



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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TAMARA PRISOCK—ADMINISTRATOR  
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3232 Elder Street  
P. O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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March 6, 2020

Dawn Meyer, Administrator  
Lincoln Country Care Center  
PO Box 830  
Shoshone, ID 83352-1502

Provider #: 135056

Dear Ms. Meyer:

On **February 21, 2020**, a survey was conducted at Lincoln County Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

Dawn Meyer, Administrator  
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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 16, 2020**. Failure to submit an acceptable PoC by **March 16, 2020**, may result in the imposition of penalties by **April 8, 2020**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 27, 2020 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 21, 2020**. A change in the seriousness of the deficiencies on **April 6, 2020**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **May 21, 2020** includes the following:

Denial of payment for new admissions effective **May 21, 2020**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 21, 2020**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 21, 2020** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:  
<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalProgram>

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[s/NursingFacilities/tabid/434/Default.aspx](#)

Go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **March 16, 2020**. If your request for informal dispute resolution is received after **March 16, 2020**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Belinda Day, RN, , Supervisor  
Long Term Care Program

bd/lj

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135056</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/21/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINCOLN COUNTY CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>511 EAST FOURTH STREET SHOSHONE, ID 83352</b>		
(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  The following deficiencies were cited during the federal recertification conducted from February 18, 2020 to February 21, 2020.  The surveyors conducting the survey were:  Presie C. Billington, RN, Team Coordinator Amy Youngman, RN  Abbreviations:  CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease DON = Director of Nursing MDS = Minimum Data Set mg = milligram RN = Registered Nurse ml = milliliter	F 000			
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5)  §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:  §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.  §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.  §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of	F 552		3/16/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/15/2020

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 552	<p>Continued From page 1</p> <p>proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure informed consent was obtained prior to administration of medication for 1 of 5 residents (Resident #34) who was reviewed for unnecessary medications. This deficient practice placed residents at risk of receiving medications without knowledge of the risks and benefits associated with the medications and the right to refuse the medications. Findings include:</p> <p>Resident #34 was admitted to the facility on 1/3/17 and was readmitted on 2/12/20, with multiple diagnoses including dementia.</p> <p>Resident #34's physician's order included Donepezil (used to treat confusion related to dementia) HCl (hydrochloride) 10 mg at bedtime, started on 2/12/20.</p> <p>Resident #34's record did not include documentation she consented to the Donepezil, or was informed about beneficial effects and possible side effects of the medication.</p> <p>On 2/20/20 at 11:00 AM, the Administrator said the facility did not obtain consent for Donepezil.</p> <p>Resident #34's record did not include an informed consent for her dementia medication.</p>	F 552	<p>F552</p> <p>Residents right to be informed/make treatment decisions</p> <p>Individual Residents:</p> <p>Resident # 34 and responsible party were informed of need for consent for medications that are prescribed to assist with mental confusion associated with dementia. Consent was signed 2/20/2020</p> <p>Identify Residents in similar Situations:</p> <p>All residents on Donepezil have potential to be affected by this practice. Two residents out of 34 have the potential to be affected. DNS/Designee have reviewed all medical records to assess who may have the potential to be affected. The responsible party was contacted and gave consent, verbally and then signed on 2/24/2020.</p> <p>Systemic Changes, measures to Prevent Reoccurrence:</p> <ol style="list-style-type: none"> <li>1. RSD/ DNS will audit all charts in IDT weekly for any possible change in orders and need for consents.</li> <li>2. RSD/DNS to obtain consent for the medications on admission.</li> <li>3. DNS or/Designee to update policy to include consent for Donepezil.</li> </ol> <p>Monitoring, ongoing compliance:</p> <p>RSD/DNS to audit charts weekly in IDT meeting for consents of Donepezil for 4 weeks, then monthly for three months.</p> <p>Identified trends related to informed</p>		

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F 552	Continued From page 2	F 552			
F 656 SS=D	<p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p>	F 656	<p>consents of Donepezil, will be brought to monthly QAPI for review. QA/Administrator will review for possible adjustment of frequency of monitoring as is deemed appropriately.</p>	3/16/20	

