STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345302	A. BUILDING _____ B. WING _____	C 07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE ON THE MOUNTAIN	417 CLOVERDALE ROAD SYLVA, NC 28779

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 1/06/18-1/11/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID UXLZ11	E 000		
F 000	INITIAL COMMENTS A recertification survey and a complaint investigation survey were completed on 7/22/19 through 7/26/19. There was a total of 30 complaint allegations investigated and 5 were substantiated. Event ID # 0V7K11.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews, the facility failed to assess if a resident was capable of self-administering medications observed at the beside for 1 of 1 resident reviewed for self-administering medications (Resident #76). Findings included: Resident #76 was admitted to the facility 06/21/19 with diagnoses which included chronic obstructive pulmonary disease (COPD) (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), wheezing, and anxiety.	F 554	1. Resident #76 discharged from the facility on 7-22-19. The Resident□s attending physician was alerted to the findings specific to inhalation therapy. No new orders were received. Nurse #3 was re-educated to medication administration, resident self-administration assessments and medication storage practice standards. 2. All residents have the potential to be impacted. The facility will conduct a facility wide review of all resident rooms; ensuring that medications maintained at the bedside for self-administration are supported by the following: a) residents	8/23/19

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

Electronically Signed | 08/16/2019

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F 554	Continued From page 1 A review of physician orders dated 06/21/19 revealed; 1. albuterol sulfate (a medication used to dilate the airways) solution 2.5 milligrams/3 milliliters administer 1 vial via nebulizer (a device used to turn liquid medicine into a mist) inhalation every 6 hours as needed for COPD, 2. albuterol sulfate aerosol inhaler 90 micrograms administer 2 puffs inhalation every 6 hours as needed. The admission Minimum Data Set (MDS) dated 06/28/19 assessed Resident #76 as being cognitively intact with the ability to understand and be understood by others. Special treatments included oxygen use while a resident. The Care Area Assessment of the MDS described Resident #76's anxiety was related to chronic shortness of breath and a diagnosis of COPD which required oxygen use at all times. A review of the care plan initiated 07/05/19 recognized Resident #76 required oxygen therapy related to COPD and chronic shortness of breath. The goal was for Resident #76 to have no signs of shortness of breath, confusion, restlessness, nasal flaring, and increased pulse and respirations. The approach included monitor and report signs of rapid breathing and discoloration of the mucous membranes due to decreased oxygen levels. There was no care plan for self-administration of medications. There were no physician orders for Resident #76 to self-administer medications. A review of medical records revealed no assessments were completed by a nurse or physician for Resident #76 to self-administer	F 554	with medications at the bedside have been assessed and determined safe for self-administration, b) have a physician□s order for self-administration, c) have safe storage for medications maintained at the bedside. Findings will be reported to and addressed promptly by the Director of Nursing (DON) and/or Assistant Director of Nursing (ADON) and forwarded to QAA for processing. 3. The facility has reviewed its□ policy on Medication Storage and Self-Administration of Medications; ensuring clarity and comprehensiveness. No revisions are needed. The facility has reviewed its□ general orientation process for newly hired licensed nurses ensuring the policies on Medication Storage and Self-Administration of Medications are presented during orientation in a comprehensive and clear manner. All licensed nurses, which includes full time (FT), part time (PT□), and per diem (PD) nurses will be re in serviced on the above policies before 8-23-19. Findings will be promptly addressed and communicated to the Director of Nursing (DON) and/or appointed designee who will determine the appropriate course of action. 4. The Licensed Nursing Home Administrator (LNHA) is responsible for the Plan of Correction (POC) implementation. The Quality Assessment and Assurance (QAA) Coordinator and its members will conduct an audit measuring the following are as noted below beginning 8/20/19 and then monthly	

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F 554	Continued From page 2 medications. An observation on 07/22/19 at 11:10 AM revealed a white oblong shaped pill on the floor in front of the bed in the room of Resident #76. On top of the bedside table was a bronchodilator (a medication used to dilate the airways) meter dosed inhaler which read 000 left in the canister. During an interview on 07/22/19 at 11:10 AM Resident #76 revealed the pill was acetaminophen (an analgesic pain medication) which he had dropped on the floor. Resident #76 had not told staff about the pill and stated, "I didn't think it mattered." When asked about the inhaler Resident #76 revealed he had been using it since admission to the facility and kept the medication on top of the bedside table within his reach. Resident #76 revealed the inhaler was used when he became short of breath and was instructed by a Medical Doctor (MD) to use it four times a day for COPD. A second observation on 07/22/19 at 2:20 PM revealed the white pill and inhaler remained in the room of Resident #76. During an interview and observation on 07/22/19 at 2:28 PM Nurse #3 revealed she was assigned to administer medication to Resident #76. She observed 1 white oblong pill on the floor and a meter dosed inhaler on the bedside table in the room of Resident #76. Nurse #3 stated she had not seen the medications till now. She confirmed the pill was acetaminophen which she had not administered to Resident #76. Nurse #3 revealed the facility provided house stock acetaminophen to residents and those pills were round. Nurse #3 asked Resident #76 where he obtained the	F 554	thereafter, and will be responsible for the ongoing monitoring of this process through 1) Daily during medication administration, the nurse or medication aide will review the resident□s room for medication stored at the bedside; confirming that a) the resident has been assessed and determined to be safe for self-administration, b) a physician□s order for self-administration is present and that c) the medications are safely stored. 2) DON, ADON or other nursing administration will conduce weekly resident room rounds x 1 month and randomly thereafter confirming medications stored at the bedside are accompanied by a physician□s order, a self-administration assessment confirming safe administration and that the medications at the bedside are stored safely. The DON or designee will bring the findings to the QAA team where they will be promptly addressed. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance: 8/23/2019	

