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F 000	INITIAL COMMENTS A complaint survey was conducted from 07/25/18 through 07/28/18. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity J CFR 483.25 at tag F686 at a scope and severity J The tags F600and F686 constituted Substandard Quality of Care. CFR 483.12 at tag F600 at a scope and severity J CFR 483.25 at tag F686 at a scope and severity J An extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff and Resident Representative (RR) interviews, and Nurse Practitioner interview, the facility neglected to	F 600	Past noncompliance: no plan of correction required.	8/16/18

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

Electronically Signed | 08/17/2018

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treat and monitor multiple pressure ulcers and neglected to attempt alternate measures to address a resident's refusals of treatment for 1 of 3 residents reviewed for pressure ulcers (Resident #3). The facility's failure to treat the wounds and address the resident's refusals to allow wound treatments as ordered resulted in maggots developing in one of the resident's wounds. Resident #3 was observed with maggots present in the pressure ulcer on his right upper leg and was transferred to the hospital for evaluation and treatment.

Findings included:

A review of the medical record revealed Resident #3 was re-admitted to the facility on 7/6/2018 from an acute long term care hospital with active diagnoses of chronic osteomyelitis (infection of the bone) of left ankle and foot and peripheral vascular disease (a blood circulation disorder).

A review of Resident #3's medical record revealed no assessment of the resident's pressure ulcers on admission to the facility on 07/06/18.

A review of Resident #3's physician orders revealed an order, written on 7/6/2018, to treat the pressure ulcer on the resident's right upper leg in the following manner; cleanse right upper leg with wound cleanser. Apply duoderm (a type of dressing), every Monday and Friday and when necessary (prn).

Further review of Resident #3's 07/06/18 readmission physician orders revealed an order for treatment of each of the resident's pressure ulcers including type of cleanser and frequency of

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treatments. There were a total of 22 treatments listed individually. The frequency of treatment varied but all 22 were to be checked on the days they were not treated.

The Admission Minimum Data Set (MDS) assessment dated 7/13/2018 noted Resident #3 was severely impaired for cognition, rejected care 1-3 days out of 7 days and needed total assistance for all Activities of Daily Living (ADLs) with the physical assistance of two persons. The MDS indicated Resident #3 had multiple pressure ulcers and had a pressure reducing device for the bed and chair, and that nutrition interventions to manage skin problems were in place. The Care Area Assessment (CAA) for Pressure Ulcers dated 7/13/18 indicated a focus on pressure ulcers and the facility would address the area of pressure ulcers on the resident's plan of care.

Review of Resident #3's current plan of care (dated 5/1/18) revealed it contained a "Focus" area of pressure ulcers related to chronic peripheral vascular disease and a goal of: pressure ulcers will show positive healing with reduction in size/stage of pressure ulcer through next review. The care plan interventions included; Treatment as ordered by physician. Weekly assessment of wound/ulcer. Notify physician of changes as indicated.

Further review of Resident #3's current care plan (dated 5/31/18) revealed it contained a "Focus" area which address the resident's refusals of all treatments at all times. The goal specified Resident #3 will receive care within resident's choices and preferences through next review. The interventions included: Document care being resisted per facility protocol and notify physician

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of patterns in behavior. Discuss with resident implications of not complying with therapeutic regimen. Elicit family input for best approaches to resident. Allow for flexibility in routines. If resident refuses care, try again later.

A review of Resident #3's Treatment Administration Record (TAR) from 7/6/18 to 7/16/18 revealed the pressure ulcer on his right upper leg and his other pressure ulcers were documented as being treated only on one occasion which was on 7/11/18. The TAR specified Resident #3 refused treatment to all of his other pressure ulcers or would not allow staff to check any of his pressure ulcers on the following dates; 7/7/18, 7/8/18, 7/9/18, 7/10/18, 7/12/18, 7/13/18, 7/14/18, 7/15/18 and 7/16/18. The reverse side of the resident's TAR noted the initials and signature of Treatment Nurse #1 and documentation that all treatments were refused on the dates noted above and that the Resident's Representative and Physician were notified of all of the resident's refusals.

A review of the progress notes revealed a note written on 7/11/2018, by Treatment Nurse #1, as a Skin/Wound/Treatment Note, which was a list of Resident #3's pressure ulcers and other wounds. The documentation included: Right leg (upper) unstageable; 2.5 cm (centimeters) x 1.5 cm with 100% brown slough (a layer of dead tissue surrounded by living tissue); peri wound intact; no signs/symptoms (s/s) of infection at this time; cleanse area with wound cleanser and apply santyl foam and absorbent dressing every other day and when necessary. This was the only wound assessment found in the resident's electronic health record system after 07/06/18 (his readmission).

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A progress note dated 7/14/2018, written by Treatment Nurse #1, specified Treatment Nurse #1 discussed the importance of receiving dressing changes with Resident #3, and he verbalized understanding, however, Resident #3 refused and stated "maybe tomorrow." The note continued with the RR was made aware of the resident's refusals via telephone and indicated she would come talk to Resident #3.

A progress notes dated 7/17/18, written by the Director of Nurses (DON) revealed Resident #3 was transferred to the local hospital for possible wound debridement and the Resident's Representative was notified.

A review of hospital records revealed Resident #3 was transported to a local hospital Emergency Department (ED) on 7/18/2018. The resident's ED records revealed the Emergency Medical Services (EMS) that transported Resident #3 to the ED reported the facility indicated there were maggots found in one of the resident's pressure ulcers. Resident #3 was admitted to the hospital with diagnoses of sepsis, cellulitis and decubitus ulcers.