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F 656	<p>Continued From page 3</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure the comprehensive resident-centered care plan included the use of oxygen and smoking. This was true for 2 of 12 residents (#7 and #34) whose comprehensive care plans were reviewed. This failure created the potential for residents to receive inappropriate or inadequate care with subsequent decline in health. Findings include:</p> <p>1. The facility's Smoking policy, undated, documented any smoking related privileges, restrictions and concerns, such as a need for close monitoring, were noted on the care plan.</p> <p>Resident #7 was admitted to the facility on 8/4/17, with multiple diagnoses including COPD (progressive lung disease characterized by increasing breathlessness).</p> <p>Resident #7's quarterly MDS assessment, dated 11/30/19, documented he had severe cognitive impairment.</p> <p>Resident #7's record included a Smoking Safety</p>	F 656	<p>F656 Develop implement Comprehensive Care Plan Individual Residents: Resident # 7 smoking preferences reviewed, and care plan updated, as well as smoking assessment. Resident #34 care plan updated to reflect the current use of oxygen. Identify Residents in Similar Situations: This has the potential to affect 2 other residents that smoke, and 8 other residents that are prescribed oxygen. DNS or Designee will audit and review all medical records to assess for any potential residents. This was completed on 3/9/2020. Smoking assessments were updated as well as the care plans to reflect resident's choices and care level. This was completed by DNS/ Designee on 3/11/2020. Systemic changes measures to prevent reoccurrence: 1. DNS or Designee will review all assessments and care plans related to smoking and oxygen usage, to update as needed. This was completed on</p>		

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F 656	<p>Continued From page 4</p> <p>Evaluation, dated 4/24/19, which documented he had smoked cigars and cigarettes and he did not always choose to flick his cigarette. The Smoking Evaluation also documented Resident #7 did not smoke much anymore but when he had cigarettes he smoked 1-2 times a day.</p> <p>Resident #7's care plan did not include smoking.</p> <p>On 2/19/20 at 3:29 PM, Resident #7 was in his wheelchair being assisted by CNA #1 to the smoking area. CNA #1 was observed to apply the smoking apron to Resident #7. CNA #1 said Resident #7 did not like to hold his cigarette. Resident #7 said he smoked twice a day every day.</p> <p>On 2/19/20 at 4:09 PM, the Corporate Nurse said he did not find smoking as part of Resident #7's care plan and it should have been included.</p> <p>2. Resident #34 was admitted to the facility on 1/3/17 and was readmitted on 2/12/20, with multiple diagnoses including dementia.</p> <p>Resident #34's Order Summary Report, documented Resident #34 may use oxygen as needed when her oxygen saturation (the percentage of oxygen in the blood) was below 90%, ordered on 2/12/20.</p> <p>Resident #34's care plan did not include her use of oxygen to keep her oxygen saturation levels above 90%.</p> <p>On 2/18/20 at 2:15 PM, 2/19/20 at 2:29 PM, and on 2/20/20 at 9:12 AM, Resident #34 was observed in bed wearing oxygen at 2 liters per</p>	F 656	<p>3/12/2020.</p> <p>2. DNS or Designee in-serviced the License Staff on the need to care plan for oxygen use and the importance of smoking assessment for individuals' that smoke. This was completed on 3/10/2020</p> <p>3. IDT members/ MDS coordinator or DNS will audit charts weekly during IDT meeting, for any needed updates to care plans.</p> <p>Monitoring, ongoing compliance: All focus round audits will occur weekly for 4 weeks and then monthly for 3 months, all focus round audits will be brought to QA monthly and will be reviewed for trends or concerns. QA committee/Administrator will review for possible adjustment of the frequency of the monitoring as is deemed appropriate.</p>		