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F 554	Continued From page 3 acetaminophen and was told family had provided them. Resident #76 then removed a bottle labeled acetaminophen 225 caplets each containing 650 milligrams from a box on his bed which he gave to Nurse #3. Nurse #3 opens the bottle to find it approximately half full of white oblong caplets. Nurse #3 asked about the inhaler and Resident #76 revealed he had used it since admission but denied having another one. Nurse #3 reviewed physician orders but was unable to provide a self-administer order for the medications found at the bedside of Resident #76. Nurse #3 stated residents were to have a physician's order and assessments to determine if they could safely self-administer medications which should be kept secured on a cart. During an interview on 07/26/19 at 12:17 PM the Director of Nursing (DON) revealed residents must have a physician's order and meet assessment criteria to self-administer medications. The DON believed family, or the resident had brought the medications from home into the facility and acknowledged there was a breakdown in the process of inventorying personal items and resident education related to medications left at the bedside.	F 554		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		8/23/19

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F 580	Continued From page 4 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	F 580		

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F 580	Continued From page 5 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, family, and staff interviews the facility failed to notify the Power of Attorney of critical lab values and an admission to the hospital for 1 of 1 resident reviewed for hospitalization (Resident #61). Findings included: Resident #61 was admitted to the facility on 05/21/19 with diagnoses which included cirrhosis of liver with ascites and encephalopathy. Review of the discharge Minimum Data Set (MDS) dated 07/11/19 revealed Resident #61 had an unplanned discharge to an acute hospital on 07/11/19 and was anticipated to return to the facility. The reentry MDS dated 07/16/19 revealed Resident #61 was readmitted to the facility from the hospital. A review of care plan for Resident #61 described the diagnosis of cirrhosis with ascites. The goal was to not exhibit signs of malnutrition. The approaches included monitor lab work as indicated. Review of a nurse note dated 07/11/19 revealed a call was received from lab services to report critical values for a potassium level of 2.5 (normal range 3.5 to 5), sodium level of 126 (normal range 135 to 145), and a ammonia level of 103 (normal range 15 to 45). The Medical Doctor was notified and instructed Nurse #4 to send Resident #61 to the emergency department. Review of the hospital discharge summary	F 580	1. Resident #61 remains at baseline. Nurse #4, who was assigned to Resident #61 on dates where the Resident was assessed and transferred to the hospital has been re-educated to the facility□s policy on Transfer and Discharge During an Emergency which addresses the expectation of communicating the same to the Resident□s responsible party. 2. All residents whose change in condition or abnormal lab values may result in a transfer to the hospital have the potential to be impacted. A facility wide audit of all current residents with hospital transfers within the past 30 days will be conducted beginning on 8/20/2019 and will continue to be reviewed weekly on-going in our RAR (resident at risk) meeting; confirming that the facility notified the Resident□s responsible party of the acute care transfer in a timely fashion. Findings will be reported to and addressed promptly by the Director of Nursing (DON) and/or Assistant Director of Nursing (ADON) and forwarded to QAA for processing. 3. The facility has reviewed its□ policy on Transfer, Discharge During an Emergency; ensuring clarity. No revisions are needed. The facility has reviewed its□ general orientation process for newly hired licensed nurses ensuring the policy on Transfer, Discharge During an Emergency is presented during orientation	

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F 580	Continued From page 6 revealed Resident #61 was admitted on 07/11/19. The discharge summary revealed Resident #61 was unable to provide useful information therefore the Power of Attorney (POA) was contacted. During a discussion held on 07/12/19 it was revealed the POA was not aware Resident #61 had been sent to the hospital. An interview conducted on 07/25/19 at 4:12 PM with the POA who stated she was unaware until the hospital staff notified her on 07/12/19 Resident #61 had been admitted on 07/11/19. The POA revealed this was the second time the facility had not notified her when Resident #61 was sent to the hospital. The POA asked Nurse #4 why she was not notified on 07/11/19 when Resident #61 was discharged to the hospital and was told it was passed on to the oncoming shift. During an interview on 07/25/19 at 4:57 PM Nurse #4 revealed she had sent Resident #61 to the emergency department on 07/11/19. Nurse #4 explained this occurred during change of shifts and she asked the oncoming Nurse to notify the POA. During an interview on 07/26/19 at 12:23 PM the Director of Nursing (DON) explained usually the reason a POA wasn't notified was because of the urgency of the matter. The DON was unsure if that was true in this case, but the expectation was for the POA to be informed of incidents, changes in condition, and when resident were sent out facility.	F 580	in a comprehensive and clear manner. All licensed nurses, which includes full time (FT), part time (PT□), and per diem (PD) nurses, will be re in-serviced on the above policy before 8-23-19. Residents experiencing hospital transfers shall be reviewed during weekly Resident at Risk (RAR) meetings; ensuring responsible party notification. Findings will be promptly addressed and communicated to the Director of Nursing (DON) and/or appointed designee who will determine the appropriate course of action. 4. The Licensed Nursing Home Administrator (LNHA) is responsible for the Plan of Correction (POC) implementation. The Quality Assessment and Assurance (QAA) Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process through 1) A Resident at Risk review of all residents with hospital transfers will be conducted weekly by the Director of Nursing (DON)/Assistant Director of Nursing (ADON), ensuring responsible party notification. Findings will be promptly addressed. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance 8/23/2019	
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655		8/23/19