On 7/27/2018 at 9:10 AM, the Quality Improvement (QI) Nurse was interviewed and stated she and Treatment Nurse #2 went into Resident #3's room on 7/17/2018 to do his treatments because Treatment Nurse #1 was not at the facility. The QI Nurse indicated she took the dressing off of Resident #3's right upper leg (the QI Nurse indicated the area to be on the outer upper area of the thigh/leg). The QI Nurse stated the dressing was loose and soiled heavily with wet, brown drainage. The QI Nurse stated "I

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pulled off the dressing on his right upper leg and saw about 15 maggots in the wound." The QI Nurse stated she knew what maggots looked like and she covered the wound and she and Treatment Nurse #2 went out and called the Director of Nursing (DON). The QI nurse stated no other wounds had maggots in them and no other wounds had drainage or loose dressings, but all of the wounds were treated as ordered.

In an interview on 7/27/2018 at 9:30 AM, Treatment Nurse #2 stated on 07/17/18 she and the QI nurse went to Resident #3's room and told him why she was there and he agreed to the treatment. Treatment Nurse #2 stated she had not taken care of Resident #3 because she worked the upper halls of the facility. Treatment Nurse #2 stated all of the dressings on Resident #3's body were dated 7/11/18. Treatment Nurse #2 indicated the right upper leg dressing was soiled and loose. Nurse #1 stated the pressure ulcer did have an odor but did not appear to be infected. Nurse #1 also noted she observed maggots in the wound, the DON was notified and she and a Nurse supervisor came and cleaned and re dressed all of the resident's pressure ulcers.

A telephone interview was attempted with the Treatment Nurse #1 on 7/27/2018 at 11:00 AM. The Treatment Nurse answered and then stated she no longer worked at the facility, she had been fired and ended the call.

On 7/27/2018 at 1:25 PM, in an interview, Nursing Assistant (NA) #3 stated she had cared for Resident #3 multiple times since his readmission to the facility on 07/06/18. NA #3 stated she usually gave the resident a bed bath at about

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9:30 AM each day. NA #3 indicated she would take the bathing supplies in and tell him she was going to do his bath and he was always agreeable when she would let him know before she started providing the bath. NA #3 stated while giving Resident #3 his bed bath on Monday 7/16/18 she noticed the dressings on his body were still dated 7/11/18. NA #3 stated she was working on 7/17/18 and Resident #3 refused his bath that morning and she went back in the afternoon and he refused and stated he did not feel good. NA #3 stated she had told Nurse #2 on 7/16/18 the dressings were dated 7/11/18.

In a telephone interview on 7/27/2018 at 3:40 PM, Nurse #2 stated NA #3 did tell her about the dates on Resident #3's dressings on 7/16/18. Nurse #2 stated she was not sure, but thought that she told the Treatment Nurse #1, who was there that day.

On 7/27/2018 at 4:00 PM, the Administrator was interviewed and stated the Treatment Nurse #1 had been terminated relating to falsifying documents that were unrelated to Resident #3. The Administrator stated she could not verify the documentation for Resident #3 was valid for the care Treatment Nurse #1 provided or the resident's refusals to allow staff to perform dressing changes or check the resident's pressure ulcers. The Administrator stated her expectations were all treatments would be completed as ordered.

In an interview on 7/27/2018 at 4:05 PM, the Resident Representative (RR) stated since the resident's readmission to the facility on 07/06/18 she had only received one phone call from staff, which was on 7/14/2018, to inform her that

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Resident #3 had refused his wound treatments. The RR stated she had filed a grievance on 7/16/18 because Resident #3's wounds were not being treated. The RR indicated she was told if Resident #3 refused his treatment, the staff could educate him, but could not force him.

On 7/27/2018 at 4:20 PM, in an interview, the Nurse Practitioner (NP) stated she had referred Resident #3 for management of his pressure ulcers to the wound clinic and Infectious Disease physician when he was admitted. The NP did not recall if she was notified about his Resident #3's refusals of treatment, but did say she spoke to Resident #3 on 7/16/2018 about his refusing treatment. The NP stated she spoke to the MD about Resident #3 having an elevated temperature on 07/16/18 and the physician agreed the resident would be started on an antibiotic. The NP stated she did not look at the pressure ulcers on 07/16/18.

On July 28, 2018 the facility provided the following plan of correction with a compliance date of 7/24/2018:

On 7/17/18 at 2:55pm Treatment nurse #2 and the QI nurse entered resident #3 room to change resident #3 dressings. Treatment nurse #2 and the QI nurse began to undress resident #3 wounds. Dressing to resident #3 right upper thigh noted to be secure at the base of the dressing but not secured at the top of the dressing. Upon removing resident #3 dressing to right upper thigh, white larvae approximately 0.5cm in length in the wound was noted. The QI nurse exited resident #3 room and notified the DON of the

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larvae.
On 7/17/2018 the DON notified RR and physician and assessed and measured the wound by 8:15 pm and order was received by the physician to send to the Emergency Room for evaluation.
On 7/18/18 Resident #3 was admitted to the local hospital with a diagnosis of Sepsis, cellulitis, and decubitus ulcers.
A thorough investigation was initiated on 7/17/2018 to identify the root cause of fly larva in the residents wound. During the investigation it was found that resident #3 wounds were not assessed on admission and wound care was only provided once in eleven days by treatment nurse #1 prior to larvae being discovered in a wound. It was determined by the Administrator that the cause was the failure of treatment nurse #1 to continuously seek alternatives to aide in the encouragement of resident #3 compliance with wound care. The licensed nurse failed to seek alternate treatment options due to a systematic failure of educating the licensed nurses on the process of actions to take when a resident refuses care or treatments.
Treatment Nurse #1 was terminated on 7/24/18 for other reasons.

Corrective Actions
On 7/23/18, all alert and oriented residents were interviewed regarding neglect by the Activity Staff and Social Workers. There were no negative findings.