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F 656	Continued From page 5 minute by nasal cannula.	F 656			
F 684 SS=D	On 2/19/20 at 4:09 PM, the Corporate Nurse said Resident #34's care plan did not address her use of oxygen.  Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure professional standards of practice were followed for 1 of 12 residents (#16) reviewed for quality of care. This created the potential for adverse effects or worsening of health status if residents did not receive care and services as ordered by the physician. Findings include:  Resident #16 was admitted to the facility on 3/6/17, with multiple diagnoses including diabetes mellitus and dementia.  Resident #16's quarterly MDS assessment, dated 12/30/19, documented she was cognitively intact.  Resident #16's physician's order, dated 2/5/20, directed staff to cleanse her wound on her gluteal	F 684	F684 Quality of Care Individual Residents: Resident #16 orders were reviewed. The DNS in-serviced staff of the importance of following Physician orders, for dressing changes. This was completed on 3/10/2020 Identify Residents in Similar Situations: This has the potential to affect 3 of 34 residents. All medical records were reviewed by DNS/ Designee for resident's with orders for dressing changes, this was completed on 3/9/2020. All Licensed staff were trained and monitored for appropriate procedure on dressing changes. This was completed on 3/10/2020 Systemic changes, measures to prevent reoccurrence:	3/16/20	

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F 684	<p>Continued From page 6</p> <p>cleft with normal saline, pat dry, apply calcium alginate (type of wound dressing) and cover with Allevyn (a border dressing) every two days and as needed.</p> <p>Resident #16's 2/2020 TAR, documented her wound dressing was completed on 2/15/20, 2/17/20, and 2/19/20.</p> <p>On 2/19/20 at 10:05 AM, CNA #2 was observed assisting Resident #16 to a commode. Resident #16 had a wound dressing on her lower back with a handwritten dated of 2/15/20.</p> <p>On 2/19/20 at 10:29 AM, RN #1 said Resident #16 had a wound dressing on her lower back and the dressing was to be changed every two days. RN #1 said Resident #16's Treatment Administration Record (TAR) documented her dressing was changed that morning, 2/19/20.</p> <p>On 2/19/20 at 10:34 AM, Resident #16 said she thought her dressing on her lower back was being changed two times a week. Resident #16 said she did not think it was changed that morning.</p> <p>On 2/19/20 at 11:58 AM, the Corporate Nurse was observed performing the wound care and dressing change for Resident #16. The Corporate Nurse removed the dressing dated 2/15/20 and said it should have been changed every two days and it was not done. Resident #16's skin between her buttocks was observed to be intact with redness. The Corporate Nurse said Resident #16 had moisture associated skin damage on her lower back and it was getting better. The Corporate Nurse said the nurse on</p>	F 684	<p>1. DNS/ Designee will audit all orders for any possible changes to the treatment orders. This was completed on 3/10/2020</p> <p>2. DNS or Designee will observe /audit all license staff regarding the performance of treatments as ordered by Physician. Monitoring ongoing compliance: DNS or Designee will perform focus audits of wound treatments to ensure wound care is being completed as ordered weekly for four weeks and then bi-weekly for three months, then monthly for three months.</p> <p>All audits will be reviewed by Administrator/QA committee in monthly meetings. The Administrator/QA committee may adjust the frequency of monitoring as deemed appropriate.</p>		

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F 684	Continued From page 7 duty that morning prepared the wound dressing supplies for Resident #16 and marked the wound dressing on the TAR as completed, but the wound dressing change was not completed as documented earlier.	F 684			
F 693 SS=D	Resident #16's physician orders for her wound were not followed. Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)  §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-  §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and  §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, policy review, and record review, the facility failed to follow current professional standards of nursing	F 693	F693 Tube Feeding Individual Resident: License Staff were trained on proper way	3/16/20	