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F 655	Continued From page 7 Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting	F 655		

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F 655	Continued From page 8 on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the residents for 3 of 4 sampled residents reviewed for baseline care plan (Resident #9, #16, #48). Findings included: 1. Resident #9 was admitted on 10/10/18 with diagnoses that included diabetes mellitus, seborrheic dermatitis, and pain. Review of Resident #9's medical records indicated the baseline care plan was created by Nurse #6 on 10/30/18. Further review of the baseline care plan revealed it was not completed as none of the approaches under each care plan were checked by Nurse #6. Review of the facility's care planning policy that was last revised on 12/21/07 indicated a baseline care plan was to be initiated and completed within 48 hours. Nurse #6 was not available for an interview. She was no longer employed in the facility and unable to be reached via phone or other mean of communications. During an interview conducted on 07/24/19 at 12:24 PM, the Minimum Data Set (MDS) Coordinator stated the baseline care plan was	F 655	1. Residents #9, #16, and #48 remain at baseline. All Resident□s now have comprehensive care plans that succeed the 48-hour baseline care plan. Nurse #6 is no longer employed by the facility. Nurse #7 will be reeducated to the base line care plan tool, policy and expectation. Nurse #7 will also be reeducated on accessing Nursing Management with concerns specific to staffing. 2. All residents admitted to the facility have the potential to be impacted. A facility wide review of current residents who were admitted to the facility within the past 30 days will be conducted; confirming the completion of 48-hour baseline care plans. Findings will be reported to and addressed promptly by the Director of Nursing (DON) and/or Assistant Director of Nursing (ADON) and forwarded to QAA for processing. 3. The facility has reviewed its□ a 48 Hour Baseline Care Plan policy and process. No revisions are needed at this time. The facility has reviewed its□ general orientation process for newly hired licensed nurses ensuring the process on the 48 Hour Baseline Care Plan is presented during orientation in a comprehensive and clear manner. The LNHA, DON, ADON, MDS Nurse, SW, Activities Director, Rehab Manager and all	

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F 655	Continued From page 9 supposed to be in place within 48 hours after a resident was admitted. She acknowledged that the baseline care plan for Resident #9 was not completed in a timely manner. The MDS Coordinator indicated the hall nurse of the resident during admission was responsible for completing the initial assessment and the baseline care plan. She attributed the incident as lack of communication and confusion of roles between floor nurse and the MDS nurse. An interview was conducted with the Director of Nursing (DON) on 07/25/19 at 1:10 PM. She stated the above incident occurred before she started her role as DON in the facility. According to the DON, the baseline care plan had to be completed by the hall nurse within 48 hours after a resident was admitted. It was her expectation for all the nurse to follow the Centers of Medicare & Medicaid Services (CMS) rules and regulations to complete baseline care plan as required in timely manner. 2. Resident #16 was admitted on 11/01/18 with diagnoses that included diabetes mellitus, seizure, depression, chronic pain, and insomnia. Review of Resident #16's medical records indicated the baseline care plan was created by Nurse #7 on 11/09/18. Further review of the baseline care plan revealed it was completed with appropriate approaches selected by Nurse #7 for each respective problems. Review of the facility's care planning policy that was last revised on 12/21/07 indicated a baseline care plan was to be initiated and completed within 48 hours.	F 655	licensed nurses which includes full time (FT), part time (PT□), and per diem (PD) nurses assigned the responsibility of 48 hour baseline care plan development will be re-in-serviced to the above process by 8-23-19. 4. The LHNA is responsible for the Plan of Correction (POC) implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1) The DON/ADON will conduct an audit beginning 8/20/19 of all newly admitted Resident medical record daily (M-F) x 1 month, then on-going as new residents are admitted into the facility; ensuring the timely activation and completion of one□s 48-hour baseline care plan. Baseline care plans for Residents scheduled for admission to the facility Friday through Sunday will assigned and reviewed by the 7A-7P charge nurse; ensuring timely activation and completion. 2) Weekly during RAR meetings, the DON/ADON will review medical records of newly admitted residents; again, ensuring the timely activation and completion of one□s 48-hour baseline care plan. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing. Date of Compliance: 8/23/2019	

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F 655	Continued From page 10	F 655		

During an interview conducted on 07/24/19 at 12:24 PM, the Minimum Data Set (MDS) Coordinator stated the baseline care plan was supposed to be in place within 48 hours after a resident was admitted. She acknowledged that the baseline care plan for Resident #16 was not completed in a timely manner. The MDS Coordinator indicated the hall nurse of the resident during admission was responsible for completing the initial assessment and the baseline care plan. She attributed the incident as lack of communication and confusion of roles between floor nurse and the MDS nurse.

