



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE- Governor  
DAVE JEPPESEN- Director

TAMARA PRISOCK—ADMINISTRATOR  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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September 20, 2019

Dallas Clinger, Administrator  
Power County Nursing Home  
510 Roosevelt Street (83211-1362)  
American Falls, ID 83211-0420

Provider #: 135066

Dear Mr. Clinger:

On **September 6, 2019**, a survey was conducted at Power County Nursing Home 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 an isolated deficiency that constitutes actual 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.) **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.

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 **September 30, 2019**. Failure to submit an acceptable PoC by **September 30, 2019**, may result in the imposition of civil monetary penalties by **September 30, 2019**.

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*.

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

- **Denial of payment for new admissions effective December 6, 2019**
- **Civil money penalty**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 6, 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.**

Dallas Clinger, Administrator  
September 20, 2019  
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If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, 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.

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/StateFederalPrograms/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 **September 30, 2019**. If your request for informal dispute resolution is received after **September 30, 2019**, 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

Enclosures

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

PRINTED: 10/04/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135066</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/06/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>POWER COUNTY NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211</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 survey conducted at the facility from September 3, 2019 through September 6, 2019.  The surveyors conducting the survey were:  Jenny Walker, RN Team Coordinator Sallie Schwartzkopf, MLSW Laura Thompson, RN  Abbreviations:  cm = centimeter CNA = Certified Nursing Assistant DON = Director of Nursing MDS = Minimum Data Set RN = Registered Nurse	F 000			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		10/30/19	

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

TITLE

(X6) DATE

Electronically Signed

09/30/2019

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 657	<p>Continued From page 1</p> <p>medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>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' care plans were revised as skin care needs changed. This was true for 1 of 9 residents (Resident #6) reviewed for care plan revision. This failure had the potential for the residents to receive inappropriate or inadequate care with subsequent decline in health.</p> <p>Resident #6 was admitted to the facility on 6/21/13, with multiple diagnoses including Type 2 diabetes mellitus, chronic kidney disease, and Alzheimer's disease.</p> <p>The Quarterly MDS Assessment, dated 3/25/19, documented Resident #6 was at risk for developing pressure ulcers and did not have an unhealed ulcer. The assessment also documented moisture associated skin damage was not present.</p> <p>A Nurse's Progress Note, dated 6/14/19 at 12:47 PM, documented an order request from the physician for Diflucan for redness, splitting (linear skin opening), and yeast to Resident #6's groin</p>	F 657	<p>F657 SS=D 483.21(b) Comprehensive care plans 483.21 (b)(2) (i)-(iii)</p> <p>What corrective actions will be accomplished for residents found to be affected by the deficient practice. Resident #6 was affected by skin care updates not on the care plan. The DON updated Resident #6 care plan to reflect the recurring skin problems, rashes under breast, abdomen fold, and breakdown of skin on buttocks for treatment and monitoring to try and prevent further skin breakdown on 9/24/19. The care plan was also updated for staff to complete an incident report for future recurring skin issues and resident physician notification for treatment suggestions.</p> <p>Identify other resident(s) with potential to be affected and what corrective action(s) will be taken.</p> <p>All residents with skin issues or those at risk for skin issues have potential to be affected. Nursing staff will complete an</p>		

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F 657	<p>Continued From page 2</p> <p>area. The order was received, placed on alert charting, and faxed to the pharmacy.</p> <p>Progress Notes documented from 6/14/19 to 8/16/19, 22 nursing notes in total, documented care was provided to Resident #6's skin folds, including under her breasts and her lower abdomen/groin area.</p> <p>A Nurse's Progress Note, dated 6/21/19 at 8:25 AM, documented Resident #6 had a "thin skinned" area to her upper right inner buttock, and the area was not open, and Resident #6 had redness under both breasts but the areas were not open.</p> <p>The Annual MDS Assessment, dated 6/23/19, documented Resident #6 was at risk for developing pressure ulcers, and she did not have an unhealed ulcer. The assessment also documented moisture associated skin damage was present.</p> <p>A Nurse's Progress Note, dated 8/28/19 at 3:51 PM, documented Resident #6 had an open area on the right side of her coccyx (tail bone) and cream was applied. It was unclear from the documentation whether this was a new area or the one previously described in earlier nursing notes.</p> <p>The care plan for Resident #6 did not include the wound on her buttocks the redness and excoriation under Resident #6's breasts or lower abdomen/groin area.</p> <p>On 9/5/19 at 10:00 AM, CNA #1 and CNA #2 were observed providing incontinence care to</p>	F 657	<p>incident report for all new and recurring skin issues. The procedure for all incident reports is to call the family and doctor, this will ensure the doctor gets notified. All new skin issues will be updated in the care plan and added to alert charting by DON or skin nurse.</p> <p>What measures will be put in place to ensure the deficient practice does not recur. The DON wrote and distributed an in-service for all staff to review and sign about alerting the physician for recurring skin issues and completing incident reports when recurring skin issues happen for updated treatment. The DON will review all other resident care plans to ensure documentation is current for any recurring skin issues, physician notification of changes, and discuss any changes with staff to be more are aware of them.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The DON will review all incident reports. A log of skin incident report will be kept with notation of updates to resident care plans and physician notification compliance, for all new or recurring skin issues. Beginning 10/1/19, the DON will monitor and report findings from the skin incident report log and the resident care plans as part of the facility QAPI program. A report on the findings will be submitted monthly to the QAPI Director and discussed at</p>		