All current residents with wounds were physically assessed on 7/18/2018 and completed on 7/20/18 by the Quality Improvement (QI) nurse, West Wing Treatment nurse, and Registered Nurse (RN) to ensure wound care had been completed and no signs or symptoms of

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worsening of wounds. All wounds were measured and documented in each resident's electronic record. No issues were identified.
On 7/20/18 a 100% audit of all current residents progress notes x 30 days was completed by the Wound Consultant to determine if any resident had been refusing wound care. There were no other residents identified in the progress notes that refused wound care.
On 7/21/18 a 100% audit of all current residents Treatment Administration Records for the month of June and July, was completed by the Director of Nursing to identify any refusals of wound care. There were three other residents identified that refused wound care at times in the progress notes. The care plan was updated on 7/21/18 by the MDS nurse to address alternatives to aide in the encouragement of resident allowing wound care.
A head to toe assessment was completed on 100% of all residents on 7/21/18 by the Assistant Director of Nursing and RN Supervisor to identify all residents with wounds. There were two residents identified with wounds that had not been addressed. The two identified wounds were assessed, documented, measured, treatment initiated and the physician and resident representative was notified on 7/21/18 by the treatment nurse.
On 7/21/18, a questionnaire was initiated by the SF with 100% of all license nurses and medication aides to validate knowledge and understanding of steps to take when a resident refuses wound care. Retraining was completed by the SF during the time of the questionnaire for any identified areas of concerns.
On 7/23/18, an in-service was initiated for 100% of all staff to include license nurses, agency nurses, nursing assistants, housekeeping,

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dietary, therapy, maintenance, pay roll, book keeper, social workers, was initiated by the SF regarding Neglect to include examples of neglect, prevention of neglect, and notification. This in-service was completed by 7/24/18.

On 7/19/18, the facility revised the Nursing Admission Assessment form to ensure the admitting nurse assess, document, and measure all residents with wounds on admission.
On 7/19/18 an in-service was initiated by the Wound Nurse Consultant for the Administrator, the Director of Nursing (DON), and Staff Facilitator (SF) in regards to the revised Nursing Admission Assessment to include:
1. Upon admission, the admitting nurse will do a full skin assessment of all wounds to include location, description, and measurements.
2. The treatment nurse will complete a second skin assessment to validate or clarify location, description and measurement of all wounds and document on the applicable flow sheet.
This in-service was completed by 7/19/18.
The in-service in regards to the revised Nursing Admission assessment was initiated with all other licensed nurses to include agency nurses on 7/19/18 by the Staff Facilitator. This in-service was completed by 7/22/18.
On 7/18/18 a 100% in service for all licensed nurses to include agency nurses was initiated by the DON in regards to Notification of refusals to include:
1. Each time medications, treatments, or any form of care is refused by a resident it must be reported to the RR and the provider.
2. Nurses must document all refusals of care to include notification of RR and MD
This in-service was completed by 7/22/18.
On 7/21/18 an in-service was initiated with all

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F 600	Continued From page 11 license nurses to include agency nurses and Medication Aides regarding Alternatives for residents that resist wound care. This in-service was completed by 7/22/18. This in-service included: " People may refuse help from some but not others " Give clear explanations and repeat ourselves as necessary " Work at building a closer relationship with the individual, showing that they are valued as a person and not just seen as a focus for a care task " Ensure that we are going at a pace with which the person feels comfortable and safe, and are respecting their modesty as much as possible. " When necessary seek a staff member that resident trust to encourage wound care " Family involvement-notify family and get family involved to come and encourage the resident. Ask family for ideas that will motivate the resident to agree to wound care. " Explain the risk factors of not allowing wound care to residents " Explore if resident is fearful and reason why " Be patient, allow the resident time to process requests or tasks to be complete or questions to answer " Assess for pain and ensure resident has adequate pain control prior to treatment/care " Notify MD for pain orders if resident complains of pain not relieved with prn pain medication. " Psych consult " Wound clinic referrals ***Note: Most of these alternatives can be utilized for resistance to other types of care as appropriate.	F 600		

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The decision to monitor the system for wound care was made on 7/22/2018 by the Administrator and Director of Nursing. 25% of residents with wounds will be physically assessed and documentation on the TAR, progress notes and wound ulcer flow sheet will be reviewed by the ADON, SF, RN Supervisor, or Quality Improvement Nurse 3 x per week x 4 weeks, weekly x 4 weeks, then monthly x 1 month utilizing a Wound Care Audit Tool. This audit is to ensure all wounds have been identified, wound care has been completed per physician's orders, alternatives attempted to encourage residents that refuses, no larvae and no signs and symptoms of worsening of wounds. Any areas of concern identified during the audits will be addressed during the audit by the ADON, SF, RN Supervisor, or Quality Improvement Nurse to include providing additional staff training. The DON will review and initial the Wound Care Audit Tools weekly x 12 weeks for completion and to ensure all areas of concern were addressed.
The Quality Improvement Organization was contacted by the administrator as witnessed by the Regional Vice President of Operations on 7/27/18 for assistance in evaluation of specific steps to be taken to address neglect and training, staff position/title designated to be responsible for the steps, timeline for accomplishment of the steps, specific methodology to be used to evaluate the plan's success, and frequency of monitoring the effects of the plan initiation.
The DON will present the findings of the Wound Care Audit Tools to the Executive Quality Assurance (QA) committee monthly for 3 months.
The Executive QA Committee will meet monthly for 3 months and review the Wound Care Audit Tools to determine trends and/or issues that may

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F 600	Continued From page 13 need further interventions put into place and to determine the need for further frequency of monitoring. The decision to review the monitoring of wound care during the quality assurance committee meeting was made by the Administrator and Director of Nursing on 7/22/2018. Final date of compliance is 7/24/2018. The Administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. Validation of the above referenced plan of correction was completed on 7/28/2018 during an extended survey. Validation included staff interviews regarding residents refusing care and residents refusing treatments. In-services regarding Admission Assessments were reviewed. In-service for staff regarding notification of refusals. Staff were interviewed regarding in-service for neglect and for notification. Wound care audit tools were reviewed that will be and are used 3 x per week for 4 weeks, weekly x 4 weeks, then monthly x 1 month as stated in the plan of correction. The date of 07/24/18 was validated as the facility's date of compliance.	F 600		
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 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff	F 677	Hunter Hills Nursing and Rehabilitation	8/17/18