An interview was conducted with the Director of Nursing (DON) on 07/25/19 at 1:10 PM. She stated the above incident occurred before she started her role as DON in the facility. According to the DON, the baseline care plan had to be completed by the hall nurse within 48 hours after a resident was admitted. It was her expectation for all the nurse to follow the Centers of Medicare & Medicaid Services (CMS) rules and regulations to complete baseline care plan as required in timely manner.

During a phone interview conducted on 07/26/19 at 2:59 PM, Nurse #7 stated she could not recall she was the hall nurse for Resident #16 during admission. She did not know why the baseline care plan was not completed within 48 hours. However, she added she was busy most of the time due to insufficient staffing and that could cause her to forget the completion of baseline care plan for newly admitted resident. As the hall nurse, Nurse #7 was very clear that she was responsible for the completion of the baseline care plan for the newly admitted resident.

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F 655	Continued From page 11	F 655		

3. Resident #48 was admitted on 05/22/19 with diagnoses that included diabetes mellitus, depression, acute embolism and thrombosis of deep veins of right lower extremity, and hypertension.

Review of Resident #48's medical records indicated the baseline care plan was created by the Minimum Data Set (MDS) Coordinator on 05/28/19. Further review of the baseline care plan revealed it was not completed as none of the approaches were checked by the MDS Coordinator except "Own Teeth" under oral care of Goal #1.

Review of the facility's care planning policy that was last revised on 12/21/07 indicated a baseline care plan was to be initiated and completed within 48 hours.

During an interview conducted on 07/24/19 at 12:24 PM, the MDS Coordinator stated the baseline care plan was supposed to be in place within 48 hours after a resident was admitted. She acknowledged that the baseline care plan for Resident #48 was not completed in a timely manner. The MDS Coordinator indicated the hall nurse of the resident during admission was responsible for completing the initial assessment and the baseline care plan. She attributed the incident as lack of communication and confusion of roles between floor nurse and the MDS nurse.

An interview was conducted with the Director of Nursing (DON) on 07/25/19 at 1:10 PM. She stated the above incident occurred before she started her role as DON in the facility. According to the DON, the baseline care plan had to be completed by the hall nurse within 48 hours after

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F 655	Continued From page 12 a resident was admitted. It was her expectation for all the nurse to follow the Centers of Medicare & Medicaid Services (CMS) rules and regulations to complete baseline care plan as required in timely manner.	F 655		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to follow physician orders to change wound dressings for two Stage 4 pressure ulcers two times a day for 1 of 1 resident reviewed for pressure ulcers (Resident #2). Findings include: Resident #2 was admitted 4/16/16 with diagnoses including paraplegia, anxiety disorder and depression. Review of the most recent comprehensive	F 686	1. Resident #2 remains at his baseline. A review of Resident #2□s wound(s) confirm ongoing healing. Nurses #1, #2 and #4 were reeducated to the expectation of following physician□s orders as well as how to access the DON or ADON with concerns regarding staffing. 2. All residents with treatment orders for wound care have the potential to be impacted. The facility will identify all residents with treatment orders for wound care and then conduct a review of the August 2019 Treatment Administration	8/23/19

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F 686	Continued From page 13 Minimum Data Set (MDS) assessment dated 6/28/19 revealed Resident #2 was cognitively intact and required minimal assistance with most activities of daily living. There was no rejection of care noted in the MDS. The MDS further revealed Resident #2 had 2 (two) unhealed Stage 4 pressure ulcers and a suprapubic catheter. Review of Resident #2's current care plan revealed he/she was care planned for pressure ulcers with a goal of the pressure ulcers not to increase in size and show no signs of infection. Interventions included: apply dressings per MD order, assess pressure ulcer for stage, size (length/width/depth) presence/absence of granulation tissue and epithelization and condition of surrounding skin, conduct a systematic skin inspection weekly, report any signs of any further skin breakdown (sore, tender, red, or broken areas), encourage and assist resident with turn and reposition every 2 hours, encourage resident to limit time in wheelchair to 2 hours, use cushion for pressure reduction when resident is in chair, use lifting device to move resident in bed, use moisture barrier product to perineal area. Resident's catheter leaks often, assist resident with catheter care and encourage resident to change clothing that is wet. A review of the physician orders revealed the following: 5/22/19 cleanse sacral (bottom of the spine) and ischial (lower back part of the hip bone), wounds with normal saline and dry. Pack with gauze moistened with ¼ strength strong antiseptic solution and cover with absorbent dressing BID (two times a day). The order was discontinued 6/21/19.	F 686	Record (TAR); ensuring compliance with treatment orders as evidenced by a nurse□s initials signaling administration. At least weekly the DON/ADON will conduct TAR reviews; confirming the completion of prescribed wound treatments are occurring as ordered. Findings will be reported to and addressed promptly by the Director of Nursing (DON) and/or Assistant Director of Nursing (ADON) and forwarded to QAA for processing. 3. The facility has reviewed its□ policies/processes on Physician□s Orders, Wound Care and Pressure Injury Treatment. No revisions are needed. The facility has reviewed its□ general orientation process for newly hired licensed nurses ensuring the policies on Physician□s Orders, Wound Care and Pressure Injury Treatment are presented during orientation in a comprehensive and clear manner. All licensed nurses will be re-educated to these policies and procedures. All licensed nurses which includes full time (FT), part time (PT□), and per diem (PD) nurses assigned the responsibility of performing treatments to wounds will be reeducated to the above processes by 8-23-19. 4. The LHNA is responsible for the Plan of Correction (POC) implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1) At least weekly beginning on August 21, 2019 x 1 month the	

