

The care plan dated 2/15/18 included a problem of requiring total care due to persistent vegetative state as well as a left below the knee amputation. The current care plan did not include use of splinting of the bilateral hands.

On 4/27/18 at 9:10 AM an interview was conducted with OT#1. Interview revealed she should have referred her to restorative after discharge from OT on 11/21/17. She explained she did not know where the referral was, or what happened and the referral may have been misplaced. During the interview OT#1 explained she would expect the carrot and palm guard to continue to be used in the resident's hands for contracture prevention.

Follow up interview with OT #1 on 4/27/18 on 12:48 PM revealed the resident's hands were contracted and the carrot in the one hand was to keep the space between the fingers and palm. The other hand required the palm guard for the same reason.

2. Resident #31 was originally admitted to the facility on 1/24/18 with diagnoses including stroke, diabetes, respiratory failure with ventilator dependency and pressure ulcers.

The Admission Minimum Data Set (MDS) dated 1/31/18 indicated Resident #31 had severe impairment with long and short-term memory and decision-making abilities. He required total assistance of two staff with bed mobility,

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transfers, personal hygiene and bathing. The MDS indicated he had limitation in functional movement on one side of his body.

Review of the care plan dated 2/23/18 included a problem of ventilator dependent and history of a stroke contributing to risk for contracture development. The approaches were for restorative nursing to perform passive range of motion two times for 3 to 6 days a week over the next 3 months to assist with decreasing the progression of potential contracture development. A note was included by the nurse who supervised the restorative nursing which indicated the program was discontinued due to Resident #31 was in the hospital.

Interview with the Director of Nursing (DON) on 4/26/18 at 2:18 PM revealed the process when the resident goes out to hospital, restorative would be discontinued. She explained upon the resident ' s return to the facility, therapy would do a screen/evaluation. Currently, restorative did not have any treatment for him.

Interview with the Therapy Director on 4/26/18 at 3:11 PM revealed she had not received a referral for this resident. She explained any staff member could do the referral. She explained the usual process after receiving a referral included to check the payer source, screen or evaluate as needed and provide therapy if needed.

Review of the aides ' documentation revealed the resident had not received range of motion from the aides on the floor.

Resident was discharged to the hospital on 4/1 and returned 4/9/18.

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F 688	Continued From page 34 Interview with restorative aides #1 and #2 on 4/27/18 at 7:31 AM revealed they had provided restorative for the resident. The resident went out to the hospital, and therapy had picked him up for treatment. Therapy had not referred him back to restorative since his return to the facility. Interview with the Nurse Supervisor for Restorative and the DON on 4/27/18 at 1:35 PM revealed therapy was supposed to evaluate the new or readmits. The communication with therapy was weekly for residents on Medicare. The reason Resident #31 was not provided therapy or restorative nursing was not provided by the DON.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide intervention for fall prevention for 1 of 2 residents (Resident #16) reviewed for falls. Findings included: Resident #16 was admitted to the facility on 3/15/17 with diagnoses that included, in part,	F 689	The facility failed to provide fall mats consistently near a resident's bed while the resident was in bed. Staff member providing care was immediately educated as well as the Unit Manager. The resident's mats were replaced by bedside. Resident's care card was audited to reflect individual needs. The Unit Supervisor has included this resident's	5/25/18

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hypertension, pneumonia and anxiety disorder. Resident #16 discharged to the hospital on 12/27/17 and was re-admitted to the facility on 1/3/18.

A review of the comprehensive Minimum Data Set (MDS) assessment dated 1/12/18 revealed Resident #16 had severe cognitive impairment. She required extensive assistance with transfers and did not walk. The MDS further indicated the resident had not fallen since she re-entered the facility.

A review of the care plan revealed Resident #16 was at high risk for falls. A care plan intervention dated 12/12/17 after the resident fell out of bed revealed, "Mats to floor at bedside."

A review of a fall report dated 12/12/17 revealed Resident #16 was found on the floor next to her bed at approximately 3:51 AM. Nursing staff completed a head to toe assessment and determined there was no injury. The care plan was updated after the fall and floor mats were provided at bedside.

On 4/26/18 at 9:25 AM an observation was made of Resident #16's room. The resident was in her bed, eating breakfast. One side of her bed was up against the wall. The fall mat was not on the floor beside the other side of her bed.

On 4/26/18 at 9:46 AM an observation of Resident #16's room revealed the resident was in bed and the fall mat was not on the floor beside her bed.

