STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOWAN RIVER NURSING AND REHABILITATION CENTER	1341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932

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F 000	INITIAL COMMENTS An onsite revisit was conducted on 10/25/2018. Tags 622 and 690 were corrected as of 10/25/2018. However, new tags were cited as a result of the recertification survey and complaint investigaion that was conducted at the same time as the revisit. The facility is still out of compliance.	F 000		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must	F 585		11/19/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/15/2018

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F 585	Continued From page 1	F 585		

include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the

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F 585	Continued From page 2 provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to provide a grievance book which maintained grievance records for a period of 3 years. The findings include: Review of facility grievances revealed there were no grievances maintained prior to 7/8/18. During an interview on 10/25/18 at 11:45 AM, the Director of Nursing (DON) revealed she did not know what happened to the grievance book. She	F 585	Chowan River Nursing and Rehabilitation 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. Chowan River Nursing and Rehabilitation response to this Statement of Deficiencies	

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F 585	Continued From page 3 revealed she began employment at the facility on 6/28/18, and she spent a couple of days orienting to the building and the former Administrator retired and a new Administrator started the next day. She stated they looked for the grievance book and could not find it. She revealed the previous Administrator handled all grievances and when the Administrator retired the grievance book was no where to be found. During an interview on 10/25/18 at 12:07 PM, the current Administrator revealed his expectation would be that the facility adequately investigated all grievances and kept records of grievances for three years as the regulation states.	F 585	does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Chowan River 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. F585 The process that led to this deficiency was the facility failed to provide a grievance book which maintained grievance records for a period of 3 years. On 11/7/18 a 100% audit of all grievances x 30 days was completed by the Medical Records Coordinator to ensure all resident grievance logs were maintained according to facility protocol, the grievance was investigated completely and that the resident or resident representative (RR) was informed of the grievance summary. All areas of concern were immediately addressed by the Administrator to include completion of grievance investigation, grievance summary follow up with resident/resident representative and maintaining of the grievance log. On 11/7/18 an in-service was completed by the Facility Nurse Consultant with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Medical Records Coordinator and the Social Worker in regards to the Resident	

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F 585	Continued From page 4	F 585	Concerns and Grievance Guidelines to include the Administrator's responsibility to ensure all grievances are investigated completely, that upon completion of the grievance investigation a grievance summary follow up is completed with the resident and/or resident representative and that the facility maintains all grievance logs/files for a period of 3 years per facility protocol. All newly hired Administrators, DON, ADON, Medical Records Coordinator and Social Worker will be in-serviced during orientation by the Staff Facilitator in regards to the Resident Concerns and Grievance Guidelines to include the Administrator's responsibility to ensure all grievances are investigated completely, that upon completion of the grievance investigation a grievance summary follow up is completed with the resident and/or resident representative and that the facility maintains all grievance logs/files for a period of 3 years per facility protocol. 10% of Resident Grievances will be reviewed weekly for 8 weeks, then monthly for one month by the Medical Records Coordinator to ensure all grievances are investigated completely, that upon the grievance investigation a grievance summary follow up is completed with the resident and/or resident representative and that the facility maintains all grievance logs/files per facility protocol utilizing the Grievance Summary Audit Tool. Any areas of	

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F 585	Continued From page 5	F 585	concern will be immediately addressed by the Administrator/DON during the audit to include completion of grievance investigation, grievance summary follow up with the resident or resident representative notification, completion of the grievance log and/or additional staff training. The Medical Records Coordinator will forward the results of the Grievance Summary Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the Grievance Summary Audit Tool 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. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		11/19/18

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F 656	Continued From page 6 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to follow the care plan for 1 of 2 residents reviewed for accidents (Resident #87). Findings included:	F 656	F656 The process that led to this deficiency was the facility failed to follow the care plan for 1 of 2 residents reviewed for accidents. (Resident #87)	

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F 656	Continued From page 7 Resident #87 had been admitted on8/21/15. Her diagnoses include cerebellar ataxia, dysarthria, dysphagia, gastrostomy, autonomic neuropathy, muscle weakness, abnormal posture, anxiety and depression. Resident #87's Care Guide, revised on 2/1/17, indicated "Falls: Do not leave on bedside commode (BSC) unattended, attendant to stay beside resident within reach of resident while on BSC." Resident #87's urinary incontinence care plan, revised on 1/31/18, indicated "Do not leave on BSC unattended." Resident #87's falls care plan, revised on 3/16/18, indicated "Do not leave on BCS unattended." Her most recent quarterly Minimum Data Set (MDS) dated 9/25/18 indicated she was cognitively intact. She did not walk and required extensive assistance with transfers and total assistance with toileting and hygiene. She was noted as frequently incontinent of urine and occasionally incontinent of bowel. No falls had been noted. Nursing documentation dated 9/29/18 at 4:28 PM indicated the nurse had been called to Resident #87's room by staff. Upon entering the room, the nurse observed Resident #87 lying on floor in front of the BSC. Resident #87 was assessed and noted to have a laceration to right side of forehead, right top lip, bleeding to her gums, bruising to the right forearm, and an abrasion to her left knee. Neurological checks were initiated. The physician and the responsible party (RP) had been made aware of the accident. On 10/22/18 at 11:11 AM an interview with Nurse	F 656	On 11/1/18 100% audit of all incident reports to include resident # 87 was completed by the Assistant Director of Nursing (ADON) to ensure all incidents had been investigated for the root cause and appropriate interventions were initiated, MD/RR notified and care plan/care guides were updated. All areas of concern were immediately addressed by the ADON, Administrative Nurses and Quality Assurance nurse (QA) to include investigating root cause, initiating appropriate interventions, notification of MD/RR and updating care plan/ care guide. Audit will be completed by 11/12/18. On 11/5/18 100% audit of all residents care plan/care guide to include resident # 87 was completed by the Minimum Data Set nurse (MDS) to ensure all residents are care planned and have updated care guide for appropriate safety interventions. MDS nurse will update care guide/care plan for any identified areas of concern. There were no areas of concern noted. On 11/6/18 100% Resident Care Audit with all nurses and NAs to include NA #1 and resident # 87 in regards to safe handling and following care guides was initiated by the Staff Facilitator (SF) to include: 1. Care guide reviewed prior to initiating care 2. Care provided according to care guide to include toileting with appropriate safety interventions	

