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 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERO HEALTH & REHAB OF SYLVA	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
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 10/16/23 through 10/18/23. Event ID# VD0S11. The following intakes were investigated: NC00206676, NC00207101, NC00207735, NC00208035, NC00208237 and NC00208865. 3 of the 16 complaint allegations resulted in deficiency.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		11/11/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/08/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550 Continued From page 1

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, resident, and staff interviews, the facility failed to treat a resident in a respectful and dignified manner when the Social Worker completed a Brief Interview for Mental Status (BIMS) assessment on 1 of 3 residents (Resident #12) reviewed for dignity and respect. This occurred while he was in the therapy gym with other residents and therapists in the same area of the gym. Resident #12 stated it made him feel "embarrassed, singled out, and targeted."

The findings included:

Resident #12 was admitted to the facility on 10/06/23 with diagnoses which included type II diabetes mellitus, chronic pain, low back pain, and cellulitis.

A Minimum Data Set (MDS) assessment had not been completed; however, according to the initial nursing assessment completed on 10/06/23, Resident #12 was alert and oriented to person, place, time, and situation. The assessment also revealed the resident required extensive

F 550

F 550 Resident Rights

1. Immediate action to correct this alleged deficient practice includes the following: On 10-19-2023, the Administrator met with Resident #12 on 10-19-2023 and made him aware that the Social Services Worker was re-educated on the Policy and Procedure of ensuring resident privacy, confidentiality, and dignity. The resident was also assured that the Social Services Worker will conduct his interviews in privacy with dignity and respect going forward.
The Social Services Worker was re-educated by the Administrator on 10/19/2023 regarding the resident's right to be treated in a respectful and dignified manner
and to conduct interviews in a private location.

2. The facility recognizes that all residents have the potential to be affected

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F 550 Continued From page 2

assistance with transfers and his mobility was in a wheelchair.

An observation and interview on 10/18/23 at 2:46 PM with Resident #12 and his family member revealed the resident sitting in his wheelchair in his room and was fidgeting in his chair, his eyes were wide open and he was sighing. Resident #12 stated he felt like he was being "targeted" by the facility administrative staff because the Social Worker (SW) had asked him "personal questions" in the therapy gym within a distance that both therapy staff and other residents could hear the interview. Resident #12 explained the SW "abruptly walked in and looked at me and said I need to ask you some questions." The resident further stated he said okay not knowing what she had to ask him. He said she proceeded with questions that he felt she was asking to "test my mental capacities." Resident #12 further stated he answered her questions but was "embarrassed" that the therapists and other residents in the gym could hear their conversation. He further explained he felt he had been "singled out" because he had complained yesterday about not getting showers as he preferred and felt like the facility was retaliating against him for complaining and filing a grievance. Resident #12 went on to say that he was not sure he felt safe staying in the facility because he felt like he was being "targeted" by the administrative staff.

An interview was conducted on 10/18/23 at 3:23 PM with the therapy staff including the Rehab Director, Occupational Therapist #1, Certified Occupational Therapy Assistant (COTA) #1, COTA #2 and Physical Therapy Assistant (PT-A) #1. The Occupational Therapist (OT) #1

F 550

by this alleged deficient practice:
All residents that were alert oriented and interviewed by the Administrative team (Administrator, Administrative Assistant, and Nurse Supervisor on 10-20-2023 to ensure the residents had no other concerns regarding being treated with dignity and respect by conducting interviews and care with privacy.

3. Measures put into place to ensure that this alleged deficient practice does not recur includes:

All staff (fulltime, part time, and contract including agency staff) were re-educated by the Director of Nursing , Administrator, Nurse, and / or Nurse Consultant on the resident's right to be treated in a respectful and dignified manner and to conduct interviews and care to protect the resident's privacy. This education was provided by the Nurse Unit Manager and the Administrative Assistant on 10-19-2023,10-23-23, and 10-24-23. Any staff that did not receive the education by 11-11-2023 will not be allowed to work until they receive the education.

Newly hired employees and agency staff will be educated on the resident's right to be treated in a respectful and dignified manner and to conduct interviews and care to protect the resident's privacy during their orientation and onboarding.