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F 686	Continued From page 14 6/21/19 cleanse sacral and ischial wounds with normal saline and pat dry, pack with gauze moistened with a solution to stop bacteria from growing), secure with border gauze, change BID (two times a day). 6/25/19 from Hospital Wound Center, use 1/4 strength strong antiseptic solution on gauze twice daily to sacral and ischial ulcers/large gauze pad/soft adhesive dressing. Further review of the medical record revealed Resident #2 had been seen by Harris Wound Center, with the last visit dated 2/20/19. Resident #2 was scheduled to return to Mission Hospital wound center the week of July 22, 2019. A review of Resident #2's treatment record for June and July 2019 revealed during the month of June, 19 of 60 scheduled dressings were not documented as being completed. From 07/01/19 to 07/23/19, 15 out of 46 scheduled dressings were not documented as being completed. An interview with Resident #2, conducted on 7/23/19 at 3:30 PM, revealed the pressure ulcer dressings were supposed to be changed two times a day. Resident #2 stated the staff have not always changed the dressings two times a day because they did not have time. On 07/24/19 at 11:30 AM, observed Nurse #1 provide wound care to the sacral and ischial Stage 4 pressure ulcers. An interview with Nurse #1 revealed there are times she has missed doing a dressing change during her 12 hour shift, 7am-7pm, because the facility has been short staffed and she has been too busy passing	F 686	DON/ADON will conduct TAR reviews; confirming via audit tool the completion of prescribed wound treatments are occurring as ordered; 2) Weekly during the RAR meeting, the DON/ADON will review all residents with pressure injuries; confirming treatment orders are occurring and are documented. Findings will be addressed promptly reported to the QAA team. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance: 8/23/2019	

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F 686	Continued From page 15	F 686		

medications. Nurse #1 also stated Resident #2 would sometimes refuse a dressing change. Nurse #1 stated she documented that the dressing was not completed and reported to the next shift that the dressing was not completed.

An interview, conducted with Nurse #2 on 7/25/19 at 12:38 PM, revealed she has provided wound treatments to Resident #2 for the past 3 months. Nurse #2 stated she had missed doing wound dressing changes on Resident #2 when the facility was short-staffed and she was the only nurse on both med carts on the 100 hall. She indicated she told the next shift that the wound care was not done. She also stated there were lots of days that the dressing was not done two times a day due to staffing. Nurse #2 also stated the facility had a wound care nurse but she was let go about 2 months ago. The previous ADON (Assistant Director of Nursing) would sometimes help with wound treatments on the weekends.

An interview, conducted with Nurse #4 on 07/26/19 at 8:51 AM, revealed that when the facility was short staffed and she was responsible for med pass and treatments for one hall and half of another hall, the wound dressing changes for Resident #2 were not done as ordered. Nurse #4 stated she documented that the dressing was not completed and reported to the next shift. Nurse #4 stated if there was no documentation that the dressings were not completed, it could have been because the nurse did not have time or that Resident #2 refused.

An interview, conducted with the DON (Director of Nursing) on 7/26/19 at 11:15 AM, revealed she started as a new employee in the DON position on 7/15/19. She stated that upon her first day at

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F 686	Continued From page 16 the facility, she immediately recognized that the facility needed a change in staffing to assure the residents received the treatments that were ordered, including Resident #2's dressing changes. She stated she and the Administrator had developed a plan to increase staffing to address the needs of the residents.	F 686		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced	F 725		8/23/19

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F 725	Continued From page 17 by: Based on record reviews, observations, resident, and staff interviews, the facility failed to provide sufficient nursing staff to ensure wound care was completed as directed by physician orders for 1 of 1 resident reviewed for pressure ulcers (Resident #2). Findings included: This tag was crossed referenced to: F-686: Based on observation, record review, resident and staff interviews, the facility failed to follow physician orders to change wound dressings for two Stage 4 pressure ulcers two times a day for 1 of 1 resident reviewed for pressure ulcers (Resident #2). Review of hours worked revealed on 07/03/19 Medication Aide #2 worked a total of 17.5 hours. On 07/05/19 Med Aide #2 worked 23.75 hours with one 15-minute break. On 07/06/19 Medication Aide #2 worked 16.5 hours. On 06/27/19 through 06/28/19 Nurse #4 clocked in at 4:00 PM and worked till 2:00 AM. Nurse #4 clocked out for a 3-hour break then back at 5:00 AM through 8:00 PM. During an interview, on 07/23/19 at 3:30 PM, Resident #2 stated his wound dressings should be changed twice a day but didn't always get changed as directed by physician orders. During an interview, on 07/24/19 at 12:33 PM, Nurse #4 explained the facility did have a wound care nurse who quit the end of June 2019. The facility had not filled the wound care position and currently the nurses were responsible for	F 725	1. Resident #2 is stable and remains at his baseline. A review of Resident #2□s wound(s) confirm ongoing healing. All licensed nurses will be reeducated to the expectation of following physician□s orders as well as how to access the DON or ADON with concerns regarding staffing. The facility continues its□ recruiting efforts with success. The facility has augmented its□ licensed nurse needs with the use of a supplemental agency. 2. All residents with treatment orders for wound care have the potential to be impacted. The facility will identify all residents with treatment orders for wound care and then conduct a review of the August 2019 Treatment Administration Record (TAR); ensuring compliance with treatment orders as evidenced by a nurse□s initials signaling administration. Education was provided to the licensed nurses from 8/20/2019-8/22/2019 instructing them to notify nursing administration for any reason if daily care of any kind could not be performed. All nursing staff verbalized understanding of education provided. Furthermore, the DON/ADON will review the nursing staffing from the past two (2) weeks beginning on 8/20/2019 ensuring the presence of licensed staff to meet the needs of the residents. Findings will be reported to and addressed promptly by the Director of Nursing (DON) and/or Assistant Director of Nursing (ADON) and forwarded to QAA for processing.	