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F 677	Continued From page 14 interviews, the facility failed to provide incontinence care in a front to back manner during perineal care for 1 of 3 sampled residents (Resident #2) dependent on staff for incontinent care. Findings included: Resident #2 was re-admitted to the facility 7/2/18. Review of a Quarterly MDS (Minimum Data Set-a tool used to assess residents) dated 7/9/18 revealed Resident #2 was severely cognitively impaired, and required extensive to total assistance for all Activities of Daily Living (ADLs). Resident #2 was always incontinent of stool and urine. A care plan initiated 5/16/18 included a focus of Assistance required for ADLs/Personal Care due to impaired cognition, weakness. Stated goals included ADLs/Personal Care will be completed with staff support as appropriate to maintain or achieve highest practical level of functioning. Interventions included total dependence for bathing, personal hygiene, and dressing. An observation of Resident #2 was made on 7/25/18 at 3:00 PM. She was observed leaned forward in a high backed chair in the dining room, food debris which resembled vomitus was seen in her lap, and she appeared to be sleeping. NA #1 (Nursing Assistant #1) was in the dining room and brought Resident #2 to her room for ADL care. After the brief was removed, Resident #2 was incontinent of stool. A continuous observation was conducted from 3:15 PM through 3:50 PM of incontinent care,	F 677	acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Corrections is submitted as a written allegation of compliance. Hunter Hills Nursing and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Hunter Hills Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The process that led to this deficiency was the facility failed to provide incontinent care in a front to back manner during perineal care for 1 of 3 sampled residents. On 8/16/18 Resident #2 was provided perineal care utilizing appropriate technique by the assigned nursing assistant. On 8/15/18 Nursing Assistant #2 (NA) was in-serviced in regards to Perineal Care to include providing incontinent care in a front to back manner with return demonstration by the Staff Facilitator. On 8/10/18 a 100% Resident Care Audit	

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F 677	Continued From page 15 bathing and ADL care by NA #1 and NA #2. The resident was transferred from the chair to the bed and was undressed by NA #2. She washed her hands, donned gloves, and bathed the resident. NA #2 washed the perineal area using a circular motion going from the rectal area to the vaginal area (back to front) and back and forth again using a circular motion. An interview was conducted with NA #1 on 7/25/18 at 4:10 PM. She stated, "You wash from the top (face) down. You keep the resident covered from the waist down, wash the top, rinse and dry. Then cover the resident, change washcloths and do the bottom. The private areas are last. Always wash the privates from front to back. First wipe down each side, then go down the middle. Never go in a circle and never go back to front." An interview was conducted with NA #2 on 7/25/18 at 4:15 PM. She stated she had not properly completed care because she was nervous. She stated she knew the proper way to bathe and dress a resident, but was too nervous to do it today and also correctly described incontinent care and bathing but was too nervous today. She stated she washed Resident #2's perineal area in circles and back to front." An interview was conducted with the Director of Nursing (DON) on 7/25/18 at 6:55 PM. She stated staff were trained during orientation on proper incontinent care to avoid a potential urinary tract infection, were observed by more senior NA's during the orientation period, and were in-serviced annually and as needed. The DON also stated her expectation was for all NA's to provide incontinent care in a way to prevent	F 677	of Incontinent Care to include NA #2 and resident #2 was initiated by the Staff Facilitator, Nurse Managers and Quality Assurance nurse (QA) with all nurses and NAs to ensure staff are utilizing appropriate technique when providing perineal care. All areas of concern were immediately addressed by the Staff Facilitator, Nurse Managers and QA nurse to include retraining of staff. Resident care audits will be completed by 8/23/18. On 8/10/18 an 100% in-service was initiated by the Nurse Managers with all nurses and NAs to include NA #2 in regards to Perineal Care to include: 1. Explain procedure to resident 2. Provide privacy 3. Expose perineal area 4. Wash perineal area with soap and water or pericare products a. For the female resident: cleanse the labia with strokes from top to bottom then rinse b. For the male resident: cleanse the penis then rinse 5. Discard soiled items in appropriate containers 6. Removed soiled gloves 7. Wash hands and reapply clean gloves before continuing care 8. Apply clean brief/clothes 9. Make resident comfortable In-service will be completed by 8/23/18. All newly hired nurses and NAs will be in-serviced by the Staff Facilitator during orientation in regards to Perineal Care to include:	

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F 677	Continued From page 16 potential urinary tract infections by cleansing the resident from front to back and not in a circular or back to front motion.	F 677	1. Explain procedure to resident 2. Provide privacy 3. Expose perineal area 4. Wash perineal area with soap and water or pericare products a. For the female resident: cleanse the labia with strokes from top to bottom then rinse b. For the male resident: cleanse the penis then rinse 5. Discard soiled items in appropriate containers 6. Removed soiled gloves 7. Wash hands and reapply clean gloves before continuing care 8. Apply clean brief/clothes 9. Make resident comfortable 10% Resident Care Audits of Incontinent Care will be completed by the Staff Facilitator, Nurse Managers, and Quality Assurance Nurse (QA) with nurses and NAs to include NA #2 and resident #2 utilizing the Resident Care Audit Tool-Incontinent Care to ensure staff are utilizing appropriate technique when providing perineal care weekly x 8 weeks, then monthly x 1 month. The Director of Nursing will review and initial the Resident Care Audit Tool-Incontinent Care weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will forward the results of the Resident Care Audit Tool-Incontinent Care to the Executive QA Committee monthly x 3 months. The	

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F 677	Continued From page 17	F 677	Executive QA Committee will meet monthly x 3 months and review the Resident Care Audit Tool-Incontinent Care to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 686 SS=J	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Resident Representative (RR) interviews, and Nurse Practitioner interview, the facility failed to treat and monitor multiple pressure ulcers and did not implement measures to address a resident's refusals of treatment for 1 of 3 residents reviewed for pressure ulcers (Resident #3). The facility did not treat and change pressure ulcer dressings as ordered and did not monitor a pressure ulcer to prevent maggots from developing in the wound. When the resident refused treatment the facility did not contact the resident's representative as	F 686	Past noncompliance: no plan of correction required.	8/16/18

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specified in the resident's care plan to elicit their input. Failure to treat and check Resident #3's pressure ulcers allowed maggots to be present in one of the resident's wounds. Resident #3 was transferred to the hospital for evaluation and treatment.