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F 657	Continued From page 3 Resident #6. Resident #6 had an open wound located in the upper part of the right gluteal cleft area (right buttock near the central crease), which measured 2 cm x 3.5 cm and was red in the center with peeling skin around the right side.  On 9/6/19 at 12:06 PM, RN #1 said that she, or the DON, entered changes in the care plan if there were changes in a resident's condition. She said there should have been an entry for a change in Resident #6's care plan after the skin issues were identified.	F 657	monthly staff meetings for continued process improvement suggestions if necessary.  Date corrective action completed: 10/30/19		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)  §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, record review, and staff interviews, it was determined the facility failed to ensure residents did not develop recurrent avoidable Stage II pressure ulcers, treatment of the pressure ulcers was directed by a physician, and licensed nurses providing pressure ulcer assessments and	F 686	F686 SS=G CFR 483.25 (b)(1)(i)(ii) Treatment/ Svcs to Prevent /Heal Pressure Ulcer  What corrective actions will be accomplished for residents found to be affected by the deficient practice.	10/30/19	

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F 686	<p>Continued From page 4</p> <p>treatments were competent to do so. This was true for 1 of 2 residents (Resident #6) reviewed for pressure ulcers. Resident #6 was harmed when she developed a recurrent Stage II pressure ulcer to her right buttock and her physician was not notified. Findings include:</p> <p>The facility's Policy and Procedure for Skin Assessments and Treatment, dated 4/21/14, documented:</p> <ul style="list-style-type: none"> <li>*Residents were to receive weekly skin assessments, institute preventive measures as necessary, and monitor the healing of pressure sores, skin tears, abrasions, and bruises.</li> <li>* A resident who entered the facility without pressure sores did not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.</li> <li>* A resident having pressure sores received necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.</li> <li>*An avoidable pressure ulcer meant the resident developed a pressure ulcer and the facility did not evaluate the resident's clinical condition, implement interventions or revise the interventions as appropriate.</li> <li>*A pressure sore was defined as any lesion caused by unrelieved pressure resulting in damage of underlying tissue and they were staged to classify the degree of tissue damage observed.</li> <li>* Stage I pressure sores are not open wounds. They may be painful, appear reddened, do not blanch (lose color briefly when you press your finger on it then remove your finger), and can feel either firmer or softer than the area around the</li> </ul>	F 686	<p>Resident #6 was affected by the deficient practices related to a pressure ulcer. Resident #6 care plan has been updated to keep off the affected area between meals. Resident #6 head to toe skin assessment and all recurring and current skin issues have all been identified and added to the care plan as well as physician notified and updated orders for skin treatments to each affected area. DON came in to do skin checks with wound nurse every Friday for 2 weeks 9/13 and did training with wound nurse to make sure wound charting is accurate and contains wound descriptions such as: size of wound bed, percentage and type of tissue visible, size of entire affected area, color, character, odor, drainage, and character of surrounding tissue, if applicable. Dressing and wound care was given. Resident #6 will now have a turning schedule task set up in the EMR that will require charting by all aides for better monitoring and resident movement. A larger TV was also placed in the room and staffs will also use facility mobile computer and music-memory options to entertain the resident while lying down more.</p> <p>Identify other resident(s) with potential to be affected and what corrective action(s) will be taken.</p> <p>All residents have potential to be affected. The DON held an in-service at the 9/18/19 and 9/19/19 and staffs including wound nurse were advised about physician notification for all new or</p>		