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F 725	Continued From page 18 providing wound care to their assigned residents. Nurse #4 revealed wound care was inconsistent and at times not provided due to short staffing. Nurse #4 revealed recently the facility had lost multiple staff and suffered what she called, "a staffing crisis" which started the end of May 2019. Nurse #4 stated she and other staff had covered multiple shifts and described times when only 1 nurse was in the building she stayed at work so there would be two nurses. Nurse #4 stated sometimes only 1 Nurse and 1 Nurse Aide showed up for the next shift and she worked back to back shifts. A second interview on 07/26/19 at 8:51 AM Nurse #4 revealed she was familiar with Resident #2's wound care orders. Nurse #4 explained when she was assigned 1.5 halls to administer medications and provide treatments it was difficult for her to complete the treatments due to short staffing. During an interview, on 07/25/19 at 12:38 PM, Nurse #2 revealed she had provided wound care treatments along with other assigned duties over the past 3 months. Nurse #2 stated when she was assigned two carts she was unable to provide wound care treatments and there were lots of days dressing were not changed as directed by the physician. Nurse #2 stated treatments were missed due to being short staffed at the facility. An interview was conducted on 07/25/19 at 12:51 PM with Nurse #3 who stated were times when she had missed a treatment due to the acuity of care. Nurse #3 would document in the computer that due to patient care, treatments were not done. Nurse #3 would report to the next shift treatments were not done or at times stay over to provide the wound care.	F 725	3. The facility has reviewed its□ policy on Staffing and the Vero NC Employee Handbook to address breaks and meal times for scheduled employees. The facility has reviewed its□ general orientation process for newly hired licensed nurses, medication aides and certified medical assistants (CNAs) ensuring the policies on Staffing and the Vero NC Employee Handbook to address breaks and meal times for scheduled employees are presented during orientation in a comprehensive and clear manner. All current licensed nurses, medications aide and CNAs which includes full time (FT), part time (PT□), and per diem (PD) will be re-educated to the policy and handbook. The DON, ADON, and LNHA will review the nursing master schedule daily; ensuring the presence of licensed staff to meet the needs of the residents. The facility only has 6 positions for licensed nurses open. We are continuing to advertise on Indeed, Jazz HR and other online sites as well as a facility Facebook page. Flyers advertising open positions, benefits, and new hire bonuses were distributed to at least 3 surrounding counties for licensed nurses at the beginning of August. We have also used a staffing agency to supplement staffing. 4. The Licensed Nursing Home Administrator (LNHA) is responsible for the Plan of Correction (POC) implementation. The QAA Coordinator and its members as noted below will be	

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F 725	Continued From page 19 During an interview, on 07/26/19 at 9:25 AM, Medication Aide #2 revealed he had worked at the facility approximately 2 months. Medication Aide #2 confirmed he had worked 23.75 hours with one 15-minute break and revealed he had worked approximately three 24 hour shifts since his employment. Medication Aide #2 revealed he had worked extra shifts when the facility had been short of staff which occurred mainly on the 7:00 PM through 7:00 AM shift. Medication Aide #2 stated there were times when he and one Nurse Aide were assigned to provide resident care on two halls which made it impossible to complete assignments on time. During an interview on 07/26/19 at 11:13 AM the Director of Nursing (DON) recognized there were concerns related to insufficient staff at the facility and revealed she obtained the DON position approximately 1 week ago. The DON revealed having 1 Medication Aide and 1 Nurse Aide assigned to provide resident care for 2 halls was not her expectation and recognized wound care wasn't being provided as directed by physician orders. The DON revealed the new company planned to address insufficient staffing issues and budgeted to have 3 nurses assigned from 7:00 PM through 7:00 AM.	F 725	responsible for the ongoing monitoring of this process as follows: 1) Daily audits of the staffing schedule will begin on 8/20/2019 in the morning clinical meeting by the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Staffing Coordinator x1 month then weekly on-going; ensuring the presence of licensed staff to meet the needs of the residents. Staff were educated on 8/21/2019 to call DON or ADON for any call out and the addition of the management nurse on call for emergencies. DON or designee will determine if staffing needs are sufficient or if other staff members need to be called in. If additional staff is needed, DON or designee will begin along with the scheduler to find additional coverage. If no additional coverage can be found and staffing numbers are not sufficient for resident care, then DON or designee will report to the facility and call additional administrative staff as needed. DON or designee will report staffing to the administrator.2) Routine resident care unit rounds ensuring the presence of licensed staff as scheduled. Findings will be addressed promptly by the Director of Nursing (DON) and/or Assistant Director of Nursing (ADON). After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance: 8/23/19	

