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	345282	A. BUILDING ______ B. WING ______	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 07/15/24 through 07/18/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 3BMB11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/15/24 through 07/18/24. Event ID# 3BMB11. The following intakes were investigated: NC00207596 and NC00208099. 4 of the 4 complaint allegations did not result in deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		8/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/08/2024

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 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to clarify and update the medical records to reflect the desired advance directive for 1 of 1 resident (Resident #64) reviewed for code status. The findings included: Resident #64 was admitted to the facility on 1/30/24. A review of Resident #64's paper chart at the nurses' station revealed a paper copy of Resident #64's Medical Orders for Scope of Treatment (MOST) form dated 1/30/24 which indicated to attempt resuscitation with full scope of treatment. The MOST form was signed by Resident #64 and	F 578	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F578 On 7/16/24, the RN Supervisor completed a new Medical Orders for Scope of Treatment (MOST) form in accordance with Resident #64's 7/16/24 physician's order defining the resident's code status.	

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the Nurse Practitioner on 1/30/24.

A review of Resident #64's electronic medical record indicated a physician's order dated 3/27/24 for Do Not Attempt Resuscitation (DNAR)/limited scope of treatment.

A progress note in Resident #64's medical record dated 3/27/24 by the Medical Director (MD) indicated Resident #64's family wanted to keep her at facility for now and not to send to hospital. (The family) noted that they were aware of decline. (The MD) discussed with multiple family members in room and they wished to have her be Do Not Resuscitate/Do Not Intubate. Resident #64 had a poor long term prognosis.

An interview with Nurse #1 on 7/16/24 at 12:20 PM revealed she would refer to Resident #64's paper chart at the nurses' station for her code status. Nurse #1 reviewed the MOST form and stated that Resident #64 was a full code so she would attempt cardiopulmonary resuscitation. After Nurse #1 was prompted to check Resident #64's electronic medical record, she noted that Resident #64's most recent code status order was DNAR. Nurse #1 stated that she was not sure why there was a discrepancy in Resident #64's code status, and said that she would want them to match. Nurse #1 added that if she received a new order from the doctor, she would notify the Unit Coordinator who would give the new code status to the office secretary to get scanned into the electronic medical record and placed in the paper chart.

An interview with Unit Coordinator #1 on 7/16/24 at 12:29 PM revealed he didn't know why Resident #64 had conflicting advance directive in

On 7/16/24, the Nursing leadership team completed a facility-wide 100% audit to ensure each resident’s code status designated on the MOST form and physician’s order matched. No discrepancies were identified.

On 8/7/24, the Director of Nursing (DON) conducted an in-service with the Medical Director and Nurse Practitioner on the code status process to ensure each resident’s code status designated on the MOST form and physician’s order matched.

Beginning 8/12/24, the Unit Coordinators and/or designee will audit for 12 weeks, 5 MOST forms a week times 4 weeks and 10 a month times 2 months, to ensure each resident’s code status designated on the MOST form and physician’s order matched. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and DON on a weekly basis and with Quality Assurance and Performance Improvement (QAPI) monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.

Plan of Correction Date is 8/15/24

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her electronic medical record and paper chart. Unit Coordinator #1 stated Resident #64's family might have requested for her code status to be changed. Unit Coordinator #1 shared that the facility's process when there was a change to a resident's advance directive was when they receive an order, the nurse should have a new MOST form signed by the family and the doctor, and then it should be placed in the office secretary's box so it could be filed. Unit Coordinator #1 stated that the advance directives in Resident #64's electronic medical record and paper chart should match.

An interview with Unit Coordinator #2 on 7/16/24 at 12:47 PM revealed she remembered when Resident #64 was first admitted to the facility, her family wanted her to be a full code. Unit Coordinator #2 stated that the MD did not fill out a new MOST form when he changed Resident #64's code status to DNAR on 3/27/24. Unit Coordinator #2 confirmed that she acknowledged the 3/27/24 order, but the MD did not tell her about it, and she did not pay much attention to it because it wasn't about her medications. Unit Coordinator #2 stated that she acknowledged a lot of orders each day. Unit Coordinator #2 stated that she thought the MD might have initiated a new MOST form for Resident #64, and she was not aware that he did not.