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F 686	<p>Continued From page 5</p> <p>sore.</p> <p>*Stage II sores are broken open, worn away, or form an ulcer, which is usually tender and painful. The sore expands into deep layers of skin, can look like a scrape, blister, or shallow crater in the skin. At this stage, some skin may be damaged beyond repair and die.</p> <p>*If skin breakdown was noted the resident's physician was notified. Any treatment was to change to what the doctor ordered immediately after the order was given.</p> <p>*Pressure sores will be documented on every shift, and whenever any changes or problems occur; when a pressure sore or strong potential for a pressure sore has been identified the treatment plan shall be implemented, the goals of treatment include keeping the physician informed of progress of healing and the physician's orders for treatment are to be followed.</p> <p>*Interventions for pressure sores included the licensed nurse was to monitor all wounds every shift.</p> <p>*The skin licensed nurse team was to evaluate wounds weekly and as needed, and document location, stage, length, width, color, treatment, progress, and any wound condition changes.</p> <p>The Lippincott Manual of Nursing Practice, tenth edition, directs nurses to stage pressure ulcers so appropriate treatment can be started by following the staging system of the National Pressure Ulcer Advisory Panel which includes Stages I-IV, Unstageable and Suspected Deep Tissue Injury.</p> <p>The National Pressure Ulcer Advisory Panel website (<a href="http://www.npuap.org">www.npuap.org</a>), accessed on 9/11/19, defines Stage I and Stage II pressure injuries as</p>	F 686	<p>recurring skin issues and treatment recommendations. If the physician has no specific suggestions, staffs are to continue to treat wounds according to the current Medical Director approved skin care policy, which includes Allevyn, steri-strips, and bandaid, and an incident report with physician notification of the wound is to be done; if the physician orders a different treatment this will be used instead of skin care policy instructions.</p> <p>What measures will be put in place to ensure the deficient practice does not recur.</p> <p>The DON will review all resident Braden scales and set up a task schedule in the EMR for 2-hour positioning changes for those residents at high risk for skin breakdown to remind staff to move them and monitor for changes.</p> <p>The DON will do staff training on daily skin care procedures as well as identification of areas for potential skin breakdown such as changes in feel of skin (boggy or firmness), color (redness, non-blanching), and areas more prone to breakdown, as well as interventions (ie: getting pressure off) via written in-services and review of the education at the October staff meeting and future meetings. The wound nurse will also attend additional training offered by EIRMC and/or the state annually as well.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice</p>		

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F 686	<p>Continued From page 6 follows</p> <p>*Stage I - Intact skin with a localized area of non-blanchable erythema (redness), which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.</p> <p>*Stage II - Partial-thickness loss of skin with exposed dermis (thick layer of living tissue below the top of the skin that contains blood capillaries, nerve endings, sweat glands, hair follicles, and other structures). The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible.</p> <p>Resident #6 was admitted to the facility on 6/21/13, with multiple diagnoses including Type 2 diabetes mellitus, chronic kidney disease, and Alzheimer's disease.</p> <p>Resident #6's care plan, dated 4/2/19, directed staff to turn/reposition and change Resident #6 at night every 2-3 hours and as needed. The care plan did not document specific nursing care for Resident #6's pressure ulcer.</p> <p>Resident #6's annual MDS assessment, dated 6/23/19, documented she was severely cognitively impaired and required extensive physical assistance of two or more persons with bed mobility, transfers, walking, toilet use, and personal hygiene. The MDS documented Resident #6 was at risk of developing pressure</p>	F 686	<p>will not recur.</p> <p>Beginning 10/1/19, the DON and will monitor staff with random spot checks that high risk residents are moved every 2 hours, as part of the facility QAPI program. These checks will be done three days per week for the first month, then weekly for 2 months, and monthly spot checks thereafter. A report on the findings will be submitted monthly to the QAPI Committee. Deficiencies will be discussed with individual staff for more training and at monthly staff meetings.</p> <p>The DON will review all weekly skin assessments done by the wound nurse for the next 6 months, then monthly to ensure correct documentation with details that contain size, depth, character of wound bed, surrounding tissue, odor, drainage, treatment and residents response to treatments offered; and will suggest contacting physician if treatments appear to be unsuccessful. Problems with documentation will be addressed by the DON with additional one-on-one training with the wound nurse.</p> <p>Date corrective action completed: 10/30/19</p>		