Findings included:

A review of the medical record revealed Resident #3 was re-admitted to the facility on 7/6/2018 from an acute long term care hospital with active diagnoses of chronic osteomyelitis (infection of the bone) of left ankle and foot and peripheral vascular disease (a blood circulation disorder).

A review of Resident #3's medical record revealed no assessment of the resident's pressure ulcers on admission to the facility on 07/06/18.

A review of Resident #3's physician orders revealed an order, written on 7/6/2018, to treat the pressure ulcer on the resident's right upper leg in the following manner; cleanse right upper leg with wound cleanser. Apply duoderm (a type of dressing), every Monday and Friday and when necessary (prn).

The Admission Minimum Data Set (MDS) assessment dated 7/13/2018 noted Resident #3 was severely impaired for cognition, rejected care 1-3 days out of 7 days and needed total assistance for all Activities of Daily Living (ADLs) with the physical assistance of two persons. The MDS indicated Resident #3 had multiple pressure ulcers and had a pressure reducing device for the bed and chair, and that nutrition interventions to manage skin problems were in place. The Care

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Area Assessment (CAA) for Pressure Ulcers dated 7/13/18 indicated a focus on pressure ulcers and the facility would address the area of pressure ulcers on the residents' plan of care.

Review of Resident #3's current plan of care (dated 5/1/18) revealed it contained a "Focus" area of pressure ulcers related to chronic peripheral vascular disease and a goal of: pressure ulcers will show positive healing with reduction in size/stage of pressure ulcer through next review. The care plan interventions included; Treatment as ordered by physician. Weekly assessment of wound/ulcer. Notify physician of changes as indicated.

Further review of Resident #3's current care plan (dated 5/31/18) revealed it contained a "Focus" area which address the resident's refusals of all treatments at all times. The goal specified Resident #3 will receive care within resident's choices and preferences through next review. The interventions included: Document care being resisted per facility protocol and notify physician of patterns in behavior. Discuss with resident implications of not complying with therapeutic regimen. Elicit family input for best approaches to resident. Allow for flexibility in routines. If resident refuses care, try again later.

A review of Resident #3's Treatment Administration Record (TAR) from 7/6/18 to 7/16/18 revealed the pressure ulcer on his right upper leg and his other pressure ulcers were documented as being treated only on one occasion which was on 7/11/18. The TAR specified Resident #3 refused treatment to all of his other pressure ulcers or would not allow staff to check any of his pressure ulcers on the

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following dates; 7/7/18, 7/8/18, 7/9/18, 7/10/18, 7/12/18, 7/13/18, 7/14/18, 7/15/18 and 7/16/18. The reverse side of the resident's TAR noted the initials and signature of Treatment Nurse #1 and documentation that all treatments were refused on the dates noted above and that the Resident's Representative and Physician were notified of all of the resident's refusals.

A review of the progress notes revealed a note written on 7/11/2018, by Treatment Nurse #1, as a Skin/Wound/Treatment Note, which was a list of Resident #3's pressure ulcers and other wounds. The documentation included: Right leg (upper) unstageable; 2.5 cm (centimeters) x 1.5 cm with 100% brown slough (a layer of dead tissue surrounded by living tissue); peri wound intact; no signs/symptoms (s/s) of infection at this time; cleanse area with wound cleanser and apply santyl foam and absorbent dressing every other day and when necessary. This was the only wound assessment found in the resident's electronic health record system from 07/06/18 (his readmission).

A progress note dated 7/14/2018, written by Treatment Nurse #1, specified Treatment Nurse #1 discussed the importance of receiving dressing changes with Resident #3, and he verbalized understanding, however, Resident #3 refused and stated "maybe tomorrow." The note continued with the RR was made aware of the resident's refusals via telephone and indicated she would come talk to Resident #3.

A progress notes dated 7/17/18, written by the Director of Nurses (DON) revealed Resident #3 was transferred to the local hospital for possible wound debridement and the Resident's

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Representative was notified.

A review of hospital records revealed Resident #3 was transported to a local hospital Emergency Department (ED) on 7/18/2018. The resident's ED records revealed the Emergency Medical Services (EMS) that transported Resident #3 to the ED reported the facility indicated there were maggots found in one of the resident's pressure ulcers. Resident #3 was admitted to the hospital with diagnoses of sepsis, cellulitis and decubitus ulcers.

On 7/27/2018 at 9:10 AM, the Quality Improvement (QI) Nurse was interviewed and stated she and Treatment Nurse #2 went into Resident #3's room on 7/17/2018 to do his treatments because Treatment Nurse #1 was not at the facility. The QI Nurse indicated she took the dressing off of Resident #3's right upper leg (the QI Nurse indicated the area to be on the outer upper area of the thigh/leg). The QI Nurse stated the dressing was loose and soiled heavily with wet, brown drainage. The QI Nurse stated "I pulled off the dressing on his right upper leg and saw about 15 maggots in the wound." The QI Nurse stated she knew what maggots looked like and she covered the wound and she and Treatment Nurse #2 went out and called the Director of Nursing (DON). The QI nurse stated no other wounds had maggots in them and no other wounds had drainage or loose dressings, but all of the wounds were treated as ordered.