A follow-up interview with UC #1 on 7/16/24 at 12:55 PM revealed he had noticed that some orders got put in the electronic medical records without the nurses knowing about them. He stated that the facility probably needed to have a better process with changing code status especially without the resident going out and coming back from the hospital.

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F 578	Continued From page 4 An interview with the Director of Nursing (DON) on 7/18/24 at 2:59 PM revealed she found out that the MD spoke with Resident #64's family and they wanted to change her code status, so he put in the order but did not say anything to nursing that he was changing her code status. The DON stated the MD should have went ahead and filled out a new MOST form when he changed Resident #64's code status. The DON further stated that the code status in Resident #64's electronic medical record and paper chart should be the same.	F 578		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record reviews, facility activity calendars, and resident and staff interviews, the facility failed to ensure group activities were planned for outside of the facility to meet the needs of residents who expressed that it was important to them to attend group activities outside of the facility for 6 of 8 residents reviewed for activities. (Residents #58, #8, #53, #20, #63, and #16). The residents expressed not being	F 679	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.	8/30/24

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able to leave the facility for almost 2 years made them feel more dependent, sad, depressed, and they missed getting out with the group to shop and socialize with other people.

The findings included:

A review of the activity calendars for January 2024 through July 2024 revealed activities for inside of the facility or grounds during the week and some activities on the weekends. There were no activities scheduled for outside of the facility and grounds.

Review of the Resident Council Meeting minutes for April 2023 through June 2024 revealed the residents requested in July 2023 and August 2023 to go on "outings outside the facility."

Observation on 07/17/24 at 12:30 PM revealed the facility was located within driving distance to several local and commercial shops, grocery stores, local and commercial coffee shops, fast food and sit-down restaurants.

a. Resident #58 was admitted to the facility on 10/20/21.

An annual MDS assessment dated 10/20/23 indicated Resident #58 felt it was very important to have activities that that included going outside of the facility and doing things in a group setting. The assessment further indicated that Resident #58 was cognitively intact.

An interview was conducted with Resident #58 on 07/17/24 at 10:38 AM during the resident council meeting which revealed there had not been a scheduled group outing outside the facility in

F 679

F679

On 8/9/24, the Activity Director and Activity Assistant met with Resident #58, #8, #53, #20, #63, and #16 to assess and review each resident's activity need and preference for outside activities. The Activity Director and Activity Assistant reviewed the August activity calendar, including the outside group activity scheduled on 8/15/2024 and arrangements will be made to include each of the above mentioned residents interested in participating. The Activity Director will plan quarterly outside group activities as appropriate going forward and to include any resident that expresses interest.
Care plans will be updated to reflect any changes in needs or preferences.

Beginning 8/12/24, the Activity Director, Activity Assistant, and Administrator will conduct facility-wide interviews with residents to determine if the activity calendar provided activities that met their needs and preferences. Each residents care plan will be updated to reflect any changes in needs and preferences.

On 8/12/24, the Administrator will conduct in-services with the Activity Director and Activity Assistant on the new Resident Council follow-up form process, with a focus on documenting residents activity needs and preferences. This education will be reviewed annually and during new hire orientation for any change in Activity