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F 686	<p>Continued From page 7</p> <p>ulcers and did not have an unhealed pressure ulcer.</p> <p>A Skin Observation Assessment Tool, dated 6/21/19 at 8:24 AM, documented to "See nurse's notes". The tool included areas to document the site, type, length, width, depth, and stage of the wound. These areas were not completed.</p> <p>A Nursing Progress Note, dated 6/21/19 at 8:25 AM, documented Resident #6 had a "thin skinned" area to her upper right inner buttock, and the area was not open. Further description including stage, length, width, color, and treatment of the area were not documented.</p> <p>A Nursing Progress Note, dated 6/28/19 at 9:11 AM, documented Resident #6 had a small "thin skinned" area to her left inner buttock and a large "thin skinned" area to her right inner buttock, and they were cleaned well, and barrier cream was applied. Further description including an identifying number for each area, and the stage, length, width, and color of the 2 areas and the surrounding tissue were not documented. Further documentation regarding the "thin-skinned" area on Resident #6's left inner buttock was not found in subsequent skin assessments or Nursing Progress Notes.</p> <p>A Nursing Progress Note, dated 6/30/19 at 5:26 PM, documented Resident #6 had a small open sore to her right buttock which was cleaned, barrier cream was applied, and the nurse left Resident #6's buttock open to air with a pillow under her. The progress note documented the dressing of the wound was deferred to the night shift nurse to apply. Further description including</p>	F 686			

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F 686	<p>Continued From page 8</p> <p>stage, length, width, color, and progress of the open sore and the surrounding area were not documented.</p> <p>A Nursing Progress Note, dated 7/1/19 at 4:29 PM, documented Resident #6 was laid down, turned and repositioned since "scab to right buttocks was still visible", not bleeding, not open, and barrier cream application was continued. Further descriptions of the open sore and surrounding area were not documented.</p> <p>A Skin Observation Assessment Tool, dated 7/5/19 at 8:29 AM, documented to "See nurse's notes". The site, type, and dimensions for length, width, depth and the stage of the observed wound were not documented.</p> <p>A Nursing Progress Note, dated 7/5/19 at 8:33 AM, documented Resident #6's right inner buttock had a 1 cm diameter open area, the wound bed was pink with flat edges, and there was minimal serosanguinous drainage (contains both blood and a clear yellow liquid). The wound was cleaned well with normal saline, covered with Mepilex border lite (self- adherent dressing that absorbs drainage and maintains a moist wound environment), and barrier cream was applied to the buttocks. Further description of stage, length, width, depth, and color of the open sore and surrounding area were not documented.</p> <p>A Nursing Progress Note, dated 7/6/19 at 4:36 AM, documented Resident #6's right buttock had a 1 cm open area and it was cleaned, antibiotic ointment was applied, and barrier cream was applied and secured with Mepilex dressing. The dressing was dated. Resident #6 was</p>	F 686			

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F 686	<p>Continued From page 9</p> <p>repositioned after meals and at bedtime from side to side off her buttocks. Further description of the open sore and of the surrounding area were not documented.</p> <p>A Nursing Progress Note, dated 7/6/19 at 4:54 PM, documented Resident #6's right buttock still had a Mepilex dressing and she was repositioned after meals and at bedtime from side to side off her buttocks, and staff would continue to monitor. Further description of the open sore and the surrounding area were not documented.</p> <p>A Nursing Progress Note, dated 7/8/19 at 5:03 PM, documented barrier cream was applied to Resident #6's small open area on her right inner buttock and staff would continue to monitor. Further description of the open sore and the surrounding area were not documented.</p> <p>A Nursing Progress Note, dated 7/9/19 at 1:07 PM, documented Resident #6 had a small red area on her right inner buttock. The area was not open and was "healing". The area was cleansed, and zinc was applied. Further description of the sore and the surrounding area were not documented.</p> <p>A Skin Observation Tool, dated 7/12/19 at 8:44 AM, documented to "See nurse's notes". The site, type, and dimensions for length, width, depth, and the stage of the observed skin conditions were not documented.</p> <p>A Nursing Progress Note, dated 7/12/19 at 8:46 AM, documented Resident #6 had a 1/2 cm x 3/4 cm open area to her right upper inner buttock, with flat edges, the wound bed was pink, and no</p>	F 686			

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F 686	<p>Continued From page 10</p> <p>foul odor was noted. The note documented the wound was cleaned well and Mepilex lite border dressing was applied. Further description including the stage of the open sore, depth of the sore, and specific description of surrounding area were not documented.</p> <p>A Nursing Progress Note, dated 7/13/19 at 9:13 AM, documented continued treatment of the open area to Resident #6's right upper inner buttock, with no foul odor, and the Mepilex border dressing was still intact. Further description of the open sore and the surrounding area were not documented. Notification of Resident #6's physician regarding the wound was not documented.</p> <p>A Nursing Progress Note, dated 7/14/19 at 4:00 AM, documented Resident #6 had an open area on her right inner buttock which was cleaned, zinc cream applied, a Mepilex dressing was not in place, and Resident #6 continued to be repositioned from side to side. Further description of the open sore and the surrounding area were not documented.</p> <p>A Nursing Progress Note, dated 7/14/19 at 10:25 AM, documented Resident #6's open area on her right inner buttock had no foul odor, was cleaned well, and a Mepilex lite border dressing was applied. Further description of the open sore and the surrounding area were not documented.</p> <p>A Nursing Progress Note, dated 7/15/19 at 3:23 PM, documented a soiled Mepilex dressing was removed from Resident #6's right inner buttock, the open area was cleansed, and zinc ointment was applied, with no signs and symptoms of</p>	F 686			