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F 656	Continued From page 8 Aide (NA) #1 was conducted. The NA stated Resident #87 was alert, oriented and able to express her needs. On 10/22/18 at 2:30 PM an interview was conducted with Resident #87. She stated that on the day she fell, NA #1 had assisted her to the BSC and she had fallen while the NA was not in the room. She stated NA #1 had been new to her and she did not think the NA knew how to care for her. On 10/23/18 at 10:55 AM an interview with the Nurse Aide (NA) #1 who had cared for Resident #87 on the day she fell was conducted. The NA stated the day of the fall was the first day she had cared for Resident #87. She stated the previous NA had told her Resident #87 had been able to stand and pivot for transfers. The NA stated she had looked for the care guide and it was not posted where she expected it to have been, inside the resident ' s close door. The NA stated it had been after Resident #87 had fallen when she learned the care guides were now located in the computer. She then learned Resident #87 was not to be left unattended while on the BSC. An interview with the Director of Nursing (DON) was conducted on 10/24/18 at 2:58 PM. The DON stated it was her expectation of staff to review the care plan when they are caring for a resident they are not familiar with or to ask the nurse. She also stated it was her expectation of staff to stay with Resident #87 while she was sitting on the BSC.	F 656	3. If care performed incorrectly, staff member retrained regarding: All areas of concern will be immediately addressed by the SF, Administrative nurses and ADON. Resident Care Audits will be completed by 11/19/18. On 11/6/18 100% in-service was initiated by the Staff Facilitator with all nurses and NA staff to include NA # 1 in regards to Safe Handling and Movement Policy to include: 1. Resident handling and movement activities a. Activities of daily living b. Repositioning in bed or chair c. Providing treatments d. Transfers e. Ambulation f. Obtaining weights g. Toileting-assisting resident or not leaving resident unattended while on toilet per care guide h. Any other activity which involves movement of resident 2. Ensuring safety interventions are in place in accordance with resident care guide 3. Use of any other appropriate and reasonable assistive devices and/or techniques when moving or repositioning residents 4. Checking and following care guide each time care is provided In-service will be completed by 11/19/18. After 11/19/18 no nurse or NA will be	

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F 656	Continued From page 9	F 656	allowed to work until in-service has been completed. All newly hired nurses and NAs will be trained by the Staff Facilitator during orientation on the Safe Handling and Movement Policy to include: 1. Resident handling and movement activities a. Activities of daily living b. Repositioning in bed or chair c. Providing treatments d. Transfers e. Ambulation f. Obtaining weights g. Toileting-assisting resident or not leaving resident unattended while on toilet per care guide h. Any other activity which involves movement of resident 2. Ensuring safety interventions are in place in accordance with resident care guide 3. Use of any other appropriate and reasonable assistive devices and/or techniques when moving or repositioning residents 4. Checking and following care guide each time care is provided 25 % Resident Care Audit in regards to Safe Handling and following care guides will be completed with nurses and NA staff to include NA # 1 by the Administrative nurses 3 times a week x 4 weeks, weekly x 4 weeks, then monthly x 1 month utilizing the Resident Care Audit Tool to ensure staff follow safe handling and	

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F 656	Continued From page 10	F 656	movement policy and use appropriate safety interventions when providing care. All areas of concern will be immediately addressed with staff retraining by the Staff Facilitator. The Administrator/DON will review and sign the Resident Care Audit Tool for completion weekly x 8 weeks then monthly x 1 month to ensure that all areas of concern are addressed appropriately. The DON will forward the results of the Resident Care Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the Resident Care Audit Tool 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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow professional standards care during medication administration observation for 1 of 9 residents observed (Resident #7). Findings included:	F 658	F658 The process that led to this deficiency was the facility failed to follow professional standards care during medication administration observation for 1 of 9 residents observed. (Resident #7)	11/19/18