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F 679	Continued From page 6 almost two years and the resident council had requested one during their monthly meetings and were told it was not possible to go on outings outside the facility because they did not have a van that could transport a group on outings outside the facility. She stated she felt it was important for residents to get outside in the world and socialize with people other than those at the facility because it allowed them some independence and socialization with other people. Resident #58 further stated she would love to go out to eat with a group and go shopping and be able to touch things and be able to pick out her own belongings. She revealed personally being able to do her own shopping and socializing with other people outside of the facility was very important to her and would make her feel more normal and like she still had some independence. Resident #58 further revealed not getting outside the walls of the facility had made her sad and dependent on others for her needs. b. Resident #8 was admitted to the facility on 08/25/22. An annual MDS assessment dated 09/01/23 indicated Resident #8 felt it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated that Resident #8 was cognitively intact. An interview was conducted with Resident #8 on 07/17/24 at 10:36 AM during the resident council meeting which revealed there had not been a scheduled group outing outside the facility in almost two years and the resident council had requested one during their monthly meetings and were told it was not possible to go on outings	F 679	staff. Beginning 8/12/24, the Administrator and/or designee will audit the monthly Resident Council follow-up form to determine compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with Quality Assurance and Performance Improvement (QAPI) monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction Date is 8/30/24	

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outside the facility because they did not have a van that could transport a group on outings outside the facility. She stated she felt it was important for residents to get outside the walls of the facility because it allowed them some freedom and independence to socialize with other people outside the facility. Resident #8 stated not being able to go on outings had made her feel depressed and sad because she would like to be able to go out to eat and go shopping and pick out her own belongings.

c. Resident #53 was admitted to the facility on 0805/22 and readmitted on 12/11/23.

An annual MDS assessment dated 06/21/24 indicated Resident #53 felt it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #53 was cognitively intact.

An interview was conducted with Resident #53 on 07/17/24 at 10:40 AM during the resident council meeting which revealed there had not been a scheduled group outing outside the facility in almost two years and the resident council had requested one during their monthly meetings and were told it was not possible to go on outings outside the facility because they did not have a van that could transport a group on outings outside the facility. He stated he felt it was very important for residents to get outside the walls of the facility and be able to socialize with one another and other people outside the facility because it made them feel more normal. Resident #53 stated he had been requesting to go to a particular restaurant for some time but had been told it was not possible because there

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was no transportation to take residents outside the facility. He revealed he did not care about going shopping but knew that was important to some of the residents but said it was important to him to be able to go out to eat with a group and socialize and not being able to do so made him sad.

d. Resident #20 was admitted to the facility on 02/08/21 and readmitted on 07/11/23.

An annual MDS assessment dated 01/18/24 indicated Resident #20 felt it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #20 was cognitively intact.

An interview was conducted with Resident #20 on 07/17/24 at 10:32 AM during resident council meeting which revealed there had not been a scheduled group outing outside the facility in almost two years and the resident council had requested one during their monthly meetings and were told by administrative staff they did not have a van to transport residents in for 'fun" outings just medical appointments. She agreed with other residents they had been told by the administrator that it was impossible to go on outings outside the facility because there was not a van available for transport of the residents. She agreed with other residents that it was important to go on group outings outside the facility because it allowed the residents some independence, socialization with the group and with people outside of the facility and made them feel more like a normal person and not just a resident stuck in a facility.

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e. Resident #63 was admitted to the facility on 11/23/23.

An admission Minimum Data Set (MDS) assessment dated 01/18/24 indicated Resident #63 felt it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated that Resident #63 was cognitively intact.

An interview was conducted with Resident #63 on 07/17/24 at 10:30 AM during resident council meeting which revealed there had not been a scheduled group activity outside the facility since her admission and the resident council had requested one during their monthly meetings and were told by administrative staff, they did not have a van to transport residents in for 'fun" outings just medical appointments. She agreed she felt group activities outside of the facility were important to residents that were able to go and participate because it allowed them to exercise some independence, socialization with the group and outside world and made them feel more like a normal person. Resident #63 agreed with other residents not being able to leave the facility with residents and participate in group activities outside the facility had sometimes made her feel as though she had lost some of her independence and was having to rely on someone else to do her personal shopping instead of doing it herself.

f. Resident #20 was admitted to the facility on 02/08/21 and readmitted on 07/11/23.

An annual MDS assessment dated 01/18/24 indicated Resident #20 felt it was very important

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to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #20 was cognitively intact.