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F 693	<p>Continued From page 8</p> <p>practice for 1 of 1 resident (Resident # 5) who had a feeding tube. This deficient practice had the potential to affect resident care and a potential for a negative outcome in the provision of resident care. Findings include:</p> <p>The facility's policy for Maintaining Patency of a Feeding Tube (Flushing), dated 3/15, documented " ...6. Attach sixty ml catheter tip syringe with 10 to 30 ml (milliliters) of air to tube. Unclamp tube. 7. Verify placement of tube by aspiration. 8. Clamp tube and remove empty syringe. 9. Attach 60 ml catheter tip syringe without plunger to tube. Unclamp tube and unless otherwise ordered, pour 30 ml warm water into syringe. Allow water to flow by gravity into syringe."</p> <p>Resident #5 was admitted to the facility on 2/13/16, with multiple diagnoses including quadriplegia (paralysis [loss of the ability to move] of all four limbs) and persistent vegetative state (a chronic state of brain dysfunction in which a person shows no signs of awareness) after a motor-vehicle accident.</p> <p>Resident #5's annual MDS assessment, dated 11/27/19, documented he was unable to complete the Brief Interview for Mental Status (BIMS) due to his persistent vegetative state. The assessment also documented he received all his nutrition and medication through his g (gastrostomy)-tube.</p> <p>Resident #5's physician's order, directed the staff to flush his g-tube with 30 ml of water before and after administration of all medications, and 10 ml of water in between the administration of each</p>	F 693	<p>to administrate medications through a G-tube. For resident #5. This was completed on 3/10/2020</p> <p>Identify Residents with Similar Situations: This only effected one resident of 34 (#5)</p> <p>Systemic Changes, Measures to prevent reoccurrence:</p> <p>1. DNS will audit all License staff of compliance and competency with medications with medication pass for resident #5. All Licensed staff were in-serviced on 3/10/20, on procedure and policy for performing a gravity medication pass, on a resident with G-tube.</p> <p>Monitoring ongoing compliance: DNS or designee will audit medication pass 3 times weekly for 4 weeks, 1 time weekly for 3 months. All audits will be brought to QA, for review monthly. Administrator or QA committee may adjust frequency as necessary.</p>		

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F 693	<p>Continued From page 9 medication, ordered on 2/20/20.</p> <p>Resident #5's Care Plan, revised 8/27/19, documented he received nutrition and medication through a g-tube. The goal was to ensure he received adequate hydration and nutrition through his g-tube. The care plan directed licensed nurse to administer his medications as ordered and to check his g-tube placement before initiation of formula, medication administration and flushing tube.</p> <p>On 2/19/20 at 9:43 AM, RN #2 was observed administering Resident #5's medication and water flushes through his g-tube. RN #2 pulled the initial 30 ml water flush up into a 60 ml syringe with a plunger, attached the syringe to Resident #5's g- tube, and used the plunger to push the water into the resident's stomach. The remaining flushes and all the resident's medication were administered through the g-tube via gravity (without using the plunger to push the water or medication into the resident's stomach.)</p> <p>On 2/20/20 at 11:28 AM, RN #2 stated she was not aware that the plunger should not be used to push water into the resident's stomach, rather the water and medication should be allowed to flow freely by gravity, when administering fluid and medication through the resident's g-tube. She stated she did not administer Resident #5's medication very often.</p> <p>On 2/20/20 at 2:05 PM, the DON and the Regional Nurse both stated all fluid and medication administered through a g-tube should be done so by gravity.</p>	F 693			

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F 693	Continued From page 10 Resident #5's g-tube was not flushed according to facility policy and procedure.	F 693			
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)  §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a comprehensive assessment of a resident, the facility must ensure that---  §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;  §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;  §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and  §483.45(e)(4) PRN orders for psychotropic drugs	F 758		3/16/20	

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F 758	<p>Continued From page 11</p> <p>are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure residents receiving a psychotropic medication had resident-specific target behaviors identified and monitored. This was true for 3 of 5 residents (#7, #19 and 34) who were reviewed for unnecessary medications. This deficient practice created the potential for harm if residents received medications that may result in negative outcomes without clear indication of need. Findings include:</p> <p>1. Resident #7 was admitted to the facility on 8/4/17, with multiple diagnoses including depression and schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly).</p> <p>Resident #7's quarterly MDS assessment, dated 11/30/19, documented he had severe cognitive impairment, and received anti-depressant medication on 7 of the last 7 days.</p>	F 758	<p>F758 Free from Unnecessary medications (Psychotropic) Individual Resident: Resident #7#19 and #34 care plans were reviewed, as well as behavior sheets. Behaviors sheets were revised to address all three residents behaviors, and interventions were care planned. This was changed and completed on 3/11/2020 Identify residents in similar Situations: This has the potential to affect 21 residents of the 34. RSD/ DNS to review all medical records for residents with potential to have behavior sheets interventions not care planned. All care plans and behavior sheets were reviewed and updated. 3/14/2020 Systemic Changes, measures to prevent Reoccurrence: 1. RSD/DNS to audit care plans and behavior sheets to ensure that all behaviors and care plans reflect</p>		