4. Monitoring will be completed by the following :

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F 550	Continued From page 3 assigned to work with Resident #12 on 10/18/23 revealed she had completed her session with the resident when the Social Worker (SW) came into the gym and wanted to ask the resident some questions. The OT stated it was not typical that the SW came into the gym to interview residents while receiving therapy but said she stepped back to allow the SW to question the resident. She further stated after the interview Resident #12 seemed offended and was visibly upset according to his facial expressions. The OT indicated Resident #12 said to her, "I don't know why she asked me those questions in here." She said she told him she probably asked those questions to complete her assessment of him for his record. The OT further indicated there were other therapists working with other residents in the gym that could have overheard the conversation between the SW and Resident #12. The Rehab Director and COTA #1 stated it was not typical for the SW to come into the rehab gym to question residents about anything and could not remember that ever happening before while therapy was going on with residents. An interview on 10/18/23 at 4:45 PM with the Social Worker (SW) revealed around 10:00 AM or 10:30 AM she had gone into the rehab gym and completed a Brief Interview for Mental Status (BIMS) assessment on Resident #12. She stated there were other residents and therapists in the gym and she was not sure if they could hear the conversation between, she and Resident #12 and said she had not asked him if it was ok to do the interview in the gym. The SW further stated she was in a hurry to get the assessment done because she was behind on her work and had been to the resident's room several times and couldn't find him in the room so she decided to do	F 550	The Director of Nursing, Administrator, Nurse Consultant or designee will interview 5 residents weekly for 4 weeks and then 5 residents monthly for 2 months to ensure interviews and care have been conducted on the audit tool titled Resident Rights : Dignity and Respect. Results will be reviewed and discussed in the monthly quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date: 11-11-2023	

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F 550	Continued From page 4 it in the gym. The SW was aware the resident had filed a grievance about not getting his showers and she had been told by the Unit Manager that he had received 2 showers and a bed bath since admission and they had resolved the grievance with him and he had received a shower just yesterday. She said there was no retaliation about the grievance, she said she simply was behind on her work and had to get the assessment done so she did while he was in the gym. The SW indicated she should not have done the interview in the gym but should have done it in the privacy of Resident #12's room. An interview on 10/18/23 at 5:15 PM with the Administrator revealed she was aware of the conversation with the SW and Resident #12 in the rehab gym. She stated she was not aware of the feelings of the resident and was not aware he felt like they were retaliating against him regarding the grievance. The Administrator further stated she had spoken with the resident about his grievance and it had been resolved and he had been showered yesterday. She indicated there was no retaliation for the grievance the SW was simply behind on the assessment and had taken the opportunity to do the interview in the therapy gym. The Administrator further indicated the interview with the SW and Resident #12 should have taken place in the privacy of the resident's room or in the privacy of the SW's office not in the rehab gym around other therapists and residents.	F 550		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically	F 636		11/11/23

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F 636	Continued From page 5 a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.	F 636		

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§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to complete and transmit a comprehensive Minimum Data Set (MDS) assessments within the regulatory time frame as specified in the Resident Assessment Instrument (RAI) manual for 1 of 5 residents reviewed for resident assessments (Resident #6).

Findings included:

Resident # 6 was admitted on 9/26/23.

A review of Resident #6 admission Minimum Data Set (MDS) had an assessment reference date (ARD) 10/2/23 and due date of 10/9/23. The MDS showed it was not complete, and still in progress on 10/18/23.

The MDS coordinator was interviewed on 10/18/23 at 12:15 PM and stated she was aware

The statements included are not an admission sand do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outline. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.

#1 Address how corrective action will be accomplished for those resident found to have been affected by the deficient practice;

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F 636	Continued From page 7 Resident # 6's admission assessment had not been completed. She said there were additional MDS assessments that were not completed or had been transmitted late. The MDS Coordinator stated that Performance Improvement Plan (PIP)was started on 8/28/23 with a completion date of 10/16/23. The PIP was to audit all resident assessments to identify missing and late transmitted assessments and correct them by 10/16/23. She stated the completion date (10/16/23) would be extended because the PIP was not completed due to not having enough help (staff) to complete the assessments on time. The Administrator was interviewed at 5:05 PM on 10/18/2023. She stated the facility had a contracted nurse working part time who was helping with completing and transmitting MDS assessments along with the MDS coordinator. The MDS assessments should have been completed and submitted by the due date.	F 636	Resident# 6's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10-2-2023 was completed on 10-23-23 locked and transmitted to the CMS IQIES database on 10-30-2023 by the MDS Coordinator. The MDS Coordinator was re-educated by the Contracted Registered Nurse Consultant on 11-7-2023 regarding the Resident Assessment Instrument (RAI) requirement to complete the comprehensive minimum data set within 14 days of admission and the completion schedule for all federally required minimum data sets (MDS). #2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by this alleged deficient practice. #3 Measures put into place to ensure that this alleged deficient practice does not recur includes the following: The MDS Coordinator was re-educated by the Contracted Registered Nurse Consultant on 11-7-2023 regarding the Resident Assessment Instrument (RAI) requirement to complete the comprehensive minimum data set within 14 days of admission and the completion schedule for all federally required minimum data sets (MDS). The Minimum Data Set, (MDS), Coordinator completed an assessment of all resident's with an MDS assessment that required completion and the type of assessment	