An interview was conducted with Resident #20 on 07/17/24 at 10:32 AM during resident council meeting which revealed there had not been a scheduled group outing outside the facility in almost two years and the resident council had requested one during their monthly meetings and were told by administrative staff they did not have a van to transport residents in for 'fun" outings just medical appointments. She agreed with other residents they had been told by the administrator that it was impossible to go on outings outside the facility because there was not a van available for transport of the residents. She agreed with other residents it was important to go on group outings outside the facility because it allowed the residents able to go some independence, socialization with the group and with people outside of the facility and made them feel more like a normal person and not just a resident stuck in a facility.

g. Resident #16 was admitted to the facility on 12/01/23.

An admission MDS assessment dated 12/08/23 indicated Resident #16 felt it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated that Resident #16 was cognitively intact.

An interview was conducted with Resident #16 on 07/17/24 at 10:34 AM during the resident council meeting which revealed there had not been a

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F 679	Continued From page 11	F 679		

scheduled group outing outside the facility since her admission and the resident council had requested one during their monthly meetings and were told it was impossible because there was not a van that could transport the residents on outings outside of the facility. She stated she thought that had a great activities program at the facility and was pleased with the activities staff and the programs they offered She agreed with other residents it was important to go on group outings outside the facility because it allowed the residents some independence and socialization with outside people and made them feel more like a normal person. Resident #16 further stated she would love to go on outings to restaurants to eat and go shopping but wanted the internal activities to continue as well.

An interview was conducted with the Activities Director (AD) on 07/18/24 at 10:49 AM which revealed she was aware the residents wanted to go on group outings and said they brought it up all the time during resident council meetings. She stated she had been told with the van they currently have there is only room for two to three residents at a time, so they were not able to go on group outings. The AD further stated there was only one van driver and when they had taken the residents to the local fair two years ago it had been a long process for the van driver to take two to three at a time and then get everyone back and forth so last year they had brought the residents food from the fair and set up an inhouse carnival with games for them to play. She explained they had popcorn, snow cones, fried Oreos and funnel cakes provided for the residents. The AD further explained residents had requested to go grocery shopping, shopping at Walmart, Dollar General, and requested to go out to eat at one of the local

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F 679	Continued From page 12 restaurants. She stated she would love to take the residents on outings because she knew it was important to them, but was told they did not have a van to accommodate outings for fun. An interview was conducted with the Administrator on 07/18/24 at 3:22 PM which revealed she was aware the residents wanted to go on group outings and she wanted them to be able to go out on group outings but said the barrier to group outings was their van only being able to accommodate a couple of residents at a time, only having one van driver, and having the staff to send with the residents on outings. She stated that currently their van was only used for transporting residents to medical appointments. The Administrator further stated they had started a "Make a Wish" program in which residents wanting to do special things would be accommodated but said they had just started it and it would be a single resident wish and not a group event. She explained they had taken residents who needed to bank appointments and attorney appointments but had not done any group outings or "fun" activities in the van. The Administrator further explained the social workers were available to do shopping for the residents monthly and were able to get what they needed at stores but said she knew it was not the same as the residents being able to go and pick out their own belongings.	F 679		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in	F 688		8/15/24

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Continued From page 13

range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, resident, staff, and Nurse Practitioner interview the facility failed to follow physician's order to provide and apply a left resting hand splint to prevent further contracture for 1 of 3 resident reviewed for limited range of motion. (Resident #30)

The findings included:

Resident #30 was admitted to the facility on 7/11/22 with diagnoses that included hemiplegia and hemiparesis of left side and muscle weakness.

A quarterly Minimum Data Set for Resident #30 dated 6/25/24 revealed the resident was cognitively intact with no refusals or rejection of care and no orthotic use documented.

The care plan for Resident #30 updated on 6/25/24 revealed, Resident #30 had an Activities of Daily Living deficit related to physical functioning with weakness status post hemiplegia

F 688

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F688
On 7/22/24, Resident #30's splint was applied as ordered.