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F 658	Continued From page 11 Resident #7 had been admitted on 1/3/18. His diagnoses included hypertension, diabetes, gastrostomy status, dysphagia following cerebral infarction, and mild cognitive impairment. On 10/24/18 at 4:56 PM an interview with Nurse #8 was conducted. The nurse stated the nurse was to administer any medication the Medication Aide (MA) was not allowed to give. A medication pass observation was conducted with MA # 1 on 10/24/18 at 5:28 PM. The MA disconnected Resident #7's tube feeding. She was not observed to check the tube placement before administration of the medication. She administered 30 milliliters (ml) of water through the gastrostomy tube. She then administered liquid acetaminophen 650 milligrams (mg) followed by another 30 ml of water, then a 200 ml bolus of water. The MA then reconnected the tube feeding. An interview with MA #1 was conducted on 10/24/18 at 5:35 PM. The MA stated she had learned how to administer gastrostomy feeding during Nurse Aide II (NAII) training. She stated she was allowed to administer acetaminophen for complaint of pain and the nurse would check the resident post medication administration for relief of pain. On 10/25/18 at 9:14 AM an interview with the Nurse #1 was conducted. The nurse stated the facility used the services of MAs. The nurse stated MAs were not to administer medications via gastrostomy tube, even if the MA was NAII trained, according to the facility policy. The nurse stated if a MA gave medications via gastrostomy tube, they were out of their scope of practice. The	F 658	On 10/24/18 Medication Aide (MA) #1 was immediately in-serviced by the Director of Nursing (DON) in regards to Medication Aide Scope of Practice for administering medications and the facility's expectations for Med Aide's compliance with scope of practice when administering medications. On 10/24/18 Medication Pass Audit was initiated by the DON with all MAs to include MA #1 to ensure that MAs administer medications within the scope of practice. All areas of concern will be immediately addressed by the DON, Assistant Director of Nursing (ADON), Staff Facilitator (SF) to include re-education of the Medication Aides in regards to scope of practice and facility's expectations for Med Aide's compliance with scope of practice when administering medications, notification of the physician and assessment of the resident. Audit will be completed by 11/19/18. Resident #7 was assessed by the Registered Nurse on 10/25/18 for proper Gastrostomy tube placement and there were no areas of concern or acute changes noted. The physician was notified of assessment. The DON notified Agency Director on 10/25/18 in regards to Medication Aide Scope of Practice and facilities expectation of MA compliance with scope of practice. The Agency will supply the facility with proof of Medication Aide Scope of Practice in-service training of all Medication Aides and nurses prior to	

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CHOWAN RIVER NURSING AND REHABILITATION CENTER	1341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932

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F 658	Continued From page 12 nurse stated only licensed nurses were to administer mediations via gastrostomy tube. On 10/25/18 at 11:25 AM an interview with the Director of Nursing (DON) was conducted. The DON stated she expected staff to work within their scope of practice and for the supervising nurses to know the scope of practice for the staff they are supervising. The DON stated MAs were not allowed to administer medications via gastrostomy tube even if they were NAII trained.	F 658	assignment to the facility. On 10/25/18 the DON notified the Director of Staffing Agency that MA #1 was to be indefinitely removed from facility staffing. 100% interviews with all medication aides to include MA #1 was completed on 10/25/18 by Staff Facilitator in regards to Medication Aide Scope of Practice to include: 1. Have you ever administered medications through a Gastrostomy Tube (PEG) in this facility? 2. Have you ever administered injections to a resident in this facility? 3. If yes to any question the MA will be immediately re-trained in regards to: Medication Aide Scope of Practice All areas of concerns were immediately addressed by the DON, ADON, SF to include re-training of Medication Aides in regards to scope of practice. In-service was initiated by DON on 10/24/18 with all nurses, medication aides to include MA #1 and agency staff in regards to Medication Aide Scope of Practice for administering medications and the facility's expectations for Med Aide's compliance with scope of practice when administering medications. In-service will be completed by 11/19/18. Any nurse or medication aide who has not completed the in-service by 11/19/18 will not be allowed to work until in-service is completed.	

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F 658	Continued From page 13	F 658	100% Medication Pass Audits will be completed by the Administrative nurses with all Medication Aides weekly x 8 weeks then monthly x 1 month to ensure that Medication Aides administer medications per scope of practice and facilities expectations. All areas of concern will be addressed by the DON, ADON, SF to include re-education of staff and assessment of resident and notification of MD. The DON will review and initial all Medication Pass Audits to ensure all areas of concern were addressed. The Administrator will forward the results of the Medication Pass Audits to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the Medication Pass Audits 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. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
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	F 689		11/19/18

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F 689	Continued From page 14 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 record review, resident and staff interviews, the facility failed to provide supervision to prevent a resident's fall from a bed side commode for 1 of 2 residents reviewed for accidents (Resident #87). Findings included: Resident #87 had been admitted on 8/21/15. Her diagnoses include cerebellar ataxia, dysarthria, autonomic neuropathy, muscle weakness, abnormal posture, anxiety and depression. Resident #87's Care Guide, revised on 2/1/17, indicated "Falls: Do not leave on bedside commode (BSC) unattended, attendant to stay beside resident within reach of resident while on BSC." Resident #87's urinary incontinence care plan, revised on 1/31/18, indicated "Do not leave on BSC unattended." Resident #87's falls care plan, revised on 3/16/18, indicated "Do not leave on BSC unattended." Her most recent quarterly Minimum Data Set (MDS) assessment dated 9/25/18 indicated she was cognitively intact. She did not walk and required extensive assistance with transfers and total assistance with toileting and hygiene. She was noted as frequently incontinent of urine and occasionally incontinent of bowel. No falls were noted. Nursing documentation dated 9/29/18 at 4:28 PM,	F 689	F689 The process that led to this deficiency was the facility failed to provide supervision to prevent a resident's fall from a bed side commode for 1 of 2 residents reviewed for accidents. (Resident #87) On 11/1/18 100% audit of all incident reports to include resident # 87 was completed by the Assistant Director of Nursing (ADON) to ensure all incidents had been investigated for the root cause and appropriate interventions were initiated, MD/RR notified and care plan/care guides were updated. All areas of concern were immediately addressed by the ADON, Administrative Nurses and Quality Assurance nurse (QA) to include investigating root cause, initiating appropriate interventions, notification of MD/RR and updating care plan/ care guide. Audit will be completed by 11/12/18. On 11/5/18 100% audit of all residents care plan/care guide to include resident # 87 was completed by the Minimum Data Set nurse (MDS) to ensure all residents are care planned and have updated care guide for appropriate safety interventions.	