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F 758	<p>Continued From page 12</p> <p>Resident #7's physician's orders included Fluoxetine Hydrochloride (anti-depressant) 40 mg once a day for depression, ordered on 4/2/18.</p> <p>Resident #7's Behavior care plan documented the following:</p> <p>*He was sometimes depressed and had verbal aggression towards staff. The care plan directed staff to offer him one on one attention, have the Administrator or nurse come talk to him, offer him activities, give medications as ordered, talk with him about cars, and when he is angry give him some space, or have someone else provide cares.</p> <p>*He had delusions related to Schizophrenia. The care plan directed staff to encourage him to do what he was capable of doing independently, have the Administrator talk to him and when he is upset about divorce and wanting custody of his son remind him that his son is now an adult and lives on his own.</p> <p>The facility's Behavior Monitoring flowsheets provided staff with 38 standardized choices of exhibited behaviors and 12 standardized choices for interventions to select. The Behavior Monitoring Flowsheet also included "other" for choices for both behavior and intervention. Each of the target behaviors were monitored each shift during the day, evening and night. The form directed the staff to enter the number of times the behavior occurred, the intervention/drug used, and the outcome.</p> <p>Resident #7 had two Behavior Monitoring Flowsheets, one was completed by the licensed</p>	F 758	<p>resident's current behaviors.</p> <p>2. RSD/ DNS in-serviced on the importance of behavior sheets and care plans to coordinate for behaviors. This was completed on 3/10/2020</p> <p>3. Behavior sheet reformatted to allow more independent interventions for behaviors. this was completed 3/14/2020</p> <p>All staff was in-serviced on new forms, for documentation, of behaviors. RSD/DNS to ensure that behaviors are applied to plan of care with change.</p> <p>Monitoring, ongoing compliance: Behavior sheets, and care plans to be audited weekly in IDT By RSD/DNS for 4 weeks, than Bi-weekly for 3 months than monthly for the next 3 months. Audits to be reviewed in monthly QA meeting. Administrator or QA committee may adjust the frequency of monitoring as is deemed appropriate.</p>		

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F 758	<p>Continued From page 13</p> <p>nurses and the other was completed by the CNAs. Resident #7's December 2019, January 2020 and February 2020 Behavior Monitoring Flowsheets, documented he was being monitored by the licensed nurse for depression and mood changes and the CNAs monitored him for hallucinations, paranoia and delusions, and others such as being loud and refusal of cares. The flowsheets did not document specific behavior for Resident #7 related to his depression and schizophrenia. The flowsheets also did not include specific behaviors for staff to monitor related to Resident #7's hallucinations and paranoia.</p> <p>On 2/20/20 at 2:40 PM, CNA #2 said she monitored Resident #7's behavior for hallucinations, paranoia, and delusions. CNA #2 said Resident #7 manifested his hallucinations by thinking that his roommate took his soda, but he did not have a soda. When asked how Resident #7 manifested his paranoia, CNA #2 did not provide an answer. When asked how Resident #7 manifested his delusions, CNA #2 did not provide an answer.</p> <p>On 2/20/20 at 2:58 PM, the Administrator said only licensed nurses could monitor the residents for depression and the CNAs monitor the residents for wandering, refusal of cares. The Administrator said Resident #7 manifested his paranoia by thinking that he was being poisoned by the staff, thought he was not in the facility and the facility was a hotel for his delusions. The Administrator stated these behaviors were not in the care plan or on the Behavior Monitoring Flowsheets.</p>	F 758			