By 8/9/24, 100% audit conducted by the Therapy Director to ensure placement of splints and/or braces as ordered.

Beginning 7/17/24, the process for obtaining orders from therapy and tracking was changed. A new log was created to monitor when equipment was ordered and items were received, to

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F 688	Continued From page 14 following a stroke. A review of the nurse practitioner order dated 4/29/24 revealed occupational therapy to evaluate and treat Resident #30 for left hand contracture, current left-hand splint provided would not fit fingers properly. A review of the occupational therapist evaluation note dated 5/06/24 revealed Resident #30 required a left-hand splint to address his contracture. OT evaluated and would place order for new left-hand splint and when received would provide OT services for Resident #30. An observation and interview on 7/15/24 at 10:52 AM revealed Resident #30 sitting up in his wheelchair dressed. The resident's left hand appeared contracted, and he was not wearing a splint. This surveyor asked Resident #30 if he wore a splint on his left hand and he stated "no" that therapy supposedly ordered a splint for him to wear but it had not come in yet. An observation on 7/16/24 at 3:55 PM revealed Resident #30 was sitting up in his wheelchair dressed in his room. Resident #30 was not wearing his splint. An interview with the Occupational Therapist (OT) on 7/17/24 at 2:30 PM revealed Resident # 30 suffered from a left-hand contracture and did require a splint for his left hand. She stated she placed an order for Resident #30 left-handed splint with the business manager she believed in March 2024 and still had not received the splint. She revealed equipment orders can sometimes take longer depending on the medical equipment company but never more than a month and she	F 688	ensure it was within a timely manner. Beginning 7/17/24, the Therapy Director conducted in-services with therapy staff on the change in order process and tracking. Any staff members who do not receive the training by 7/17/24 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 8/9/24, the Therapy Area Manager and/or designee will audit the new log for compliance, bi-weekly for 3 months. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing (DON) on a weekly basis and with Quality Assurance and Performance Improvement (QAPI) monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction Date is 8/15/24	

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F 688	Continued From page 15 should have checked on the equipment prior to now. The OT stated once Resident #30 received his left-handed splint they would begin services to address his range of motion while using his splint. An interview with the business office manager on 7/17/24 at 2:40 PM revealed she received a request from OT on 5/08/24 to order a left side hand splint for Resident #30. She stated she had completed the order at 2:20 PM on 5/08/24 and received confirmation of the order. She revealed therapy had not notified her of the missing equipment and she was not aware the splint had not been received. An interview with the Nurse Practitioner (NP) on 7/18/24 at 1:44 PM revealed she had seen Resident #30 this morning and realized he did not have his left-handed splint and asked for a temporary splint or washcloth for his contraction until his splint come in. She stated although she did not believe Resident #30 to have no actual change since she had ordered the left-handed splint in April, she had expected that he would have the splint and OT would be working with him by now. She revealed Resident #30 should have his left-handed splint and receive treatment for his contracture to assist with keeping it from contracting more. An interview with the Director of Nursing and the Administrator on 7/18/24 at 3:44 PM revealed they were not aware that Resident #30 did not have a left-hand splint as ordered and there should have been follow-up to assure Resident #30 had the correct left-hand splint as ordered and was wearing it as tolerated.	F 688		
F 880 SS=D	Infection Prevention & Control	F 880		8/15/24

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F 880	Continued From page 16 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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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 observation, record reviews, and staff interviews, the facility failed to implement their infection control policy for hand hygiene/handwashing, when the Treatment Nurse did not perform hand hygiene according to the facility's policy and procedure when she doffed her gloves after preparing her dressing for the wound and did not sanitize her hands before donning clean gloves to remove the old dressing from the wound for a resident (Resident #4). This

F 880

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Continued From page 18

occurred for 1 of 1 resident observed for wound care.

The findings included:

The facility's policy entitled Hand Hygiene last revised on 08/21/23 read in part:

The hands are the conduits for almost every transfer of potential pathogens from one patient to another, from contaminated object to a patient, and from a staff member to a patient. Because of this, hand hygiene is the single most important procedure to prevent infection.