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F 636	Continued From page 8	F 636	that was identified. This audit was completed by the MDS Coordinator, the facility's MDS consultant on 10-23-23. The assessments that required completion were scheduled for completion by the MDS Coordinator. On 11-7-2023, the Contracted Registered Consultant audited current residents' Minimum Data Set (MDS) schedules for completion. As of 11-7-2023, there were no current admission Minimum Data Set (MDS) assessments that were to noted incomplete after day 14 of the residents stay. Comprehensive assessments that were identified as in the need of transmission were completed and transmitted on 11-7-2023 by the MDS Coordinator. The MDS Coordinator will report to the clinical meeting all assessments that are in need of completion for the upcoming week. During the Department Manager's Meeting the MDS Coordinator will announce to the Interdisciplinary Team that consist of the Social Work Director, Dietary Manager, Director of Nursing, Unit Manager, Activity Director, Director of Rehabilitation, Administrator and the Administrative Assistant, (IDT), a list of residents that have MDS Assessments due and what type of assessment must be completed. All staff that complete minimum data sets (MDS) were re-educated by the Contracted Registered Nurse Consultant and Administrator on a) Resident Assessment Instrument (RAI) requirement to complete the comprehensive minimum data set within	

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F 636	Continued From page 9	F 636	14 days of admission and b) the schedule requirement for completion for all federally required minimum data sets (MDS). Any staff that did not received the education by 11-11-23 will not be allowed to work until they received the education. Newly hired staff that are responsible for completing Minimum Data Sets (MDS) will be educated on the requirement to complete the comprehensive minimum data set within 14 days of admission and the schedule for completion for all federally required minimum data sets (MDS). #4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. The Administrator, Nurse Consultant or designee will audit 5 Minimum Data Sets (MDS) weekly for 4 weeks and then 5 Minimum Data Sets (MDS) monthly for 2 months to ensure the assessments are completed within the required time frames. Audit results will be documented on the audit tool titled Minimum Data Set (MDS) Completion Audit. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion: 11-11-2023	

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F 640	Continued From page 10	F 640		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment.	F 640		11/11/23

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(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to transmit an admission Minimal Data Set (MDS) within 14 days of the admission date for 1 of 5 sampled residents reviewed for accidents (Resident #4).

Findings included:

Resident # 4 was admitted on 8/4/23.

A review of Resident # 4's MDS revealed an assessment reference date (ARD) of 8/17/23. On 10/18/23, the MDS was marked as complete and submitted.

The MDS coordinator was interviewed on 10/18/23 at 12:15 PM and stated she was aware of Resident # 4's admission assessment had not been transmitted. She said there were additional MDS assessments that were not completed or had been transmitted late. The MDS Coordinator stated that Performance Improvement Plan (PIP)was started on 8/28/23 with a completion date of 10/16/23. The PIP was to audit all resident assessments to identify missing and late

F 640

The statements included tare not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegations of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.

#1 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

Resident #4's Admission Minimum Data Set (MDS) with an ARD of 8-10-23 was transmitted to the CMS IQIES database on 10-18-23 by the MDS Coordinator.

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(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
F 640	Continued From page 12 transmitted assessments and correct them by 10/16/23. She stated the completion date (10/16/23) would be extended because the PIP was not completed due to not having enough help (staff) to complete the assessments on time. The Administrator was interviewed at 5:05 PM on 10/18/2023. She stated the facility had a contracted nurse working part time who was helping with completing and transmitting MDS assessments along with the MDS coordinator. The MDS assessments should have been completed and submitted by the due date.	F 640	The MDS Coordinator was re-educated by the Contracted Registered Nurse Consultant on 11-7-2023 regarding the Resident Assessment Instrument (RAI) requirement to transmit completed federally required Minimum Data Sets (MDS) to the CMS IQIES database within 14 days. #2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 11-7-2023, the Contracted Registered Nurse Consultant audited current residents' Minimum Data Sets (MDS) for compliance with timely transmission of MDS assessments (within 14 days of completion). #3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The part time MDS nurse was given IQIES access so she can transmit MDS assessments and is a back up to the full time MDS nurse typically responsible for transmissions. The part time MDS nurse was educated how to transmit the assessments on 11-6-2023 by the full time MDS nurse. Both MDS Nurses were re-educated by the Contracted Registered Nurse Consultant or Administrator on the Resident Assessment Instrument (RAI) requirement on 11-7-2023 to transmit	

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F 640	Continued From page 13	F 640	completed federally required Minimum Data Sets (MDS) to the CMS IQIES database within 14 days. #4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. The Minimum Data Coordinator, (MDS), the Administrator and the Nurse Consultant will review the MDS transmission report weekly to audit and ensure that all scheduled MDS transmissions have been completed timely. The Administrator, Nurse Consultant or designee will audit 5 Minimum Data Sets (MDS) weekly for 4 weeks and then 5 Minimum Data Sets (MDS) monthly for 2 months to ensure the assessments area transmitted to the CMS IQIES database within 14 days of completion. Audit results will be documented on the audit tool titled Minimum Data Set (MDS) Transmission Audit. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. This report will be presented to the Quality Assurance Committee monthly for 3 months. Completion Date : 11-11-2023	
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors.	F 759		11/11/23