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F 761	Continued From page 20	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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 observations, record review, resident, and staff interviews, the facility failed to safely secure vials of breathing treatment medication observed at the beside for 1 of 1 resident reviewed for medication storage (Resident #229). Findings included: Resident #229 was admitted to the facility	F 761	1. Resident #229 remains stable and at her baseline. With Resident #229□s support, her room was assessed for medication not dispensed by the facility□s institutional pharmacy partner; removing the medications/treatments and storing them safely for facility removal by the resident□s family. The Director of Nursing (DON) and/or Assistant Director	8/23/19

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F 761	Continued From page 21 07/19/19 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD) and hypertension. A review of a Nurse note dated 07/19/19 read in part, numerous respiratory diagnoses which included the scheduled use of a meter dose inhaler along with a hand-held nebulizer treatment. On 07/20/19 the Nurse documented Resident #229 had an episode of shortness of breath which was relieved by albuterol (a medication used to dilate lung airways) treatment as ordered by the physician. On 07/21/19 and 07/23/19 the Nurses documented Resident #229 was alert and oriented with episodes of confusion. A review of physician orders revealed: 1. albuterol sulfate solution 2.5 milligrams/3 milliliters administer 1 vial via nebulizer (a device used to turn liquid medicine into a mist) inhalation four times a day for COPD, dated 07/19/19. 2. albuterol sulfate solution 2.5 milligrams/3 milliliters administer 1 vial via nebulizer inhalation every 4 hours as needed for COPD, dated 07/23/19. A review of the baseline care plan dated 07/20/19 described complications related to diagnosis and identified a risk for respiratory complications. The goal was for Resident #229 not to develop complications from medical conditions. Approaches included observe for shortness of breath and other signs of respiratory distress. During an observation on 07/22/19 at 9:41 AM while in the room of Resident #229 a box labeled albuterol sulfate inhalation solution; 2.5	F 761	of Nursing (ADON) will ensure that replacement medications/treatments formerly kept at the bedside are ordered from the institutional pharmacy partner in accordance with orders and stored in accordance with the facility□s medication storage policy. 2. A discussion with Resident #229 and the family has been scheduled to improve communication regarding medications and/or treatment dispensing from the pharmacy directly to the facility. Resident #229, as desired, will be assessed for self-administration of medications/treatment. If determined safe, Resident #229□s physician will be alerted to the same and an order secured for self-administration. 3. All residents have the potential to be impacted. The facility will conduct a facility wide review of all resident rooms; ensuring that medications maintained at the bedside for self-administration are supported by the following: a) residents with medications at the bedside have been assessed and determined safe for self-administration, b) have a physician□s order for self-administration, c) have safe storage for medications maintained at the bedside. Findings will be reported to and addressed promptly by the Director of Nursing (DON) and/or Assistant Director of Nursing (ADON) and forwarded to QAA for processing. 4. The Licensed Nursing Home	

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	345302	A. BUILDING _____ B. WING _____	C 07/26/2019

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F 761	Continued From page 22 milligrams/3 milliliters was observed on the top of the bed. The box contained 2 unopened and 1 open packet of single dose medications for a total of 13 vials. During an interview on 07/22/19 at 9:41 AM Resident #229 revealed the she had brought the albuterol from home. Resident #229 explained the vials were kept in the top drawer of the night stand in her room. Resident #229 revealed when she became short of breath she would call the nurse who would administer a nebulizing breathing treatment using a vial of albuterol medication. Resident #229 stated she could not administer her own breathing treatments. During an interview and observation on 07/22/19 at 10:29 AM Medication Aide (MA) #1 revealed she just found and removed a box of albuterol breathing treatment vials from Resident #229's room. MA #1 handed the box of medication vials to Nurse #3. MA #1 explained a resident should not have medications at the bedside. During an interview on 07/22/19 at 10:45 AM Nurse #3 revealed she had not administered a nebulizer breathing treatment of albuterol to Resident #229. Nurse #3 reviewed the Medication Administration Record and confirmed the last treatment was on 07/21/19 at 8:00 PM. Nurse #3 stated residents' medications should be kept secured on a cart. During an interview on 07/26/19 at 12:17 PM the Director of Nursing (DON) revealed it was her expectation medications were stored on the medication cart and not left at the bedside. The DON believed family, or the resident had brought the medications from home into the facility and	F 761	Administrator (LNHA) is responsible for the Plan of Correction (POC) implementation. The Quality Assessment and Assurance (QAA) Coordinator and its members will conduct an audit measuring the following are as noted below beginning 8/20/19 and then monthly thereafter, through 1) Daily during medication administration, the nurse or medication aide will review the resident□s room for medication stored at the bedside; confirming that a) the resident has been assessed and determined to be safe for self-administration, b) a physician□s order for self-administration is present and that c) the medications are safely stored. 2) DON, ADON or other nursing administration will conduce weekly resident room rounds x1 month and randomly thereafter confirming medications stored at the bedside are accompanied by a physician□s order, a self-administration assessment confirming safe administration and that the medications at the bedside are stored safely. The DON or designee will bring the findings to the QAA team where they will be promptly addressed. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance: 8/23/19	

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F 761	Continued From page 23 acknowledged there was a breakdown in the process of inventorying personal items and resident education related to medications left at the bedside.	F 761		
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: (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	F 880		8/23/19

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F 880	Continued From page 24 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: Based on observations, staff interviews and review of the facility's Infection Control policy, the facility failed to use infection control practices during med pass and failed to wash hands between glove changes when providing wound	F 880	1. Nurse #5 is no longer employed at the facility. Nurse #1 was re-educated to proper infection control practices when performing medication and treatment administration.	