On 4/26/18 at 9:47 AM an interview was completed with Unit Supervisor #1. She stated room in her daily rounds of the facility. The CNA in question was relatively new to the facility (<90 days). She had been told in report that the roommate had a fall earlier in the week so she assumed the floor mats were for the roommate. Although she verbally stated she should have looked at the care card, she did not. Her records were reviewed and she had completed the CNA skills checklist in orientation that includes card cards. The staff involved (CNA, IC nurse, Unit Supervisor) knew the location of the care cards and the responsibility to follow the care cards. They admitted that staff did not follow the care card even though it was reflected that they had been trained on the care cards. Education and disciplinary action was given where warranted. All staff re-educated on the facility expectations to follow care card.

The facility will provide 100% education of all nursing staff on fall interventions and use of care cards. The facility will audit 100% of all residents with a history of falls to ensure interventions match resident care plans.

Fall intervention audits will be completed to ensure compliance daily x 2 weeks, weekly x 1 month, and monthly x 1 year. The Director of Nursing will present the results of the audit tool to the Monthly QAPI Committee monthly for 1 year.

The Director of Nursing, Assistant Director of Nursing and Unit Managers will implement the above corrective action.

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F 689	Continued From page 36	F 689		

Resident #16 needed two staff members to help with transferring and used a mechanical lift for transfers. She said the resident had sustained multiple falls in recent months because she had dementia and thought she still had the ability to walk. She reported Resident #16 could not remember to ask for help when she needed to be transferred. The Unit Supervisor stated one of the interventions to prevent injury from falls was that a floor mat was placed beside Resident #16's bed.

On 4/26/18 at 10:04 AM an observation of Resident #16's room and interview with the Unit Supervisor and Nurse Aide (NA) #1 was completed. An observation of the room revealed the floor mat was not beside Resident #16's bed. An interview with both the Unit Supervisor and NA #1 revealed they did not know why the floor mat was not beside Resident #16's bed. An interview with NA #1 revealed fall prevention interventions were located on the care card inside the resident's closet door. The Unit Supervisor stated she would educate staff on fall prevention interventions for Resident #16.

On 4/26/18 at 10:10 AM an interview was completed with the Staff Facilitator/Infection Control Nurse. She reported she had set up the breakfast tray for Resident #16 that morning. She stated she had not seen the fall mat beside the resident's bed when she delivered the tray. She further stated she did not put the floor mat in place beside Resident #16's bed because she did not know it was supposed to be there.

On 4/27/18 at 10:50 AM an observation of Resident #16's room revealed the resident was in bed and the fall mat was not on the floor beside

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F 689	Continued From page 37 her bed. On 4/27/18 at 11:50 AM an interview was completed with the Director of Nursing (DON). She stated she expected that staff would implement documented interventions, including the fall mat and said the staff were educated the day before regarding the placement of the fall mat.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide the	F 693	The facility failed to ensure all residents with enteral feedings had appropriate	5/25/18

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F 693	Continued From page 38 physician and registered dietician ordered enteral feeding amount and water flushes for one (Resident #215) of 5 sampled residents with enteral feeding for nutrition. The findings included: Resident #215 was originally admitted to the facility on 9/26/14 with diagnoses including respiratory failure, ventilator dependency, diabetes and anoxic brain injury. The most recent Minimum Data Set (MDS) a quarterly, dated 2/8/18 indicated Resident #215 was in a persistent vegetative state, required total assistance of 2 staff for turning, transfers, personal hygiene, and bathing. Resident #215 required total assistance of eating by one staff and received total nutrition by a feeding tube. Review of the monthly physician ' s orders for April 2018 indicated Resident #215 was to receive (brand name for an enteral feeding) at 35 milliliters (ML) per hour via a gastrostomy tube. There were no current orders for water flushes to be administered. Observations on 4/23/18 at 11:45 AM revealed the rate on the tube feeding pump was set at 37 ml/hr. (ML per hour). Observations of the open system bag with the enteral feeding was labeled with a rate of 35 ml/hr. Subsequent observations were made on 4/24/18 at 11:45 AM, 4/25/18 at 10:42 AM and 4/25/18 of the tube feeding pump with a set rate of 37 ml/hr. On 4/25/18 at 10:52 AM an interview was conducted with the Nurse #7 (charge nurse on the ventilator unit). Nurse #7 was asked what	F 693	orders for feedings and flushes. The facility staff failed to ensure the correct ordered rate was delivered. The Director of Nursing completed a 100% audit of all residents with enteral feedings to ensure all had appropriate orders for feedings and flushes. All feedings pumps were checked for appropriate tube feeding rates immediately. The facility will provide 100% education of all nurses on the importance of checking orders for rate and flushes and ensuring the pump matches orders. The facility will complete a daily admission audit to ensure physician orders are in place for feedings and flushes for new admissions. Tube feeding audits will be completed to ensure compliance daily x 2 weeks, weekly x 1 month, and monthly x 1 year. The Director of Nursing will present the results of the audit tool to the Monthly QAPI Committee monthly for 1 year. The Director of Nursing, Assistant Director of Nursing, and Unit Managers will implement the above corrective actions.	