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F 759 Continued From page 14

The facility must ensure that its-

§483.45(f)(1) Medication error rates are not 5 percent or greater;
This REQUIREMENT is not met as evidenced by:
Based on record review, observations and interviews with staff and the Medical Director, the facility failed to maintain a medication error rate of less than 5% as evidenced by medication omissions and wrong dose given (6 medication errors out of 32 opportunities), resulting in a medication error rate of 18.8% for 2 of 3 residents (Resident #10 and Resident #9) observed during medication administration.

The findings included:

1. Resident #10 was admitted to the facility on 10/6/23 with diagnoses that included anemia, constipation and hypertension.

A review of the physician's orders in Resident #10's medical record indicated the following active orders:
a. Ferrous sulfate tablet 325 milligrams (mg) give one tablet by mouth one time a day at 9:00 AM for supplementation.
b. Linaclotide oral capsule 72 micrograms (mcg) give one capsule by mouth once daily at 9:00 AM for constipation.
c. Magnesium oxide tablet 400 mg give one tablet by mouth two times a day at 9:00 AM and 9:00 PM for supplementation.

During an observation of medication administration to Resident #10 on 10/16/23 at 11:02 AM, Medication Aide (MA) #1 pulled out a tablet from a stock bottle labeled Ferrous

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The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction.
The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.

#1 Address how corrective action will be accomplished for those residents found to have been affected b the deficient practice;

The Physician was notified on 10-16-2023 by the Nurse Supervisor of Resident #10 not receiving medications (Linaclotide and Magnesium Oxide) as ordered and the resident receiving Ferrous Gluconate instead of the ordered Ferrous Sulfate. No new orders were received. The Nurse Supervisor reviewed the residents current medication orders on 10-16-2023 and ensured all ordered medication was available.

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F 759	Continued From page 15 gluconate 240 mg tablets. MA #1 administered this tablet along with Resident #10's other scheduled medications. MA #1 did not give Resident #10's dose of Linaclotide and Magnesium oxide. MA #1 stated that she was not going to give Resident #10 her dose of Linaclotide because it was not available in the medication cart and her dose of Magnesium oxide because she would need to clarify the order with the Unit Manager. MA #1 explained that she only had Magnesium oxide available in stock bottles of either 250 mg and 500 mg dosages, and none of these matched the ordered dose for Resident #10. An interview with MA #1 on 10/16/23 at 2:49 PM revealed she did not notice the bottle of Ferrous gluconate and the dosage marked on the label. During the interview, MA #1 looked in the medication cart for a bottle of Ferrous sulfate 325 mg tablets and found one. She stated she should have given the Ferrous sulfate 325 mg tablet instead of the Ferrous gluconate. MA #1 also stated she couldn't find Resident #10's card of Linaclotide and she was not sure whether it was a stock medication or something she needed to re-order from the pharmacy. An interview with the Unit Manager (UM) on 10/18/23 at 3:16 PM revealed she had to show MA #1 Resident #10's Linaclotide tablets which were in the top drawer of the medication cart. MA #1 also reported to her about the discrepancy with Resident #10's Magnesium oxide order which needed updating to accommodate what they had in stock. The UM stated MA #1 did not work as often as the other nurses and was not used to having two different kinds of bottles for Ferrous sulfate and Ferrous gluconate. The UM	F 759	The Physician was notified on 10-16-2023 by the Nurse Supervisor of Resident #9 not receiving the medications (Zinc Sulfate, Cholecalciferol and Cyanocobalamin) as ordered. NO new orders were received. The Nurse Supervisor reviewed the residents current medication orders on 10-16-2023 and ensured all ordered medication was available. The Nurse Supervisor also showed the Medication Aide where the medication storage rooms were located in the facility to access medications that may not be stored on the medication carts. #2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All current residents' medications were audited by the Director of Nursing, Nurse Supervisor and Nurses on 11-1-2023 to ensure all ordered medications were available in the facility. Any medications that were not available were requested by the Pharmacy on 11-1-2023 #3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Medication Aide #1 was re-educated by the Nurse Supervisor on 10-16-2023 on the procedure for safe medication administration, medication storage locations within the facility, how to use the Omnicell to obtain back up medications, and to notify the nurse on duty when a	

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stated that MA #1 should have slowed down during the medication administration and looked at the medication labels carefully.