In an interview on 7/27/2018 at 9:30 AM, Treatment Nurse #2 stated on 07/17/18 she and the QI nurse went to Resident #3's room and told him why she was there and he agreed to the treatment. Treatment Nurse #2 stated she had

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not taken care of Resident #3 because she worked the upper halls of the facility. Treatment Nurse #2 stated all of the dressings on Resident #3's body were dated 7/11/18. Treatment Nurse #2 indicated the right upper leg dressing was soiled and loose. Nurse #1 stated the pressure ulcer did have an odor but did not appear to be infected. Nurse #1 also noted she observed maggots in the wound, the DON was notified and she and a Nurse supervisor came and cleaned and re dressed all of the resident's pressure ulcers.

A telephone interview was attempted with the Treatment Nurse #1 on 7/27/2018 at 11:00 AM. The Treatment Nurse answered and then stated she no longer worked at the facility, she had been fired and ended the call.

On 7/27/2018 at 1:25 PM, in an interview, Nursing Assistant (NA) #3 stated she had cared for Resident #3 multiple times since his readmission to the facility on 07/06/18. NA #3 stated she usually gave the resident a bed bath at about 9:30 AM each day. NA #3 indicated she would take the bathing supplies in and tell him she was going to do his bath and he was always agreeable when she would let him know before she started providing the bath. NA #3 stated while giving Resident #3 his bed bath on Monday 7/16/18 she noticed the dressings on his body were still dated 7/11/18. NA #3 stated she was working on 7/17/18 and Resident #3 refused his bath that morning and she went back in the afternoon and he refused and stated he did not feel good. NA #3 stated she had told Nurse #2 on 7/16/18 the dressings were dated 7/11/18.

In a telephone interview on 7/27/2018 at 3:40 PM,

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Nurse #2 stated NA #3 did tell her about the dates on Resident #3's dressings on 7/16/18. Nurse #2 stated she was not sure, but thought that she told the Treatment Nurse #1, who was there that day.

On 7/27/2018 at 4:00 PM, the Administrator was interviewed and stated the Treatment Nurse #1 had been terminated relating to falsifying documents that were unrelated to Resident #3. The Administrator stated she could not verify the documentation for Resident #3 was valid for the care Treatment Nurse #1 provided or the resident's refusals to allow staff to perform dressing changes or check the resident's pressure ulcers. The Administrator stated her expectations were all treatments would be completed as ordered.

In an interview on 7/27/2018 at 4:05 PM, the Resident Representative (RR) stated since the resident's readmission to the facility on 07/06/18 she had only received one phone call from staff, which was on 7/14/2018, to inform her that Resident #3 had refused his wound treatments. The RR stated she had filed a grievance on 7/16/18 because Resident #3's wounds were not being treated. The RR indicated she was told if Resident #3 refused his treatment, the staff could educate him, but could not force him.

On 7/27/2018 at 4:20 PM, in an interview, the Nurse Practitioner (NP) stated she had referred Resident #3 for management of his pressure ulcers to the wound clinic and Infectious Disease physician when he was admitted. The NP did not recall if she was notified about his Resident #3's refusals of treatment, but did say she spoke to Resident #3 on 7/16/2018 about his refusing

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treatment. The NP stated she spoke to the MD about Resident #3 having an elevated temperature on 07/16/18 and the physician agreed the resident would be started on an antibiotic. The NP stated she did not look at the pressure ulcers on 07/16/18.

On 7/28/2018 the facility provided the following plan of correction with a compliance date of 7/22/2018:

On 7/17/18 at 2:55 PM Treatment nurse #2 and the QI nurse entered Resident #3's room to change Resident #3's dressings. Treatment nurse #2 and the QI nurse began to undress Resident #3 wounds. Dressing to Resident #3 right upper thigh noted to be secure at the base of the dressing but not secured at the top of the dressing. Upon removing Resident #3 dressing to right upper thigh, white larvae approximately 0.5 cm in length in the wound was noted. The QI nurse exited Resident #3's room and notified the DON of the larvae.

On 7/17/2018 the DON notified RR and physician and assessed and measured the wound by 8:15 pm and order was received by the physician to send to the Emergency Room for evaluation.

On 7/18/18 Resident #3 was admitted to the local hospital with a diagnosis of Sepsis, cellulitis, and decubitus ulcers.

A thorough investigation was initiated on 7/17/2018 to identify the root cause of fly larva in the residents wound. During the investigation it was found that Resident #3's wounds were not assessed on admission and wound care was only

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provided once in eleven days by treatment nurse #1 prior to larvae being discovered in a wound. It was determined by the Administrator that the cause was the failure of treatment nurse #1 to continuously seek alternatives to aide in the alternate treatment options due to a systematic failure of educating the licensed nurses on the process of actions to take when a resident refuses care or treatments.

Treatment Nurse was terminated on 7/24/18 for other reasons.

Corrective Actions

All current residents with wounds were physically assessed on 7/18/2018 and completed on 7/20/18 by the Quality Improvement nurse, West Wing Treatment nurse and Registered Nurse to ensure wounds care had been completed and no signs or symptoms of worsening of wounds. All wounds were measured and documented in each resident's electronic record. No issues were identified.

On 7//20/18 a 100% audit of all current residents progress notes x 30 days was completed by the wound Consultant to determine if any resident had been refusing wound care. There were no other residents identified in the progress notes that refused wound care.

On 7/21/18 a 100% audit of all current residents Treatment Administration Records for the month of June and July, was completed by the Director of Nursing to identify any refusals of wound care. There were three other residents identified that refused wound care at times in the progress notes. The care plan was updated on 7/21/18 by

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the MDS nurse to address alternatives to aide in the encouragement of residents allowing wound care.