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F 693	Continued From page 39	F 693		

was the correct rate for the tube feeding for Resident #215. Nurse #7 explained the electronic chart order was for 35ml/hr. Observations with Nurse #7 of Resident #215 ' s tube feeding pump revealed the rate was set at 37ml/hr. The hard chart was checked for written telephone physician's orders for clarification. Further interview revealed the telephone order was for a rate of 35 ml/hr. Additionally, the resident was to receive 135ml of water flush every 4 hours according to the monthly orders for March. Nurse #7 verified there were no current orders for a water flush to be provided. She explained Resident #215 went to the hospital in April and it was not on the re-admission orders.

Nurse #7 called the Dietary Clinician for clarification of the order for water flushes. The Dietary Clinician verified the tube feeding rate of 35 ml/hr and 135cc of water every 4 hours.

Interview with the Dietary Clinician on 4/25/18 at 1:20 PM revealed her last assessment, dated 2/19/18, indicated Resident #215 needed between 1400 and 1500 ml of water a day. She explained the resident was getting 1450 ml a day. The resident ' s weight was stable and the tube feeding rate was to be 35 ml/hr. Further interview revealed the 2 ml extra of feeding would not impact her nutritional or fluid balance.

Interview with the Director of Nursing on 4/27/18 at 2:05 PM revealed the nurses had an audit form for admissions to check for orders. She explained she didn't know why the nurses didn't catch it. She explained the night shift supervisor did the checks for new admission orders and currently she did not have that position filled.

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F 725	Continued From page 40	F 725		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to provide sufficient nursing staffing for showers and bed baths to be provided to 2 of 7 sampled dependent residents on the ventilator unit. Residents #215 and 31. The findings included:	F 725	The facility failed to provide showers and bed baths for dependent residents on the ventilator unit based on observations and staff interviews. The systems and processes that led to the deficiency include the failure to complete audits that dependent residents' ADL care including	5/25/18

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F 725	Continued From page 41 This tag is cross referenced to F 677. Based on observations, record review and staff interviews the facility failed to provide showers and bed baths for 2 of 7 dependent residents on the ventilator unit. (Residents #31 and 215) a. Resident #31 was originally admitted to the facility on 1/24/18 with diagnoses including stroke, diabetes, respiratory failure with ventilator dependency and pressure ulcers. The Admission Minimum Data Set (MDS) dated 1/31/18 indicated Resident #1 had severe impairment with long and short-term memory and decision-making abilities. He required total assistance of two staff with bed mobility, transfers, personal hygiene and bathing. The MDS indicated he had an indwelling urinary catheter and was always incontinent of bowel. Review of the care plan dated 2/5/18 included a problem of impaired mobility and activities of daily living and scheduled care task with approaches for the nursing assistants (NA ' s) to provide a bath on Monday and Wednesday by first shift, provide personal hygiene, incontinence care for bowel movements and assure that resident is clean, neat appearance and odor free. Observations on 4/23/18 at 11:15 AM revealed Resident #31 received a bed bath. Review of the documentation by the NA ' s for the timeframe of 3/27/18 to 4/26/18 revealed Resident #31 had received one shower, during the week of the survey. During that timeframe he had received 19 bed baths in 5 weeks, with one bath as "refused."	F 725	showers and bed baths were being given. The facility failed to provide disciplinary action for dependent residents' ADL care not given. The facility also failed to educate Unit Managers and staff to allocate other staff members in the building to help provide ADL care for dependent residents as scheduled for these residents. Residents' needs will be met by routine showers and ADL care as specified by regulatory standards. The Director of Nursing met with ventilator staff on coordination of residents care immediately. The facility immediately provided showers to the residents cited in the deficiency. The facility will utilize ancillary nurses, CNA staff (restorative aides, staffing coordinators, scheduler, transportation aides) when there are open positions to ensure showers are given as scheduled. The Unit Managers will assure staff are coordinated in such a manner that showers are provided to residents. The facility will provide 100% education of nursing staff on expectations for showers and for communication with supervisors when tasks are not completed or staffing is insufficient to meet needs. The Director of Nursing performed an audit for the remainder of the building to assure sufficient staffing for showers and bed baths was appropriate to meet the needs of the residents. Shower audit tools will be used facility wide daily x 2 weeks, weekly x 1 month,	