Washing with soap and water is appropriate when the hands are visibly soiled or contaminated with blood or other body fluids, when exposure to potential spore-forming pathogens is strongly suspected or proven, and after using the restroom. An alcohol-based hand rub is appropriate for decontaminating the hands:
" Before direct patient contact, putting on gloves, or inserting an invasive device
" After contact with inanimate objects in the patient's environment
" After removing gloves

Hand sanitizing:
" Apply alcohol-based hand rub to the palm of one hand and then rub your hands together, covering all surfaces of your hands.
" Continue rubbing your hands together until all the product has dried.

A wound treatment observation was made on 07/17/24 at 2:15 PM on Resident #4 with the Treatment Nurse. The Treatment Nurse gathered her supplies and placed them on the overbed

F 880

F880
On 7/18/24, the Director of Nursing (DON) educated the Wound Nurse on proper hand hygiene/handwashing.
Beginning 8/6/24, the Staff Development Coordinator conducted in-services with nurses on proper hand hygiene/handwashing during wound care. Any staff members who do not receive the training by 8/15/24 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation.

Beginning 8/6/24, the Staff Development Coordinator conducted in-services with nursing staff on proper hand hygiene/handwashing. Any staff members who do not receive the training by 8/15/24 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation.

Beginning 8/6/24, Infection Preventionist and/or designee will audit hand hygiene/handwashing for 12 weeks, 5 observations a week times 4 weeks and 10 observations a month times 2 months. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and DON on a weekly basis and with Quality Assurance and Performance Improvement (QAPI) monthly for a period of 90 days at which time frequency of monitoring will be

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F 880	Continued From page 19 table which she had covered with a clean garbage bag. The Treatment Nurse washed her hands with soap and water, dried them and donned clean gloves. She proceeded to pull up a chair to the bedside of the resident with her gloved hands and sat down in the chair and applied her isolation gown (Resident #4 was on Enhanced Barrier Precautions) after sitting down in the chair. With the same gloves on, the Treatment Nurse began preparing her dressing and applied antimicrobial skin and wound gel to her gauze and cut her bordered gauze dressing to fit the wound. She doffed her gloves and without sanitizing her hands, donned a clean pair of gloves and removed the old dressing from Resident #4's wound. The Treatment Nurse then doffed her gloves, sanitized her hands, donned clean gloves and proceeded to clean the wound with wound cleanser. She doffed her gloves after cleansing the wound, sanitized her hands, and donned clean gloves and applied the wound gel gauze dressing and covered the wound with the bordered gauze dressing. The Treatment Nurse bagged her trash, doffed her gloves, washed her hands with soap and water and discarded her trash and carried her supplies out of the room. An interview on 07/18/24 at 10:38 AM with the Treatment Nurse revealed she thought it was ok to change gloves without sanitizing her hands because she had not yet touched the resident. She stated she remembered sanitizing her hands during the process of the dressing change but said she should sanitize her hands with every change of her gloves. An interview on 07/18/24 at 11:14 AM with the Infection Preventionist (IP) revealed she did handwashing audits on all staff as part of the	F 880	determined by the QAPI Committee. Plan of Correction Date is 8/15/24	

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F 880	Continued From page 20 infection control program. The IP explained that she would have expected the Treatment Nurse to have sanitized her hands after doffing gloves and before donning clean gloves as outlined in their handwashing policy. She stated in addition, someone from corporate comes in twice a month and does random audits on staff for handwashing. The IP further stated she had not watched the Treatment Nurse or audited her during dressing changes and to her knowledge that corporate had not audited her either but said they could add her to their audit to watch her during dressing changes. An interview on 07/18/24 at 3:01 PM with the Director of Nursing (DON) revealed it was her expectation for all staff to follow the handwashing policy and procedure and sanitize their hands with alcohol-based hand rub or wash their hands with soap and water any time they removed their gloves.	F 880		