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F 689	Continued From page 15 written by Nurse #2, indicated the nurse had been called to Resident #87's room. Upon entering the room, the nurse observed Resident #87 lying on floor in front of the BSC. Resident #87 was assessed and noted to have a laceration to right side of forehead, right top lip, bleeding to her gums, bruising to the right forearm, and an abrasion to her left knee. Neurological checks were initiated. The physician and the responsible party (RP) had been made aware of the accident. On 10/22/18 at 11:11 AM an interview with Nurse Aide (NA) #1 was conducted. The NA stated Resident #87 was alert, oriented and able to express her needs. On 10/22/18 at 2:30 PM an interview was conducted with Resident #87. She stated that on the day Resident #87 fell, Nurse Aide (NA) #1 had assisted her to the BSC and she had fallen while the NA was not in the room. She stated NA #1 had been new to her and she did not think the NA knew how to care for her. On 10/23/18 at 10:55 AM an interview with the Nurse Aide (NA) #1 who had cared for Resident #87 on the day she fell was conducted. The NA stated the day Resident #87 fell was the first day she had cared for her. She stated the previous NA had told her Resident #87 had been able to stand and pivot for transfers. The NA stated she had looked for the care guide and it was not posted where she expected it to have been, inside the resident's closet door. The NA stated it had been after Resident #87 had fallen when she learned the care guides were now located in the computer. She then learned Resident #87 was not to be left unattended while on the BSC.	F 689	MDS nurse will update care guide/care plan for any identified areas of concern. There were no areas of concern noted. On 11/6/18 100% Resident Care Audit with all nurses and NAs to include NA #1 and resident # 87 in regards to safe handling and following care guides was initiated by the Staff Facilitator (SF) to include: 1. Care guide reviewed prior to initiating care 2. Care provided according to care guide to include toileting with appropriate safety interventions 3. If care performed incorrectly, staff member retrained regarding: All areas of concern will be immediately addressed by the SF, Administrative nurses and ADON. Resident Care Audits will be completed by 11/19/18. On 11/6/18 100% in-service was initiated by the Staff Facilitator with all nurses and NA staff to include NA # 1 in regards to Safe Handling and Movement Policy to include: 1. Resident handling and movement activities a. Activities of daily living b. Repositioning in bed or chair c. Providing treatments d. Transfers e. Ambulation f. Obtaining weights g. Toileting-assisting resident or not	

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F 689	Continued From page 16 On 10/24/18 at 10:35 AM an interview with Nurse #2 was conducted. She stated when Resident #87 had fallen, staff came and got her. Resident #87 was observed on the floor of her room and the NA had stated the resident had fallen off of the BSC. Resident #87 had a laceration to her right forehead and a butterfly bandage had been applied, an abrasion to her left knee was covered with a small bandage and her mouth had been rinsed. Resident #87 had stated she felt alright, had no pain and her neurological checks had been stable so she was not sent to the Emergency Department (ED). An interview with the Director of Nursing (DON) was conducted on 10/24/18 at 2:58 PM. The DON stated it was her expectation of staff to review the care plan when they are caring for a resident they are not familiar with or to ask the nurse. She also stated it was her expectation of staff to stay with Resident #87 while she was sitting on the BSC.	F 689	leaving resident unattended while on toilet per care guide h. Any other activity which involves movement of resident 2. Ensuring safety interventions are in place in accordance with resident care guide 3. Use of any other appropriate and reasonable assistive devices and/or techniques when moving or repositioning residents 4. Checking and following care guide each time care is provided In-service will be completed by 11/19/18. After 11/19/18 no nurse or NA will be allowed to work until in-service has been completed. All newly hired nurses and NAs will be trained by the Staff Facilitator during orientation on the Safe Handling and Movement Policy to include: 1. Resident handling and movement activities a. Activities of daily living b. Repositioning in bed or chair c. Providing treatments d. Transfers e. Ambulation f. Obtaining weights g. Toileting-assisting resident or not leaving resident unattended while on toilet per care guide h. Any other activity which involves movement of resident 2. Ensuring safety interventions are in place in accordance with resident care guide	

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F 689	Continued From page 17	F 689	3. Use of any other appropriate and reasonable assistive devices and/or techniques when moving or repositioning residents 4. Checking and following care guide each time care is provided 25 % Resident Care Audit in regards to Safe Handling and following care guides will be completed with nurses and NA staff to include NA # 1 by the Administrative nurses 3 times a week x 4 weeks, weekly x 4 weeks, then monthly x 1 month utilizing the Resident Care Audit Tool to ensure staff follow safe handling and movement policy and use appropriate safety interventions when providing care. All areas of concern will be immediately addressed with staff retraining by the Staff Facilitator. The Administrator/DON will review and sign the Resident Care Audit Tool for completion weekly x 8 weeks then monthly x 1 month to ensure that all areas of concern are addressed appropriately. The DON will forward the results of the Resident Care Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the Resident Care Audit Tool 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 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		11/19/18

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F 761	Continued From page 18 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain the temperature for 2 of 3 medication refrigerators reviewed (medication refrigerator #1 on D-hall and medication refrigerator #1 in the main medication room), and failed to secure 1 of 2 medication cart narcotic boxes reviewed (A-hall medication cart narcotic box). Findings included: 1. On 10/25/18 at 12:09 PM the D-hall medication room was reviewed with Nurse #4. The	F 761	F761 The process that led to this deficiency was the facility failed to maintain the temperature for 2 of 3 medication refrigerators reviewed (medication refrigerator #1 on the D hall and medication refrigerator #1 in the main medication room), and failed to secure 1 of 2 medication cart narcotic boxes reviewed (A-hall medication cart narcotic box)	