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F 725	Continued From page 42 Interview with NA#2 on 4/26/18 at 10:06 AM revealed when one aide was scheduled to work on the ventilator unit, showers could not be given to the residents. She explained two staff were needed to transfer Resident #31 and provide the shower. Interview with Nurse # 6 revealed there were times she worked with one NA on the ventilator unit. She explained the aides would provide bed baths, but could not give showers. During the interview she explained showers had not been given on the weekends since she had been working due to the lack of a second NA. Interview with the Director of Nursing on 4/27/18 at 1:46 PM revealed the staffing on the ventilator unit was with 2 nurses and 2 aides. The staff would be able to complete the showers and bed baths. An explanation for the lack of showers was not provided. b. Resident #215 was originally admitted to the facility on 9/26/14 with diagnoses including respiratory failure, ventilator dependency, diabetes and anoxic brain injury. The most recent Minimum Data Set (MDS) a quarterly, dated 2/8/18 indicated Resident #215 was in a persistent vegetative state, required total assistance of 2 staff for turning, transfers, personal hygiene, and bathing. The resident had an indwelling urinary catheter and was always incontinent of bowel. The care plan dated 2/15/18 included a problem of requiring total care due to persistent vegetative state as well as a left below the knee amputation.	F 725	and monthly x 1 year. The Director of Nursing will present the results of the audit tool to the Monthly QAPI Committee monthly for 1 year. Unit Managers, Director of Nursing, Assistant Director of Nursing, and Staffing Coordinators will implement the above corrective actions.	

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F 725	Continued From page 43	F 725		

The approach included bed baths on non-shower days to be provided by nursing.

Review of the documentation by the nursing assistants (NA) for the time frame of 3/27/18 to 4/26/18 indicated Resident #215 had received no showers in 5 weeks. Resident #215 had received a total of 47 bed baths and 2 sponge baths.

Review of the bath schedule posted on the ventilator unit revealed it was by room number and bed A or bed B. Resident #215 was supposed to have showers on Saturday on first shift, according to this schedule.

Interview with NA#3 on 4/26/18 at 10:06 AM revealed when one aide was scheduled to work on the ventilator unit, showers could not be given to the residents. She explained two staff were needed to transfer Resident #215 and provide the shower. Further interview revealed each shift was to provide a bed bath for the residents on the unit.

Interview on 4/26/18 at 10:06 AM with NA# 2 revealed she worked every other weekend. For the past three weekends she worked, there was one aide on 300 hall. She explained one aide was unable to turn residents that needed to turn because two staff were required. Two residents had to be fed, which left no aide to assist other residents. She further explained showers could not be given on weekends, because it took two aides to transfer the residents on the unit due to use of a total lift.

Interview n 4/26/18 at 11:15 AM with Nurse # 6 revealed there were times she worked with one NA on the ventilator unit. She explained the aides

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F 725	Continued From page 44	F 725		

would provide bed baths, but could not give showers. During the interview she explained showers had not been given on the weekends since she had been working due to the lack of a second NA. There was a respiratory therapist, but they also worked with residents on other halls, off the ventilator unit.

Interview on 4/27/18 at 7:00 AM with Nurse # 4 revealed if there were 14 or less residents on the vent unit, they would pull one of the nurses and she might work by herself. During the interview, she explained here had not been a night shift supervisor for about 3 weeks. There would be no one to relieve her so she can go off the unit for a break/eat. The acuity of the residents, if new residents and if they are sick can make for a busy shift. Some residents needed to be suctioned 10 to 15 times in her shift, the trachs could pop out and needed to be replaced, alarms would go off (ventilator alarms) and the residents had to be checked due to the vent was their life support. If she had one aide, she had to assist with rounds. The aide cannot turn or give incontinence care alone. She had to ask the aides when their next round would be, adjust her medication times and respond to alarms, suctioning etc. She recognizes the unit is stressful and the fatigue shows on other staff as well. There was one respiratory therapist on night shift, but that person also worked on other halls during the night with other residents.