A head to toe assessment was completed on 100% of all residents on 7/21/18 by the Assistant Director of Nursing and RN supervisor to identify all residents with wounds. There were two residents identified with wounds that had not been addressed. The two identified wounds were assessed, documented, measured, treatment initiated and the physician and resident representative was notified on 7/21/18 by the treatment nurse.

On 7/21/18, a questionnaire was initiated by the SF with 100% of all licensed nurses and medication aides to validate knowledge and understanding of steps to take when a resident refuses wound care. Retraining was completed by the SF during the time of the questionnaire for any identified areas of concerns.

On 7/19/18, the facility revised the Nursing Admission Assessment form to ensure the admitting nurse assess, document and measure all residents with wounds on admission.

On 7/19/18 an in-service was initiated by the Wound Nurse Consultant for the Administrator, the DON, and Staff Facilitator in regard to the revised Nursing Admission Assessment to include:

1. Upon admission, the admitting nurse will do a full skin assessment of all wounds to include location, description, and measurements.
2. The treatment nurse will complete a second skin assessment to validate or clarify location,

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description and measurement of all wounds and document on the applicable flow sheet.
This in-service was completed by 7/19/18.

The in-service in regards to the revised Nursing Admission assessment was initiated with all other licensed nurses to include agency nurses on 7/19/18 by the Staff Facilitator. This in-service was completed by 7/22/18.
On 7/18/18 a 100% in service for all licensed nurses to include agency nurses was initiated by the DON in regards to Notification of refusals to include:
1. Each time medications, treatments, or any form of care is refused by a resident it must be reported to the RR and the provider.
2. Nurses must document all refusals of care to include notification of RR and MD
This in-service was completed by 7/22/18.
On 7/21/18 an in-service was initiated with all license nurses and Medication Aides regarding Alternatives for residents that resist wound care. This in-service was completed by 7/22/18. This in-service included:
" People may refuse help from some but not others
" Give clear explanations and repeat ourselves as necessary
" Work at building a closer relationship with the individual, showing that they are valued as a person and not just seen as a focus for a care task
" Ensure that we are going at a pace with which the person feels comfortable and safe, and are respecting their modesty as much as possible.
" When necessary seek a staff member that resident trust to encourage wound care
Family involvement-notify family and get family

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F 686	Continued From page 28 involved to come and encourage the resident. Ask family for ideas that will motivate the resident to agree to wound care. " Explain the risk factors of not allowing wound care to residents " Explore if resident is fearful and reason why " Be patient, allow the resident time to process requests or tasks to be complete or questions to answer " Assess for pain and ensure resident has adequate pain control prior to treatment/care " Notify MD for pain orders if resident complains of pain not relieved with prn pain medication. " Psych consult " Wound clinic referrals ***Note: Most of these alternatives can be utilized for resistance to other types of care as appropriate. The decision to monitor the system for wound care was made on 7/22/2018 by the Administrator and Director of Nursing. 25% of residents with wounds will be physically assessed and documentation on the TAR, progress notes and wound ulcer flow sheet will be reviewed by the ADON, SF, RN Supervisor, or Quality Improvement Nurse 3 x per week x 4 weeks, weekly x 4 weeks, then monthly x 1 month utilizing a Wound Care Audit Tool. This audit is to ensure all wounds have been identified, wound care has been completed per physician's orders, alternatives attempted to encourage residents that refuses, no larvae and no signs and symptoms of worsening of wounds. Any areas of concern identified during the audits will be addressed during the audit by the ADON, SF, RN Supervisor, or Quality Improvement Nurse to include providing additional staff training. The	F 686		

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F 686	Continued From page 29 DON will review and initial the Wound Care Audit Tools weekly x 12 weeks for completion and to ensure all areas of concern were addressed. The DON will present the findings of the Wound Care Audit Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Wound Care Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The decision to review the monitoring of wound care during the quality assurance committee meeting was made by the Administrator and Director of Nursing on 7/22/2018. Final date of compliance is 7/22/18. The Administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. Validation of the above referenced plan of correction was completed on 7/28/2018 during an extended survey. Validation included staff interviews regarding residents refusing care and residents refusing treatments. In-services regarding Admission Assessments were reviewed. In-service for staff regarding notification of refusals. Staff were interviewed regarding in-service for residents that resist wound care. Wound care audit tools were reviewed that will be and are used 3 x per week for 4 weeks, weekly x 4 weeks, then monthly x 1 month as stated in the plan of correction. The date of 7/22/2018 was validated as the facility's date of compliance.	F 686		
F 880	Infection Prevention & Control	F 880		8/17/18

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F 880 SS=D	Continued From page 30 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be 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	F 880		

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F 880	Continued From page 31 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to follow established infection control guidelines for hand hygiene and changing gloves while incontinent care was provided for 1 of 3 residents (Resident #2) when a nursing assistant (NA #2) failed to perform hand hygiene or change gloves between contaminated and clean procedures. Findings included:	F 880	The process that led to this deficiency was facility failed to follow established infection control guidelines for hand hygiene and changing gloves while incontinent care was provided for 1 of 3 residents. On 8/16/18 Resident #2 was provided incontinent care utilizing the appropriate technique to include hand hygiene and	