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F 758	<p>Continued From page 14</p> <p>2. Resident #19 was admitted to the facility on 7/15/19, with multiple diagnoses including Parkinson's disease (a brain disorder that leads to shaking, stiffness, and difficulty with walking and coordination) and depression.</p> <p>Resident #19's quarterly MDS assessment, dated 12/8/19, documented she had moderate cognitive impairment and received anti-depressant and anti-psychotic medication on 7 of the last 7 days.</p> <p>Resident #19's physician's orders included the following:</p> <p>*Lexapro (anti-depressant) 10 mg once a day related to psychosis not due to a substance or known physiological condition, ordered on 3/8/19.</p> <p>*Loxapine Succinate (anti-psychotic) 20 mg two times a day related to idiopathic (disease condition for which the cause is unknown) orofacial dystonia (a movement disorder in which a person's muscles contract uncontrollably).</p> <p>Resident #19's Behavior care plan documented she had depression related to multiple deaths in the family and poor decision making over her life time. The care plan directed staff to administer medication as ordered, monitor her for increase in her acting out behavior or possible self-isolation, assist her in developing, and provide her with a program of activities that is meaningful. The care plan also directed staff to monitor Resident #19 for sign and symptoms of depression including hopelessness, anxiety, sadness, insomnia, anorexia, repetitive anxious or health related complaints, and tearfulness.</p>	F 758			

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F 758	<p>Continued From page 15</p> <p>The care plan did not include Resident #19's increase in acting out behavior the staff to monitor.</p> <p>The facility's Behavior Monitoring Flowsheets provided staff with 38 standardized choices of exhibited behaviors and 12 standardized choices for interventions to select. The Behavior Monitoring Flowsheet also included "other" for choices. Each of the target behaviors were monitored each shift during the day, evening and night. The form directed the staff to enter the number of times the behavior occurred, the intervention/drug used, and the outcome. The flowsheet did not document Resident #19's specific behavior related to depression and psychosis.</p> <p>Resident #19's Behavior Monitoring Flowsheets documented the following:</p> <p>*December 2019, documented she was being monitored by the CNAs for anxiety. Interventions included in the monitoring flowsheets directed staff to redirect her, offer her restorative nursing activity (RNA), and lay her down.</p> <p>*January 2020 and February 2020, documented she was being monitored by the CNAs for anxiety, restlessness, wandering and wanting to get out of bed. Interventions Staff were directed to encourage her to stay up and offer her the RNA program.</p> <p>Resident #19's Behavior Monitoring Flowsheets did not include specific behaviors for staff to monitor related to her anxiety.</p>	F 758			

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F 758	<p>Continued From page 16</p> <p>On 2/18/20 at 11:45 AM, Resident #19 was observed sitting at the table in the dining room. Resident #19 was observed to have repetitive movement (tremor like movement) of both arms.</p> <p>On 2/18/20 at 2:31 at 2:31 PM, Resident #19 was observed in the dining room with the Activity Staff having her nails done (manicure). Resident #19's tongue was sticking out of her mouth.</p> <p>On 2/19/20 at 11:11 AM, Resident #19 was observed propelling her own wheelchair. Resident #19 was observed sticking out her tongue most of the time.</p> <p>On 2/20/20 at 2:44 PM, CNA #2 said Resident #19 was being monitored by the CNAs for restlessness, anxiety, wandering, and wanting to get out of bed. CNA #2 said Resident #19 manifested her anxiety by shaking her hands.</p> <p>On 2/20/20 at 3:23 PM, the Administrator said Resident #19 manifested signs and symptoms of depression such as hopelessness, sadness, insomnia, anorexia, and verbalizing negative statements. The Administrator said she did not find behavior monitoring for Resident #19's depression and she should had one.</p> <p>3. Resident #34 was admitted to the facility on 1/3/17 and was readmitted on 2/12/20, with multiple diagnoses including dementia.</p> <p>Resident #34's quarterly MDS assessment, dated 1/30/20, documented she had severe cognitive impairment and received anti-depressant medication on 7 of the last 7 days.</p>	F 758			