Interview with the Director of Nursing on 4/27/18 at 1:46 PM revealed the staffing on the ventilator unit was with 2 nurses and 2 aides. The staff would be able to complete the showers and bed baths. An explanation for the lack of showers

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F 725	Continued From page 45 was not provided. The Director of Nursing explained she had total hours for nurses and aides was 5.5 ppd. She explained she had a total of 6 vacant nurse position and about 12 to 15 NA positions vacant. Staffing was based on the census, she would do the math, and staff accordingly.	F 725		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility's Quality Assessment and Assurance Committee (QA and Q) failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 3/30/17, in order to achieve and sustain compliance. This was for one recited deficiency on a recertification survey on 4/27/18. The	F 865	The facility had continued failure during two surveys of record which showed a pattern of the inability to sustain an effective Quality Assurance Program. The facility will maintain a functional QAPI program to ensure areas of deficiency are monitored.	5/25/18

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F 865	Continued From page 46 deficiency was in the area of resident assessment. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F280: The recertification survey on 2/16/17 cited the facility for failure to update the care plan to include the use of an indwelling urinary catheter for one of three sampled residents reviewed with urinary catheters. Resident #3 The recertification survey on 4/27/18 cited the facility at F 657 for failure to update a care plan for 2 of 31 residents. 1. The care plan for Resident #44 was not updated to resolve an infection with use of intravenous antibiotics and 2. The care plan for Resident #53 was not updated for a problem of lymphedema and use of equipment to reduce swelling of the lower extremities. Interview with the Administrator on 4/27/18 at 4:42 PM revealed there was no current plan in place to monitor care plans for updates. upuup	F 865	The facility will provide 100% education of all QAPI members on the QAPI processes. Corporate Regional Team will assess QAPI tools and minutes to ensure compliance each month for 1 year. Written Documentation of QAPI meetings will be maintained monthly to provide evidence of tools and performance improvement. All committee members will present their monitoring processes to QAPI meetings monthly and sooner if needed. The Administrator and Assistant Administrator will implement the above corrective actions.	
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	F 880		5/25/18

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F 880	Continued From page 47	F 880		

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.
(v) The circumstances under which the facility

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	345443	A. BUILDING _____ B. WING _____	C 04/27/2018

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F 880	Continued From page 48 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 and staff interviews the facility failed to follow procedures for contact isolation by a housekeeping staff member during routine cleaning of one of two rooms for residents on contact isolation. The findings included: Resident # 219 was admitted to the facility on 4/23/18 with diagnosis of sepsis, colitis and Clostridium Difficile (C. diff). The admission orders included use of contact enteric precautions due to C. diff. Observations on 4/25/18 at 1:30 PM revealed a sign was posted on the resident ' s door for use of a gown and gloves when entering the resident ' s room. The sign instructed to wash hands before and after entering the resident ' s room, remove the gown and gloves before leaving the room.	F 880	A housekeeper failed to follow contact isolation procedures during cleaning a resident's room. The housekeeper was immediately trained on utilizing the proper PPE for cleaning a resident room on isolation. The facility audited other isolation rooms for staff compliance immediately. The facility will provide 100% education to all staff on isolation precautions and infection prevention. An Infection control audit will be completed to ensure staff are educated and in compliance with isolation precautions and infection prevention weekly x 1 month and monthly x 1 year.	

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F 880	Continued From page 49 Observations on 4/27/18 at 8:15 AM of housekeeper #2 revealed she was in Resident#219's room. She was observed to have on a gown and gloves. During observations housekeeper #2 exited the resident ' s room, entered the hallway and swept paper trash into a dust pan, emptied the dust pan into her trash container on the cart. She proceeded to get the mop out of the bucket of water and entered the room to mop the floor. After mopping, she returned to the hallway, put the mop in the bucket on the cart, and removed her gown and gloves while in the hall. Housekeeper #2 took the bagged trash to the dirty utility. Continued observations revealed she washed her hands after depositing the trash, went to the housekeeping cart, rolled it down the hall to housekeeper ' s closet. Observations of housekeeper #2 revealed she changed mop head and water in bucket, rinsed out the bucket with a hose and then washed her hands. No gloves were used to remove the dirty mop head or rinse the water bucket. Interview with the Director of Housekeeping on 4/27/18 at 8:49 AM revealed the housekeeper should have changed gown and gloves before she came out of the room. She explained housekeeper #2 should have used gloves to remove the mop head and clean the bucket. Further interview revealed the housekeeper had been trained and knew what was expected when cleaning a room with contact precautions. Interview with the Administrator on 4/27/18 at 8:54 AM revealed the housekeepers have been instructed to pull the cart to the room door, and they could access the cart/supplies without leaving the room.	F 880	The Infection Control nurse will present the results of the audit tool to the Monthly QAPI Committee monthly for 1 year. The Infection Control Nurse will implement the above corrective actions.	

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F 880	Continued From page 50 Interview on 4/23/18 at 9:31 AM with the Infection Control Nurse revealed the sign on door instructs staff how to dress before they go into a room with contact precautions. She would expect the staff to take all of that (gown/gloves) off if they came out of a room. The staff would then be expected to re-dress with a gown and gloves to go back into the room.	F 880		