A phone interview with the Medical Director (MD) on 10/17/23 at 9:28 AM revealed Resident #10 should have received her medications as ordered and if any were not available, the staff should notify the pharmacy and re-order medications whenever needed.

An interview with the Interim Director of Nursing (DON) on 10/18/23 at 8:41 AM revealed MA #1 should have checked the medication labels carefully and if she noticed any discrepancy, she should talk to any nurse and clarify the order.

2. Resident #9 was admitted to the facility on 8/10/23 with diagnoses that included protein calorie malnutrition, muscle weakness, and anemia.

A review of the physician's orders in Resident #9's medical record indicated the following active orders:
a. Zinc sulfate capsule 220 milligrams (mg) give one capsule by mouth one time a day at 9:00 AM for zinc deficiency.
b. Cholecalciferol oral tablet 50 micrograms (mcg) give one tablet by mouth one time a day at 9:00 AM for supplementation.
c. Cyanocobalamin tablet 1000 mcg give one tablet by mouth one time a day at 9:00 AM for supplementation.

During an observation of medication administration to Resident #9 on 10/16/23 at 11:13 AM, Medication Aide (MA) #1 did not give

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medication is not available for administration so the physician can be notified.

All licensed Nurses and medication Aides (full time, part time, and contract including agency staff) were re-educated by the Director of Nursing, Nurse Supervisor, or Nurse Consultants on the following topics: procedure for safe medication administration, medication storage locations with the facility, how to use the Omnicell to obtain back up medications, and to notify the nurse on duty when a medication is not available for administration so the Physician can be notified. Any Licensed Nurses or Medication Aides that did not received the education by 11-11-2023 will not be allowed to work until they received the education.

Newly hired Licensed Nurses and Medication Aides and agency staff will be educated during orientation on the procedure for safe medication administration, medication storage locations within the facility, how to use the Omnicell to obtain back up medications, and to notify the nurse on duty when a medication is not available for administration so the Physician can be notified.

#4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed.

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F 759	Continued From page 17 Resident #9 her scheduled doses of Zinc sulfate, Cholecalciferol and Cyanocobalamin tablets. MA #1 stated she needed to obtain clarification on the orders for these medications. During a follow-up interview with MA #1 on 10/16/23 at 2:52 PM, MA #1 stated that Resident #9's Zinc sulfate was not available, and she still needed to re-order this medication from pharmacy. She also stated that she didn't give Resident #9's Cholecalciferol and Cyanocobalamin tablets because she also couldn't find them in the medication cart. An interview with the Unit Manager (UM) on 10/18/23 at 3:16 PM revealed Resident #9's Zinc sulfate was available, but MA #1 asked her about the order because it came in a lower dosage, and she would have to give five tablets of this medication at a time. The UM also stated that both Cholecalciferol and Cyanocobalamin tablets were available in the medication room, and she had to show MA #1 where the stock medications were kept. A phone interview with the Medical Director (MD) on 10/17/23 at 9:28 AM revealed Resident #9 should have received her medications as ordered and if any were not available, the staff should notify the pharmacy and re-order medications whenever needed. An interview with the Interim Director of Nursing (DON) on 10/18/23 at 8:41 AM revealed MA #1 should have checked the medication labels carefully and if she noticed any discrepancy, she should talk to any nurse and clarify the order.	F 759	The Director of Nursing, Nurse Consultant or designee will observe medication administration for 5 residents' weekly for 4 weeks and then 5 residents monthly for 2 months to ensure the Medication Aide or Nurse administers all medications as ordered. Audit results will be documented on the audit tool titled Safe Medications Administration. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion date: 11-11-2023	
F 760 SS=D	Residents are Free of Significant Med Errors	F 760		11/11/23

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CFR(s): 483.45(f)(2)

The facility must ensure that its-
§483.45(f)(2) Residents are free of any significant medication errors.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations, and interviews with the resident, staff, Physician Assistant and Medical Director, the facility failed to administer a short-acting insulin as ordered by the physician for 1 of 3 residents (Resident #8) reviewed for medication administration.

The findings included:

Resident #8 was admitted to the facility on 9/14/22 with diagnoses that included diabetes.

A review of Resident #8's medical record indicated an active physician's order for Insulin Aspart 35 units subcutaneously three times a day for diabetes - call the physician if blood sugar is greater than 400 and less than 60. It was scheduled for 8:00 AM, 12:00 PM and 5:00 PM.

An observation of Resident #8 on 10/16/23 at 10:51 AM revealed her talking to Medication Aide (MA) #1 and telling her that she wanted her insulin and that she needed to get her blood sugar checked again because she had already eaten breakfast. MA #1 stated to Resident #8 that she wasn't allowed to give Resident #8's insulin and she would need to get one of the nurses on the other side of the facility to give her insulin. Resident #8 stated that it had been three hours since she ate breakfast, and she was supposed to get her insulin before she ate. MA #1 walked to the other side of the facility and told

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#1 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

The Physician was notified on 10-16-2023 of Resident #8 having a high blood sugar of 456 and the insulin being administered late by the Nurse Supervisor. New orders were received to hold the PM dose of sliding scale insulin.