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F 758	<p>Continued From page 17</p> <p>Resident #34's physician's orders included the following:</p> <p>*Donezepil HCL 10 mg at bedtime for Alzheimers, ordered on 2/12/20.</p> <p>*Trazodone (sedative and anti-depressant) HCl 50 mg at bedtime for depression, ordered on 2/12/20.</p> <p>Resident #34's care plan, documented she had depression as evidenced by altered sleeping patterns. The care plan directed staff to give her medications as ordered, monitor her hours of sleep every shift, watch for changes in her mood and for possible self-isolation.</p> <p>The facility's Behavior Monitoring Flowsheets provided staff with 38 standardized choices of exhibited behaviors and 12 standardized choices for interventions to select. The Behavior Monitoring Flowsheet also included "other" for choices for both behaviors and interventions. Each of the target behaviors were monitored each shift during the day, evening and night. The form directed the staff to enter the number of times the behavior occurred, the intervention/drug used, and the outcome.</p> <p>Resident #34's Behavior Monitoring Flowsheets documented the following:</p> <p>*December 2019, documented she was being monitored by the licensed nurses for depression (withdrawn). Interventions included to remove her from the environment and "refer to nurse's notes."</p> <p>January 2020 and February 2020, documented</p>	F 758			

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F 758	Continued From page 18 she was being monitored for depression (withdrawn) and the staff were directed to offer her to play cards and to "refer to nurse's notes."  The flowsheet did not include specific behavior for staff to monitor related to Resident #34's depression.  On 2/18/20 at 2:15 PM and on 2/19/20 at 2:29 PM, Resident #34 was observed in bed sleeping.  On 2/20/20 at 9:12 AM, Resident #34 was observed in bed with her eyes closed and opened her eyes when greeted by the surveyor.  On 2/20/20 at 1:33 PM, Resident #34 was observed sitting in her wheelchair at the lobby.  On 2/20/20 at 10:29 AM, the DON said she did not find the sleep monitor of Resident #34 and she should had one.	F 758			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		3/16/20	

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F 761	<p>Continued From page 19 personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, policy review, and record review, it was determined facility failed to ensure medications were stored at appropriate temperatures and medications were appropriately labeled. This deficient practice created the potential for harm if residents received medications or vaccinations which had reduced efficacy from improper storage. Findings include:  The facility's policy for Medication Storage in the Facility, dated 3/18, documented medications were maintained within the refrigerator temperature ranges of 36 degrees F (Fahrenheit) to 46 degrees F as recommended by the United States Pharmacopoeia (USP) and the Centers for Disease Control (CDC). The policy also documented the facility should maintain a temperature log in the storage area to record temperatures at least once a day.  The facility's policy for Storage of Medications, dated 4/07, documented "The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to</p>	F 761	<p>F761 Label/ Store drugs and Biological Individual Residents: No residents had the potential to be affected by deficient practice as all medications that were stored in the medication refrigerator were disposed of per policy as refrigerator temperature and labeling were not performed to policy requirements. Identify Residents that could be affected: This has the potential to affect all residents. Systemic change, measures to prevent Reoccurrence: 1. DNS or Designee to in-service all Licensed staff of importance accurate monitoring and facility policy on refrigerator temps and storage and labeling of medications. This was completed On 3/10/2020 2. Medication refrigerator was replaced with a new refrigerator. 3. DNS or Designee to monitor the refrigerator temperature logs each week. Monitoring and ongoing compliance:</p>		

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F 761	Continued From page 20 the dispensing pharmacy or destroyed."  On 2/19/20 at 8:59 AM, the temperature in the medication refrigerator was 56 degrees F. The Refrigerator Temperature Log, located on top of the refrigerator was incomplete. There was no documentation of refrigerator temperatures on 2/1/20, 2/5/20, 2/6/20, 2/7/20, 2/14/20, and 2/15/20. The medication refrigerator also contained one vial of flu vaccine which was opened and did not have the date it was opened written on it. The flu vaccine package insert documented the vaccine was to be discarded 28 days after opening.  On 2/19/20 at 11:13 AM, the temperature in the medication refrigerator was 58 degrees F.  On 2/19/20 at 12:06 PM, the DON and Regional Nurse stated the refrigerator temperature was too high and said the Temperature Log should be completed daily. The DON stated vaccines were to be dated when opened and the package guidelines should be followed for the accelerated expiration of a drug after opening.  On 2/21/20 at 12:58 PM, the Regional Nurse stated the facility policy should be followed for refrigerator temperatures and labeling of opened multi-dose vials.	F 761	Audits on temperature log and labeling to be done weekly for 4 weeks, then Bi-weekly for 3 months than monthly for 3 months. All audits to be reviewed in QA monthly. Administrator or QA committee may adjust the frequency of the audit as deemed appropriate.		
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	F 880		3/16/20	