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F 761	Continued From page 19 medication refrigerator was observed with a temperature of 32 degrees Fahrenheit (F). The temperature log indicated the refrigerator temperature range should be 35-41 degrees F. The temperatures recorded on the log revealed refrigerator temperatures within range with the most recent temperature check completed on 10/24/18, PM. On 10/25/18 at 12:09 PM an interview with Nurse #4 was conducted. The nurse stated the refrigerator temperature had been checked at noon and she had discovered the temperature at 30 degrees F. The nurse stated she adjusted the temperature and was going to check it again shortly. Medications in D-hall refrigerator #1 included: 1- Tuberculin purified protein injection 5/0.1 milliliter (ml) vial. The medication packaging indicated to store at 35-46 degrees F. 6- Bisacodyl suppositories 10 milligram (mg). The medication packaging indicated to store between 68-77 degrees F. 3- Insulin glargine pens. The medication packaging indicated to refrigerate. 1- Darbepoetin alfa 60 microgram (mcg) injection /1 ml. The medication packaging indicated to store at 35-46 degrees F. 9- Insulin detemir injection pens. The medication packaging indicated to store at 35-46 degrees F. On 10/25/18 at 12:47 PM an interview with the Director of Nursing (DON) was conducted. The Director of Nursing (DON) stated it was the responsibility of the evening shift to check the temperatures of the medication refrigerators. If any concerns were identified, the DON would expect the nurse to report the concern of	F 761	On 10/25/18 100% audit of all refrigerator temperature logs from 10/1/18-10/25/18 was completed by the Director of Nursing to ensure refrigerator temperatures were within acceptable ranges. All areas of concern were immediately addressed by the Director of Nursing (DON), Assistant Director of Nursing (ADON) and Administrative nurses to include adjustment of refrigerator temperature to acceptable range, notification of Maintenance Director for any related repair/replacement, and removal of medications/labs if indicated. On 10/25/18 the following medications were removed from refrigerator #1 D-hall by nursing staff: (1) Tuberculin purified protein injection 5/0.1 milliliter (ml) vial, (6) bisacodyl suppositories 10 milligram (mg), (3) insulin glargine pens, (1) Darbepoetin alfa 60 microgram (mcg) injection 1ml, and (9) insulin detemir injection pens due to temperatures recorded out of acceptable temperature range. On 10/25/18 the following medications were removed from refrigerator #1 on the main medication storage room by the nursing staff: (1) 10ml vial of insulin detemir, (1) 3ml vial of Humulin regular insulin, (4) Promethegan suppositories 25 mg, (1) Latanooprostene 0.24% ophthalmic solution, (1) influenza afluria 5ml vial, (1) insulin glargine 10ml multi dose vial, (69) Formoterol nebulizer treatment 20 mcg, (10) Cefazolin injection in 0.9% normal saline (NS) 100ml for	

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F 761	Continued From page 20 abnormal findings. 2. On 10/25/18 at 12:27 PM refrigerator #1 in the main medication storage room was reviewed with the Assistant Director of Nursing (ADON). Refrigerator #1 was observed with a temperature of 19 degrees Fahrenheit (F). The temperature log indicated the refrigerator temperature range should be 35-41 degrees F. The temperatures recorded on the log revealed refrigerator temperatures within range with the most recent temperature check completed on 10/24/18, AM. Medications in the main medication storage room refrigerator #1 included: 1- 10 milliliter (ml) vial of insulin detemir. The medication packaging indicated to store at 36-46 degrees F. 1- 3ml vial of Humulin regular insulin. The medication packaging indicated to store refrigerated, do not freeze. 4- Promethegan suppositories 25 milligrams (mg). Packaging indicated to refrigerate. 1- Latanooprostene 0.24 % ophthalmic solution. Packaging indicated to refrigerate. 1- Influenza afluria 5ml vial. The medication packaging indicated to store at 36-46 degrees F. 1- Insulin glargine 10 ml multi dose vial. The medication packaging indicated to store at 36-46 degrees F. 69- Formoterol nebulizer treatment 20 mcg doses. The medication packaging indicated to store at 36-77 degrees F. 10- Cefazolin injection in 0.9% normal saline (NS) 100 ml for intravenous infusion. The pharmacy label indicated to refrigerate. 1- Insulin lispro pen. The medication packaging indicated to refrigerate.	F 761	intravenous infusion, (1) insulin lispro pen, (1) pneumococcal 13 valent conjugate vaccine vial, (1) Epoetin alfa 10, 000 unit 1ml vial, (5) insulin glargine pens 3ml, (8) insulin aspart insulin pens Novolog flex pen, and (2) Tuberculin purified protein injection 5/0 1ml vials. On 10/25/18 the temperature for refrigerator #1 D-hall and refrigerator #1 main medication storage room was adjusted by the Director of Nursing to maintain acceptable temperature range for medication storage. On 11/8/18 100% in-service was initiated by the Staff Facilitator with all nurses to include nurse #4 in regards to Refrigerator Temperatures to include: 1. Acceptable temperature range for medication storage is 36-46 degrees 2. Acceptable temperature range for lab storage is 36-46 degrees 3. Refrigerator temperatures should be monitored daily by the assigned hall nurse and documented on the refrigerator temperature log. 4. If a refrigerator temperature is not within acceptable temperature range the assigned hall nurse must discard any medications that are affected by abnormal temperature range and adjust temperature setting to maintain temperature within acceptable range. 5. If abnormal temperature readings continue after adjusting settings, the assigned nurse must submit a work order request to the Maintenance Director.	