As of 10/22/23, Nurse #1 is no longer employed by the facility.

#2 Address how the facility will identify other residents having the potential to be

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Nurse #1 that Resident #8 wanted her insulin and blood sugar re-checked.

On 10/16/23 at 11:02 AM, Nurse #1 was observed checking Resident #8's blood sugar which was 456 and at 11:10 AM, she administered Resident #8's Insulin Aspart.

An interview with Medication Aide (MA) #1 on 10/16/23 at 11:29 AM revealed she was the only one assigned to administer medications to the residents on the 300 and 400 halls. She stated she couldn't give insulin injections but there were two nurses at the other side of the facility. She further stated Nurse #1 was supposed to come and give the insulin injections on her side, but she was not sure why Nurse #1 was late giving them.

An interview with Nurse #1 on 10/16/23 at 4:09 PM revealed she did not know that she was supposed to administer the insulin injections on the 300 and 400 halls, and that she only found out when MA #1 informed her when Resident #8 was asking for her insulin. Nurse #1 reported nobody told her she had to cover these two halls. Nurse #1 stated that Resident #8's insulin should have been given to her before breakfast, but she had a whole hall assigned to her, and it was hard to cover two additional halls. Nurse #1 stated she thought she wasn't going to be assigned to do this anymore because she felt it was not safe.

An interview with Resident #8 on 10/16/23 at 1:11 PM revealed she was supposed to get a short-acting insulin before eating but no one was around to give her insulin shot. She went ahead and ate breakfast at 8:30 AM and she didn't receive her insulin until almost 11:30 AM. Resident #8 stated that she did not have any

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affected by the same deficient practice;

All residents with insulin orders have the potential to be affected.
On 10/30/23 the Director of Nursing and Contracted Nurse Consultant ran a list of all resident□s with orders for routine insulin and reviewed the medication administration record for those resident□s to determine if the insulin had been administered as ordered. The Director of Nursing then instructed the Licensed Nurses to administer the insulin to any resident who had not received the insulin as ordered.

3# Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

The Director of Nursing reviewed the process for nurse supervision and administration of medication that cannot be administered by a medication aide. The following revisions were made to the process to ensure adequate supervision of medication aides and timely administration of medications the nurse is responsible for. a) Licensed Nurses will be assigned to specific units when medication aides are administering medication on those units. b) The Licensed Nurses and Medication Aides will communicate throughout their shift if there are medications such as insulin that need to be administered only by a licensed nurse. c) The Licensed Nurses will be responsible for reviewing the

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signs or symptoms of hyperglycemia.

An interview with the Physician Assistant (PA) on 10/17/23 at 12:35 PM revealed that she received a phone call from a nurse at the facility on 10/16/23 around 12:00 PM notifying her that Resident #8's blood sugar was 456. The PA stated she asked whether Resident #8 was having symptoms of hyperglycemia and they reported to her that she was not so she gave an order to have Resident #8's blood sugar rechecked after two hours. The PA further stated she was not informed that Resident #8's Insulin Aspart was not given until after three hours after she ate her breakfast and that the blood sugar was taken after she had already eaten. The PA stated she assumed the blood sugar was taken right before Resident #8's lunch meal.

A phone interview with the Medical Director (MD) on 10/17/23 at 9:28 AM revealed Resident #8's Insulin Aspart should be given before meals to cover the increase in blood sugar brought on by the meal. The MD stated that Resident #8 receiving her short-acting insulin three hours after she had eaten a meal was not ideal and was a significant medication error. The MD stated this explained the increase in her blood sugar but since she was asymptomatic and her blood sugars tended to run high anyway, she wouldn't consider it as a negative outcome.

An interview with the Unit Manager (UM) on 10/18/23 at 3:16 PM revealed she usually oversaw the medication aides whenever they were assigned to give medications on the hall, but she didn't get in on 10/16/23 until almost 11:00 AM. The UM stated that early in the morning of 10/16/23, she received a call from the

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medication administration record periodically throughout their shift on the unit assigned to the Medication Aide to ensure all medication have been administered timely.

All Licensed Nurses and Medication Aides (full time, part time, and contract including agency staff) were re-educated by the Director of Nursing, Nurse Supervisor or Nurse Consultant on the following topics: the procedure for safe medication administration and the requirement for a Nurse to administer Insulin as ordered for the Medication Aides on duty and the Nursing assignment of supervision of Medication Aides as described above. Any Licensed Nurse or Medication Aides that did not receive the education by 11-11-2023 will not be allowed to work until they receive the education.