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F 880	Continued From page 32 Review of the Standard Precautions section of the facility Infection Control Manual reads, in part, "Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized source of infection in healthcare facilities. Standard precautions are used for the care of all residents. Handwashing- Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether gloves are worn or not. Wash hands immediately after gloves are removed, and when otherwise necessary to avoid transfer of microorganisms to other residents or the environment. It may be necessary to wash hands in between tasks and procedures on the same resident to prevent cross contamination of different body sites as appropriate. Gloves- Wear gloves when touching blood, body fluids, secretions, excretions, and contaminated items. Change gloves between task and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly, before touching non-contaminated items and environmental surfaces before going to another resident, and wash hands to avoid transfer of microorganisms to other residents or environments" An observation of Resident #2 was made on 7/25/18 at 3:00 PM. She was observed leaned forward in a high backed chair in the dining room, food debris which resembled vomitus was seen in her lap, and she appeared to be sleeping. NA #1 (Nursing Assistant #1) was in the dining room and brought Resident #2 to her room. After the brief was removed, there was no sign of urinary incontinence and Resident #2 had a small	F 880	changing gloves during incontinent care by the assigned nursing assistant. On 7/27/18 Nursing Assistant (NA) #2 was in-serviced in regards to Hand Washing Procedure to include removing gloves and hand hygiene following incontinent care with return demonstration. On 7/25/18 100% Resident Care Audit on Handwashing with return demonstration was initiated by the Director of Nursing, Nurse Managers, Staff Facilitator and Quality Assurance Nurse (QA) with all nurses and nursing assistants (NA) to include NA #2 to ensure staff were following established infection control guidelines for hand hygiene to include changing gloves after providing incontinent care. All areas of concern were immediately addressed by the Staff Facilitator, Nurse Managers and Quality Assurance nurse (NA) to include retraining of staff. Audit will be completed by 8/23/18. On 7/25/18 100% in-service in regards to Hand Washing Procedure was initiated by the Staff Facilitator with all nurses and NAs to include NA #2 to ensure all staff follow infection control guidelines for handwashing to include: 1. Technique for washing hands 2. When to wash hands a. When reporting to work and before going home b. Before and after contact with residents c. After coming in contact with any body	

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F 880	Continued From page 33 amount of stool in the brief. A continuous observation was conducted from 3:15 PM through 3:50 PM of incontinent care, bathing and ADL care by NA #1 and NA #2. The resident was transferred from the chair to the bed and was undressed by NA #2. She washed her hands, donned gloves, and bathed the resident. NA #2 used the same washcloth throughout care and washed the perineal area. Using the same cloth, NA #2 proceeded to wash Resident #2's lower back and thighs. NA #2 then touched all room surfaces (bedside table, closet door, and dresser), handles, and clean linens and clothes, dried the resident, changed the contaminated brief, put a clean incontinent brief and clean clothes on the resident, and touched the bed controls. She did not change gloves or wash her hands at any time during the care. An interview was conducted with NA #1 at 4:10 PM. She stated, "You wash from the top (face) down. You keep the resident covered from the waist down, wash the top, rinse and dry. Then cover the resident, change washcloths and do the bottom. The private areas are last. You have to change your gloves before you touch the clean things. So you wash and dry your hands, put gloves on, bathe the resident, dry the resident, cover them, then take off your gloves, wash your hands, and put new gloves on. (NA#2) didn't do any of that. I tried to get her attention, but couldn't. (Resident #2) room needs to be terminally cleaned now because (NA #2) touched everything in the room. The ADL and incontinent care was not properly done." An interview was conducted with NA #2 at 4:15 PM. She stated she had not properly completed	F 880	fluids-remove gloves after perineal care and wash hands d. After handling contaminated items (soiled incontinent briefs, linens, trash, etc.) e. Before and after eating or drinking f. After using the bathroom g. After smoking h. After coughing, sneezing, or blowing your nose i. Whenever your hands are obviously soiled. j. In between handling soiled linen and clean linen k. After leaving one resident room and before entering the next resident room. 3. Use of alcohol hand sanitizer- an alcohol based hand sanitizer may be used unless the hands are visibly soiled. The hands should be free of dirt and organic material when using an alcohol hand sanitizer. The hands should be washed with soap and water after exposure to blood or body fluids 4. Procedure for use of alcohol hand sanitizer In-service will be completed by 8/23/18. All newly hired nurses and nursing assistants will be in-serviced by the Staff Facilitator during orientation in regards to Perineal Care to include: 1. Explain procedure to resident 2. Provide privacy 3. Expose perineal area 4. Wash perineal area with soap and water or pericare products a. For the female resident: cleanse the	

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F 880	Continued From page 34 care because she was nervous. She stated she knew the proper way to bathe and dress a resident, but was too nervous to do it today and also correctly described incontinent care and bathing but was too nervous today. She stated she washed Resident #2's had not changed her gloves or washed her hands at all, and contaminated everything in the room when she touched everything with gloved hands. An interview was conducted with the director of Nursing (DON) on 7/25/18 at 6:55 PM. She stated staff were trained on hand hygiene during orientation and annually. She stated, "In fact, we had a hand washing station 2 weeks ago during our skills fair. My expectation is for all employees to follow hand hygiene at all times. (NA #2) said she was nervous and that's why she didn't perform hand hygiene, didn't change her gloves, or complete bathing or incontinent care properly."	F 880	labia with strokes from top to bottom then rinse b. For the male resident: cleanse the penis then rinse 5. Discard soiled items in appropriate containers 6. Removed soiled gloves 7. Wash hands and reapply clean gloves before continuing care 8. Apply clean brief/clothes 9. Make resident comfortable 10% Resident Care Audits-Handwashing will be completed by the Staff Facilitator, Nurse Managers, and Quality Assurance Nurse (QA) with all nurses and NAs to include NA #2 and resident #2 utilizing the Resident Care Audit Tool-Handwashing to ensure staff are following established infection control guidelines for hand hygiene to include changing gloves following incontinent care weekly x 8 weeks, then monthly x 1 month. The Director of Nursing will review and initial the Resident Care Audit Tool-Handwashing weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will forward the results of the Resident Care Audit Tool-Handwashing to the Executive QA Committee monthly x 3 months. The Executive QI committee will meet monthly x 3months and review the Infection Control Monitoring Audit Tools to determine trends and / or issues that may need further interventions put into place	

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F 880	Continued From page 35	F 880	and to determine the need for further and / or frequency of monitoring.	