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F 761	Continued From page 21 1- Pneumococcal 13-valent conjugate vaccine vial. The medication packaging indicated do not freeze, store at 36-46 degrees F. 1- Epoetin alfa 10,000 unit 1 ml vial. The medication packaging indicated to store between 35-46 degrees F. 5- Insulin glargine pens 3 ml. The medication packaging indicated to refrigerate 36-46 degrees F unopened. 8- Insulin aspart insulin pens Novolog flex pen. The pharmacy label indicated to refrigerate. 2- Tuberculin purified protein injection 5/0.1 milliliter (ml) vials. The medication packaging indicated to store at 35-46 degrees F. On 10/25/18 at 12:47 PM an interview with the Director of Nursing (DON) was conducted. The Director of Nursing (DON) stated it was the responsibility of the evening shift to check the temperatures of the medication refrigerators. If any concerns were identified, the DON would expect the nurse to report the concern of abnormal findings. 3. On 10/25/18 at 11:01 AM a review of the A-hall medication cart was conducted with Nurse #3. The lid of the locked narcotic box easily opened with minimal shaking. An interview with Nurse #3 was conducted on 10/25/18 at 11:01 AM. The nurse stated she locks the medication cart when she steps away and she always uses the key to unlock the narcotic box. She stated she had not noticed the box could be opened with minimal shaking. The nurse also stated she had counted the narcotics at the beginning of this shift and the count had been correct.	F 761	6. The DON must be notified for any concerns related to refrigerator temperatures in regards to medication and/or lab storage. 7. Assigned hall nurse will notify pharmacy of any medications affected that needs to be discarded so supply can be restocked. In-service will be completed by 11/17/18. After 11/17/18 no nurse will be allowed to work until in-service has been completed. All newly hired nurses will be in-serviced during orientation by the Staff Facilitator in regards to Refrigerator Temperatures to include: 1. Acceptable temperature range for medication storage is 36-46 degrees 2. Acceptable temperature range for lab storage is 36-46 degrees 3. Refrigerator temperatures should be monitored daily by the assigned hall nurse and documented on the refrigerator temperature log. 4. If a refrigerator temperature is not within acceptable temperature range the assigned hall nurse must discard any medications that are affected by abnormal temperature range and adjust temperature setting to maintain temperature within acceptable range. 5. If abnormal temperature readings continue after adjusting settings, the assigned nurse must submit a work order request to the Maintenance Director. 6. The DON must be notified for any concerns related to refrigerator	

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F 761	Continued From page 22 Narcotics observed within this box included: 4- Fentanyl 100 microgram/per hour (mcg/hr) 7- Fentanyl 12 mcg/hr patches 300- Oxycodone 10 milligrams (mg) tablets 84- Tramadol 50 mg tablets 15- Oxycodone/acetaminophen 7.5-325 mg tablets 155- Oxycodone 5mg tablets 114- Lorazepam 0.5 mg tablets 28- Hydrocodone/acetaminophen 5-325 mg tablets 8- Clonazepam 0.5 mg tablets 34- Brivaracetam 75 mg tablets On 10/25/18 at 12:47 PM an interview with the Director of Nursing (DON) was conducted. The DON stated it was her expectation of the nurse to report any problems with the locking mechanism of the narcotic boxes.	F 761	temperatures in regards to medication and/or lab storage. 7. Assigned hall nurse will notify pharmacy of any medications affected that needs to be discarded so supply can be restocked. On 10/25/18 100% audit of all medication lock systems to include narcotic lock box was completed by the Staff Facilitator to ensure all lock systems were working properly. All area of concerns were immediately addressed by the DON to include initiating work order for any system failures and securing medications/narcotics in an alternative secured location. On 10/25/18 all narcotic medications were removed from A-hall medication cart and stored in a double lock system by the Administrative Nurse on C-hall medication cart until the lid of the locked narcotic box A-hall medication cart could be repaired. On 10/26/18 the lid of the locked narcotic box A-hall medication cart was repaired and all narcotic medications were returned to A-hall medication cart by the assigned hall nurse. On 11/8/18 100% in-service was initiated by the Staff Facilitator with all nurses to include nurse #3 in regards to Securing Narcotic Medications to include: 1. All narcotics should be stored in a double lock system 2. It is the nurses responsibility to	

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F 761	Continued From page 23	F 761	ensure all narcotics are stored appropriately 3. Nurses should report to the DON immediately any concerns related to locking mechanism related to securing medications/narcotic medications 4. Anytime there is a failure in the locking mechanism related to securing medications/narcotics, the nurse must secure medications in an alternate secure location until medication cart can be repaired. In-service will be completed by 11/19/18. After 11/19/18 no nurse will be allowed to work until in-service is completed. All newly hired nurses will be in-serviced during orientation by the Staff Facilitator in regards to Securing Narcotic Medications to include: 1. All narcotics should be stored in a double lock system 2. It is the nurses responsibility to ensure all narcotics are stored appropriately 3. Nurses should report to the DON immediately any concerns related to locking mechanism related to securing medications/narcotic medications 4. Anytime there is a failure in the locking mechanism related to securing medications/narcotics, the nurse must secure medications in an alternate secure location until medication cart can be repaired. 100% audit of refrigerator temperatures	

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F 761	Continued From page 24	F 761	will be completed by the Administrative nurses 5 times a week x 4 weeks, weekly x 4 weeks then monthly x 1 month utilizing the Refrigerator Temperature Audit Tool to ensure all refrigerator temperatures are within acceptable ranges. All areas of concern will be immediately addressed by the Administrative nurses to include adjustment of refrigerator temperature to acceptable range, notification of Maintenance Director for any related repair/replacement, removal of medications/labs if indicated and re-education of staff. The DON will review and initial the Refrigerator Temperature Log weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed appropriately. 100% audit of medication carts to include A-hall medication cart will be completed by the Administrative nurses weekly x 8 weeks then monthly x 1 month utilizing the Medication Cart Security Audit Tool to ensure all lock systems are working properly. All area of concerns will be immediately addressed by the Administrative nurses to include initiating work orders for any system failures and securing medications/narcotics in an alternate secured location. The DON will review and initial the Medication Cart Security Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed appropriately. The DON will forward the results of the Refrigerator Temperature Log and the Medication Cart Security Audit Tool to the	