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F 880	Continued From page 25 care for 1 of 1 resident reviewed for pressure ulcers (Resident #2). Findings include: 1. Review of the policy, "Administering Medications ...22. Staff shall follow established facility infection control procedures e.g. handwashing ...for the administration of medications ..." An observation of med pass was conducted on 7/24/19 at 8:20 AM. Nurse #5 cleaned her hands using hand sanitizer before starting the med pass. Resident #35 was selected for the next med pass. With her right hand, she used a mouse to access the resident's electronic medication record. She opened the medication drawer and removed the blister pack containing Carvidelol 12.5mg. Using her left hand, she popped a single pill out of the blister pack into her right hand, then placed the pill into the medicine cup. She touched the mouse with her right hand to access the medication record for the next medication. She opened the drawer and removed the blister pack containing Cipro 250 mg, popped a single pill out into her right hand then placed the pill into the medicine cup. She touched the mouse with her right hand to access the medication record for the next medication. She opened the drawer and removed the blister pack containing Clopidogrel 75mg, popped a single pill out into her right hand then placed the pill into the medicine cup. She touched the mouse with her right hand to access the medication record for the next medication. She opened the drawer and removed the blister pack containing Hydrochlorthiazide 12.5mg, popped a single pill into her right hand then placed the pill into the	F 880	2. All residents receiving medication and treatment administration have the potential to be impacted. The facility will conduct a medication and treatment observation review with all FT, PT and PD medicine aides and licenses nurses; ensuring compliance with infection control practices. Findings will be reported to and addressed promptly by the Director of Nursing (DON) and/or Assistant Director of Nursing (ADON) and forwarded to QAA for processing. 3. The facility will review its policies and/or processes for Hand Washing, Medication Administration and Treatment Administration; ensuring clarity and comprehensiveness. No revisions are needed. The facility has reviewed its general orientation process for newly hired licensed nurses ensuring the policies on Hand Washing, Medication Administration and Treatment Administration are presented during orientation in a comprehensive and clear manner. All licensed medicine aides and nurses which includes full time (FT), part time (PT), and per diem (PD) will be re-educated to processes and policies and related expectations by 8/23/19. 4. The Licensed Nursing Home Administrator (LNHA) is responsible for the Plan of Correction (POC) implementation. The Quality Assessment and Assurance (QAA) Coordinator and its members as noted below will be responsible for the ongoing monitoring of	

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F 880	Continued From page 26 medicine cup. She touched the mouse with her right hand to access the medication record for the next medication. Nurse #5 entered Resident #35's room and administered the medications in the medicine cup. Nurse #5 returned to the medication cart, washed her hands with hand sanitizer, touched the mouse to select the next resident for med pass. An interview, conducted with Nurse #5 on 7/24/19 at 8:42 AM, revealed she popped the pills out of the blister packs into her hands and then transferred them to the medicine cup. She further stated, "I know better than that. I should not have popped the pills into my hand but directly into the medicine cup." 2. Review of the policy, "Wound Care" revealed the following steps in the Procedure ...4. Put on exam gloves. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. Put on gloves ..." On 7/24/19 at 11:30 AM Resident #2's wound dressing change was observed performed by Nurse #1. With clean hands, she put a pair of clean gloves on both hands, removed the soiled dressings from the sacral wound and the ischial wound. She removed the soiled gloves then put on a clean pair of gloves. She cleaned both wounds with normal saline then removed her gloves. She put on a clean pair of gloves then packed both wounds with Anasept moistened gauze, covered with border dressing. Nurse #1 failed to wash her hands with hand sanitizer or soap and water between changing the dressing on the sacrum and the ischial wounds. Nurse #1	F 880	this process through 1) Upon hire, all licensed nurses and medicine aides will complete a wound care competency as well as a medication administration competency conducted by the DON, ADON or staff educator; ensuring safe wound care and medication administration practices. Findings will be addressed promptly and reported to the DON. 2) Quarterly, the DON, ADON, or staff educator will conduct a treatment and medication administration audit of staff; ensuring compliance with acceptable administration techniques with a focus on infection control. 3) Annually, all licensed nurses will participate in a skills training conducted by the DON and ADON which will include medication administration safe practice review. Findings will be promptly addressed. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Audits will be conducted by the DON or designee 3x/wk for 1 week then 1x/ wk for 1 month then monthly on-going for QA and compliance beginning on 8/20/2019. This audit will monitor proper procedure for infection control practices during medication administration as well as performing a wound dressing change. Date of Compliance: 8/23/2019	

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F 880	Continued From page 27 failed to wash her hands after discarding dirty gloves and before donning clean gloves. An interview, conducted with Nurse #1 on 7/24/19 at 12:00 PM, revealed Nurse #1 did not usually wash her hands between the two wounds when she completed Resident #2's dressing change. An interview, conducted with the Director of Nursing (DON) on 7/26/19 at 11:15 AM, revealed she had been in the DON position since 7/15/19. The DON stated that the nurse should have washed her hands between the two wounds and when changing gloves, either with hand sanitizer or soap and water.	F 880		