Newly hired Licensed Nurses and Medication Aides and agency staff will be educated during orientation on the procedure for safe medication administration and the requirement for a Nurse to administer Insulin as ordered for the Medication Aides on duty and the Nursing assignment of supervision of Medication Aides.

#4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed.

The Director of Nursing, Nurse Consultant or designee will observe the medication

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F 760	Continued From page 21 night shift nurse reporting to her that a day shift nurse had called out for the day. She stated she had to re-arrange the assignments and ended up assigning MA #1 to the 300 and 400 halls but she left instructions to let the other nurses know that they needed to administer any insulin on those two halls. An interview with the Interim Director of Nursing (DON) on 10/18/23 at 8:41 AM revealed medication aides were supposed to be supervised and overseen by either the Unit Manager or any of the hall nurses. The Interim DON stated she did not know what happened with the delay in Resident #8's receiving her insulin on 10/16/23.	F 760	administration of insulin to 5 residents' weekly for 4 weeks and then 5 residents monthly for 2 months to ensure the Nurse on duty administers the Insulin timely and as ordered. Audit results will be documented on the audit tool titled Safe Insulin Administration. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion date: 11-11-2023	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and	F 867		11/11/23

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F 867	Continued From page 22 information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness	F 867		

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of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's

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governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following a complaint investigation survey conducted on 6/7/23. This was for a repeat deficiency that was cited in the area of significant medication error that was originally cited on 6/7/23 during a complaint investigation survey, and subsequently recited during another complaint investigation survey completed on 10/18/23. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.

The findings included:

This tag is cross referenced to:

F760 - Based on record review, observations, and interviews with the resident, staff, and Medical Director, the facility failed to administer a short-acting insulin as ordered by the physician

F 867

F 867 QAPI/QAA Improvement Activities

Immediate action taken place to correct this alleged deficient practice involve the following;

On 10-19-2023, the Administrator reviewed the Quality Assurance and Process improvement plans for the repeated areas of concerns expressed on 10-18-2023 during the exit review for the follow up survey. This review was completed for all department managers. The Department Managers consist of, the Director of Nursing, (DON), Unit Managers, Director of Social Work, Director of Rehabilitation, Administrator, Administrative Assistant, Activities Director, Minimum Data Set Director, (MDS), Environmental Director, Central Supply Director, Human Resource Director, and the Dietary Manager. Each area that resulted in a repeat citation, had the initial plan of correction reviewed to discuss the monitoring so that problems

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for 1 of 3 residents (Resident #8) reviewed for medication administration.

During the complaint survey on 6/7/23, the facility failed to prevent a significant medication error by not administering 12 doses of an anticonvulsant medication as ordered by the physician.

An interview with the Administrator on 10/18/23 at 5:21 PM revealed the Administrative staff was currently in the process of correcting issues that were previously identified from past surveys and identifying areas for quality improvement. The Administrator stated they needed to strengthen leadership all the way around to implement effective and sustainable systems to maintain compliance.

F 867

could be identified and modified. Education was provided to the Department Managers on the monitoring process and auditing expectations of past areas of identification area of concern and the responsibilities for monitoring process and auditing expectations of past areas of identified areas of concern and the responsibilities for monitoring corrective plans to improve areas of concern in regards to any self identified system failure.

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The facility realizes that all residents have the potential to be affected by this alleged deficient practice. Areas of concern that were cited for deficient practice was reviewed to ensure that all concerns has an acceptable plan of correction in place.

Measures put into place to ensure that this alleged deficient practice does not recur includes: Quality assurance monitoring, physician reviews, consultant reviews, and staff training are examples of the many components utilized. Plans of corrections for the areas of concern were reviewed with the Department Managers on 10-19-2023 by the facility Administrator. Education was provided on the Quality Improvement Process and the self assessments of department performance responsibilities and initiating a plan to address identified areas that need improvement. The Facility Chief Operating Office, (COO) contracted for outside consulting on 10-18-2023. This

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F 867	Continued From page 26	F 867	consulting firm is to provide external assessment of current clinical practices including the oversight to monitoring of any facility processes that were recited. These areas include F740. The plans of corrections for the areas of concern were reviewed with the Department Managers on 10-19-2023 by the Administrator. Education was provided to the Department Managers on the monitoring process process and auditing expectations of past areas of identified concerns, system failures, and the departmental responsibilities for monitoring corrective plans of actions to enable desired outcomes and improvement. Education was provided by the Administrator to the Department Managers on the Quality Improvement In addition, the facility also secured a contracted Director of Nursing to aide in providing stabilization of the clinical processes. On 11-2-2023, the facility took action to change the Nursing Administrative leadership. The facility Director of Nursing ,(DON), will be receiving oversight clinical support from the contracted DON, as well as, the contracted clinical monitoring support. New hires will receive education of the areas cited during their onboarding orientation. Agency staff will be provided a orientation packet in which communication and education will be included in the areas of deficiency.	