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F 761	Continued From page 25	F 761	Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the Refrigerator Temperature Log and the Medication Cart Security Audit Tool 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 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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:	F 880		11/19/18

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F 880	Continued From page 26 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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:	F 880		

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F 880	Continued From page 27 Based on observation, and staff interviews, the facility failed to prevent cross contamination between residents by taking a multi-use plastic bottle of wound cleanser between rooms without cleaning, for 2 of 4 residents (Resident #49 and #60) observed for wound care. The facility also failed to complete and document surveillance and data to track and trend infections in the facility during the previous 5 of 10 months (January, February, July, August and September 2018). The findings included: 1. A continuous wound care observation for Resident #49 and Resident #60 was conducted on 10/24/2018 from 10:00 AM to 11:06 AM, with Nurse #1. On 10/24/2018 at 10:00 AM Nurse #1 gathered her supplies and put them on a sheet of wax paper and took them into Resident #49's room and laid them on the bed. Nurse #1 and Nurse #2 washed their hands and donned gloves. Nurse #2 assisted Nurse #1 by helping to position and expose the resident's sacral area. Nurse #1 removed the existing dressing and asked Nurse #2 to get the wound cleanser from the treatment cart. Nurse #2 left the room and returned with a plastic bottle of wound cleanser. Nurse #1 took the bottle with her gloved hands and sprayed the cleanser on the sacral wound, touching the pad underneath Resident #49 and then sat the bottle on the bed, not on the wax paper. Nurse #1 wiped the wound with gauze and then picked up the bottle of wound cleanser and sprayed the wound a second time and placed the bottle back on the bed. The nurse finished dressing the wound, closed the bag of trash, washed her hands and left the room to get supplies for the resident's face wound.	F 880	F880 The process that led to this deficiency was the facility failed to prevent cross contamination between residents by taking a multi-use plastic bottle of wound cleanser between rooms without cleaning for 2 of 4 residents (Resident #49 and #60) observed for wound care. The facility also failed to complete and document surveillance and data to track and trend infections in the facility during the previous 5 of 10 months (January, February, July, August and September 2018.) On 10/25/18 wound care for resident # 49 and # 60 was completed by the assigned hall nurse observing appropriate aseptic technique. Resident's wounds were assessed with no identified areas of concern. On 11/8/18 100% Resident Care Audit-Treatments was initiated with all nurses to include nurse #1 by the Staff Facilitator to ensure nurses were utilizing appropriate aseptic technique during dressing changes to include cleaning items per facility protocol between use. All areas of concern will be immediately addressed by the Administrative nurse, Staff Facilitator and Assistant Director of Nursing (ADON) to include providing additional wound care utilizing appropriate technique, cleaning of supplies per facility protocol and education of staff. Resident Care Audit will be completed by 11/19/18. After 11/19/18 No nurse will be allowed to provide wound care until audit is	

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F 880	Continued From page 28 At 10:22AM, Nurse #1 returned to Resident #49s room with supplies wrapped in a sheet of wax paper and laid the supplies on the bed. The nurse used the bottle of wound cleanser left on the bed and sprayed the residents left face with the cleanser and placed the bottle back on the bed. After the treatment was completed, the nurse took the bag of trash and bottle of wound cleanser to the sink area sat them down and washed her hands. Nurse #1 then took the bag of trash and disposed of it at her treatment cart and placed the bottle of wound cleanser on top of the treatment cart. The nurse took a beach wipe labeled "Bactericidal, Fungicidal, Tuberculocidal and Viricidal in 4 minutes," and cleaned her scissors that had been used in the room and wrapped the blades of the scissors with the wipe and sat them on her cart. The bottle of wound cleanser was left untouched. The nurse then pushed her cart to Resident #60 room and went in to position the resident for a wound treatment to her heel. On 10/24/2018 at 10:36 AM, Nurse #1 took supplies for the wound care wrapped in a sheet of wax paper and the same bottle of wound cleanser into Resident #60 room and laid the supplies on the bed. When Nurse #1 was asked where she was going to put the bottle of wound cleanser, the nurse replied she would put the bottle on the bed next to the supplies, so she could reach it. When asked about cleaning the bottle of wound cleanser, the nurse replied, "I already cleaned it, but if you want it cleaned again, I can do that too". The Nurse took the bottle of wound cleanser to the treatment cart and used a bleach wipe to wipe the nozzle, handle and body of the bottle off for approximately 10 seconds and then threw the wipe away. The nurse was asked if she	F 880	completed. On 11/8/18 100% in-service was initiated by the Staff Facilitator with all nurses to include nurse #1 in regards to Clean Technique During Dressing Changes to include: 1. When applying or changing dressings, an aseptic technique or clean technique is used in order to avoid introducing infections into a wound. Even if a wound is already infected, an aseptic or clean technique should be used as it is important that no further infection is introduced. 2. Always place clean items onto a clean barrier such as wax paper, chux or other clean barrier system. Contaminated items must be placed on a separate barrier system as to not contaminate clean items. 3. If at any time you feel you may have interrupted a clean system you must stop, obtain new clean supplies or provide cleaning per facility protocol of any contaminated items. This would include multiple use spray bottles, dressing items, scissors or other items. All muti-use items must be cleaned prior to leaving the room and per facility protocol before using on the next patient. In-service will be completed by 11/19/18. After 11/19/18 no nurse will be allowed to work until in-service has been completed. All newly hired nurses will be in-serviced during orientation by the Staff Facilitator in	