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F 880	Continued From page 21 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 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	F 880			

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F 880	<p>Continued From page 22</p> <p>least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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, interview, and record review, the facility failed to follow infection control guidelines during the administration of multi-dose medications and blood sugar monitoring for 2 of 6 residents (Resident # 5 and Resident #21) whose medication administration were observed. This deficient practice created the potential for the spread of infectious organisms from cross contamination. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 2/13/16, with multiple diagnoses including quadriplegia (paralysis of both arms and legs) and persistent vegetative state (a chronic state in</p>	F 880	<p>F880 Infection Prevention &amp; control Identify Individual: Resident # 5 was receiving eye drops, Licensed nurse was in-serviced, to use a barrier when placing lid to eye drops down while performing the treatment, this has the potential for contamination. Resident's care plan was revised and updated. This was completed on 3/12/2020 Resident #21 was having his blood glucose monitored by Licensed staff. DNS in-serviced Licensed staff to use a barrier for protection when performing treatment,</p>		

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F 880	<p>Continued From page 23 which a person shows no signs of awareness) after a motor-vehicle accident.</p> <p>Resident #5's physician's order, included Lotemax (eye drops) 0.5% to both eyes two times daily for eye pain, ordered on 2/20/20.</p> <p>On 2/19/20 at 9:43 AM, during the medication pass RN #2 opened the multi-dose bottle of Lotemax and placed the open bottle and the lid directly on the resident's bed covers while she administered the resident's other medication. The vial and the lid were not placed on a clean barrier while on Resident #5's bed covers.</p> <p>On 2/20/20 at 11:28 AM, RN #2 stated she was not aware multi-dose vials of medication should be placed on a clean barrier rather than directly on surfaces in a resident's room to avoid cross contamination of medication in the facility medication cart.</p> <p>2. Resident #21 was admitted to the facility on 10/7/19, with multiple diagnoses including diabetes mellitus.</p> <p>On 2/19/20 at 11:34 AM, RN #1 removed the Resident #21's blood glucose monitor and pouch from the medication cart and placed them directly on his dresser while he used a lancet to obtain Resident #21's blood for testing. The glucose monitor and pouch were not placed on a clean barrier while on Resident #21's dresser.</p> <p>On 2/19/20 at 11:34 AM, RN#1, stated he was not aware equipment being used and placed back into the medication cart should be placed on a clean barrier rather than directly on surfaces</p>	F 880	<p>to assist in preventing an infection. Residents care plan was reviewed and updated on 3/12/2020.</p> <p>Identify Residents in similar Situations: This could affect 7 residents out of 34 receiving eye drops, and 7 residents out of 34 that received glucose monitoring. DNS reviewed all care plans for residents with potential to be affected. All potential residents that could be affected care plan were reviewed and updated on 3/13/2020.</p> <p>Systemic changes, measures to prevent Reoccurrence:</p> <p>1. DNS or Designee to train all Licensed staff members on proper technique of placement of barriers when performing treatments, and medication pass. This was completed on 3/10/2020</p> <p>Monitoring, ongoing compliance: DNS or designee to complete focus rounds to audit treatment and medical pass requiring a barrier. Audits to be performed weekly for 4 weeks, than monthly for three months.</p> <p>All audits will be reviewed monthly by QA committee and administrator for compliance. Administrator and QA committee may adjust the frequency of the audit as deemed appropriate.</p>		

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F 880	Continued From page 24 in a resident's room to avoid cross contamination of other equipment in the medication cart.  On 2/20/20 at 2:05 PM, the DON and Regional Nurse both stated medication and equipment being kept in the medication cart should be placed on a clean barrier rather than directly on surfaces in resident rooms or facility common areas to avoid contamination of the facility medication carts.	F 880			