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F 867	Continued From page 27	F 867	Monitoring will be completed by the following : All areas that received a citation for a deficient practice was added to the morning meeting discussion and for review to ensure corrective measures are being effective. Nursing Administration will provide random checks to ensure that staff are proficient in the areas that have been cited for deficient practice. Ad hoc quality assurance discussion will occur weekly citations will report their corrections to the Quality Assurance and Process Improvement Committee monthly for 3 months.	
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	F 880		11/11/23

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arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

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

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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 observation, record review, and staff interviews, the facility failed to implement their infection control policy when Nurse #2 did not perform hand hygiene after removing a soiled dressing with drainage on it and before donning new gloves to cleanse the wound with saline-soaked gauze for 1 of 3 residents (Resident #1) reviewed for wound care.

The findings included:

The facility's policy entitled Handwashing/Hand Hygiene which is part of their Infection Control Policies and Procedures last revised on 08/2014 under Policy Interpretation and Implementation read in part:
7. Use an alcohol-based hand rub (ABHR) containing at least 62% alcohol; or alternatively, soap and water for the following situations:
a. Before and after direct contact with residents;
g. Before handling clean or soiled dressings, gauze pads, etc.;
k. After handling used dressings, contaminated equipment, etc.;
m. After removing gloves;
8. Hand hygiene is the final step after removing and disposing of personal protective equipment.
9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as

F 880

The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.

#1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
Resident #1 did not have any adverse effects from the Nurse not performing hand hygiene after removing the soiled dressing and before donning new gloves to clean the wound on 10-17-2023

#2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
All residents with current wounds have the potential to be affected.

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the best practice for preventing healthcare-associated infections.

An observation of wound care by Nurse #2 was made on 10/17/23 at 2:30 PM. Nurse #2 washed her hands with soap and water and then donned clean gloves. Resident #1 was sitting in her wheelchair with her right foot resting on the foot pedal of her wheelchair. Nurse #2 removed the old dressing from Resident #1's right foot which had a moderate amount of serous drainage on the dressing. She then doffed her gloves and without sanitizing her hands, donned a new pair of clean gloves. Nurse #2 proceeded to cleanse the wound with saline-soaked gauze. Wearing the same gloves, Nurse #2 patted the wound dry with another dry clean gauze pad. After patting the wound dry, she applied collagen to the wound and then applied a dressing over the collagen and initialed the dressing. Nurse #2 doffed her gloves and without sanitizing her hands collected her supplies and left the room.

An interview on 10/17/23 at 3:23 PM with Nurse #2 revealed she was not aware she had not sanitized her hands prior to donning her 2nd pair of clean gloves. She also didn't realize she had not sanitized her hands and changed her gloves prior to applying the collagen to the resident's wound on her foot and covering with a new dressing. Nurse #2 stated she was nervous and said she knew she should have cleansed her hands prior to putting on new gloves but just forgot and said it was an oversight that she didn't change her gloves when moving from a dirty to clean procedure.

An interview with Unit Manager #1 who also served as the Infection Preventionist (IP)

F 880

#3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

Nurse #2 was re-educated by the facility's Infection Preventionist on 10-17-2023 on when and how to perform hand hygiene while providing wound care.
All licensed Nurses (full time, part time, and contract including agency staff) were re-educated by the Director of Nursing, Infection Preventionist or designee on performing hand hygiene after the removal of the existing dressing and before donning new gloves to clean/re-dress the wound. Any Licensed Nurses that did not receive the education by 11-11-2023 will not be allowed to work until they receive the education.

Newly hired Licensed Nurses and agency Licensed Nurses will be educated during orientation on performing hand hygiene after the removal of the existing dressing and before donning new gloves to clean/re-dress the wound.

#4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed.

The Director of Nursing, Nurse Consultant or designee will observe wound care for 5 residents weekly for 4 weeks and then 5 residents monthly for 2 months to ensure the Nurse performs hand hygiene during the wound care. Audit results will be documented on the audit tool titled Hand

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F 880	Continued From page 31 revealed Nurse #2 should have sanitized her hands each time she removed her gloves. The IP stated any time a nurse went from a dirty to clean procedure she needed to sanitize or wash her hands and don new gloves prior to starting the procedure. An interview on 10/18/23 at 9:21 AM with the Interim Director of Nursing (DON) revealed she had heard about the wound observation with Nurse #2. The DON stated she expected Nurse #2 to clean her hands and don new gloves when moving from a dirty to a clean procedure and said anytime she doffed her gloves she should have sanitized or washed her hands.	F 880	Hygiene during Wound care. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance Completion date: 11-11-2023	