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F 880	Continued From page 29 considered the bottle ready to be taken into the resident's room, and the nurse replied, "well I used a bleach wipe so 99% of the germs were killed." When the nurse was asked about the directions for the wipe and the 4-minutes listed on the label, the nurse replied the bottle needed to be wet for 4 minutes and it wasn't wet that long, so she would just use a bottle of unopened normal saline to clean the wound. At 10:47 AM Nurse #1 went back in the resident's room, conducted the dressing change and was back to the treatment cart at 11:04 AM. The nurse took a bleach wipe and wiped the plastic bottle of wound cleanser again and wrapped the nozzle and handle in a bleach wipe, and the body of the bottle with another bleach wipe, leaving approximately ½ "at the bottom of the bottle exposed. When Nurse #1 was asked if she realized the bottom of the bottle was sitting on a resident's bed, the nurse replied, "yes, I had not thought about cross contamination, my bad." On 10/24/2018 at 2:24 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she had expectations that her nurses know the difference of what was clean and what was dirty and how to maintain infection control. The DON further stated she believed Nurse #1 cleaned the bottle of wound cleanser if she said she cleaned it. 2. Review of the facility's policy title Infection Control Preventionist noted the responsibilities of the Infection Control Preventionist (ICP) dated 9/2014, included the following: "Performs surveillance for the identification, investigation, and documentation of facility acquired infections, community acquired infections, and communicable disease outbreaks as necessary.	F 880	regards to Clean Technique During Dressing Changes to include: 1. When applying or changing dressings, an aseptic technique or clean technique is used in order to avoid introducing infections into a wound. Even if a wound is already infected, an aseptic or clean technique should be used as it is important that no further infection is introduced. 2. Always place clean items onto a clean barrier such as wax paper, chux or other clean barrier system. Contaminated items must be placed on a separate barrier system as to not contaminate clean items. 3. If at any time you feel you may have interrupted a clean system you must stop, obtain new clean supplies or provide cleaning per facility protocol of any contaminated items. This would include multiple use spray bottles, dressing items, scissors or other items. All muti-use items must be cleaned prior to leaving the room and per facility protocol before using on the next patient. On 11/15/18 a review of all events that meet criteria of infection per facility protocol x 60 days was completed by the Staff Facilitator to include performing surveillance for the identification, investigation and documentation of facility acquired infections, community acquired infections and communicable disease. All infections were assessed for trending to include utilizing a color code system. All identified areas of concerns were	

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F 880	Continued From page 30 Complies surveillance data monthly for reviews." Review of the Infection Control records for 2018, revealed no trending reports for the months of January, February, July, and September. No tracking reports were available for August of 2018. On 10/24/2018 at 4:33 PM, an interview was conducted with the Director of Nursing (DON), who stated the infection control nurse resigned in July 2018, right after the DON had started at the facility. The DON stated she was the only administrative nurse trying to cover all areas. The DON was unable to provide trending data for January, February, July, and September of 2018, and was unable to provide tracking data for August 2018. On 10/25/2018 at 11:25 PM, an interview was conducted with the Administrator who stated he expected to have a suitable infection control program in place, and for it to be implemented and followed per the guidelines.	F 880	immediately addressed by the ADON/DON. Audit will be completed by 11/19/18. On 11/9/18 100% in-service was completed with Unit Nurse Managers, Quality Assurance Nurse (QA) and the ADON by the DON in regards to Infection Control to include but not limited to: 1. Performing surveillance for the purpose of identifying, investigating and documentation of facility acquired infections, community acquired infections and communicable disease 2. Tracking and trending facility acquired infections, community acquired infections and communicable diseases utilizing the color code system 3. Implementing preventative and corrective measures for any related trends in regards to infections 4. The facility will discuss during Cardinal IDT meeting all newly acquired infections to identify potential trends or concerns. 5. The facility Infection Control Preventionist will maintain logs of facility acquired infections, community acquired infections and communicable disease logs along with documentation of tracking/trending monthly for a period designated per facility protocol. All newly hired Unit Nurse Managers, QA Nurse and ADON will be in-serviced by the Staff Facilitator in regards to Infection Control to include but not limited to:	

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F 880	Continued From page 31	F 880	1. Performing surveillance for the purpose of identifying, investigating and documentation of facility acquired infections, community acquired infections and communicable disease 2. Tracking and trending facility acquired infections, community acquired infections and communicable diseases utilizing the color code system 3. Implementing preventative and corrective measures for any related trends in regards to infections 4. The facility will discuss during Cardinal IDT meeting all newly acquired infections to identify potential trends or concerns. 5. The facility Infection Control Preventionist will maintain logs of facility acquired infections, community acquired infections and communicable disease logs along with documentation of tracking/trending monthly for a period designated per facility protocol. 100% Infection Control Logs will be reviewed weekly x 8 weeks then monthly x 1 month by the Unit Nurse Managers, ADON and QA Nurse to ensure all identified infections are investigated with documentation of trends with appropriate preventative or corrective measures initiated. The DON will review and initial the Monthly Infection Control Log weekly x 8 weeks then monthly x 1 month to ensure all areas of concern have been addressed. 25% Resident Care Audits-Treatments will be completed with nursing staff to include	

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F 880	Continued From page 32	F 880	nurse #1 weekly x 8 weeks then monthly x 1 month by the Administrative nurses to ensure nurses are utilizing appropriate aseptic technique during dressing changes. All areas of concern will be immediately addressed by the Administrative nurses and Staff Facilitator to include providing additional wound care utilizing appropriate technique, cleaning of supplies per facility protocol and education of staff. The DON/ADON will review and initial the Resident Care Audit weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed appropriately. The DON will forward the results of the Resident Care Audit-Treatments and the Infection Control Log to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the Resident Care Audit-Treatments and the Infection Control Log 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.	