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F 686	<p>Continued From page 11</p> <p>infection. Resident #6 was frequently turned at least every 2 hours. Further description of the open sore and the surrounding area were not documented.</p> <p>A Nursing Progress Note, dated 7/16/19 at 5:37 PM, documented Resident #6's right inner buttock was cleansed, zinc ointment was applied, and the wound was left to open air. Further description of the open sore and the surrounding area was not documented.</p> <p>A Nursing Progress Note, dated 7/17/19 at 12:09 AM, documented zinc paste was applied to Resident #6's "coccyx area" (tailbone). Further description including stage, length, width, depth, color, and progress of the open sore and the surrounding area were not documented.</p> <p>A Nursing Progress Note, dated 7/18/18 at 1:17 AM, documented Resident #6 was kept dry and zinc was applied to the open area of her right buttock. Further description of the open sore and the surrounding area were not documented.</p> <p>A Skin Observation Tool, dated 7/18/19 at 6:58 AM, documented to "see nurse's notes". The site, type, and dimensions for length, width, depth and the stage of the observed wound(s) were not documented.</p> <p>A Nursing Progress Note, dated 7/18/19 at 7:00 AM, documented Resident #6's small area to right inner buttock where skin had been open was now closed but still "thin skinned", and the area was cleaned well, and barrier cream was applied. Further description of the wound and surrounding area was not documented.</p>	F 686			

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F 686	Continued From page 12  A Nursing Progress Note, dated 7/18/19 at 10:23 AM, documented the "skin nurse" assessed Resident #6 this morning and findings were: Resident #6's right inner buttock upper area was resolved with only "thin skin". The area was cleaned, barrier cream applied, and Resident #6 was being turned side to side. Further description of the area and surrounding tissue were not documented.  Nursing Progress Notes, dated 7/19/19 to 7/24/19, 5 notes total, documented Resident #6 had zinc cream applied to her "resolved" right buttock open site, the area "appears closed", "continues to resolve", and "is resolved" were used to describe the wound. Further description of the wound and surrounding area was not documented.  A Skin Observation Tool and Nursing Progress Note, each dated 7/26/19, did not include documentation of Resident #6's buttock wound.  A Nursing Progress Notes, dated 7/27/19 at 1:05 AM, documented Resident #6's open area on her right buttock had "resolved". Further description of the area was not documented.  A Skin Observation Tool, dated 8/2/19 at 7:48 AM, did not document the condition of her right buttock area.  A Nursing Progress Note, dated 8/2/19 at 12:13 PM, did not document the condition of her right buttock area.  A Nursing Progress Note, dated 8/9/19 at 10:58	F 686			

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F 686	<p>Continued From page 13</p> <p>AM, documented Resident #6's pannus area had redness and splits on both sides. The note did not document the condition of the skin on her right buttock.</p> <p>A Skin Observation Tool, dated 8/9/19 at 4:09 PM, documented Resident #6 had no skin issues and her skin was clean, warm, pink, and dry. The documentation on the Skin Observation Tool conflicted with the documentation in the Nursing Progress Note completed on the same day.</p> <p>A Skin Observation Tool, dated 8/16/19 at 7:53 AM, documented Resident #6 had clean, dry, and intact pink skin. The note did not document the condition of the skin on her right buttock.</p> <p>A Nursing Progress Note, dated 8/16/19 at 7:54 AM, documented treatment of other skin issues. It did not document the condition of the skin on her right buttock.</p> <p>Resident #6's record did not include documentation of the condition of the skin on her right buttock from 7/28/19 through 8/22/19, 26 days.</p> <p>A Skin Observation Tool, dated 8/23/19 at 7:57 AM, documented a .5 x 1.25 cm purplish red "thin skinned" area to Resident #6's right inner buttock. The area was cleansed, and barrier cream was applied. Further description was not documented. The site, type, and dimensions for length, width, and stage of the observed area were not documented.</p> <p>A Nursing Progress Note, dated 8/23/19 at 2:10 PM, documented Resident #6 had purplish "thin</p>	F 686			

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F 686	<p>Continued From page 14</p> <p>skin" area on the right buttock, barrier cream was applied, and the plan was for Resident #6 to lay down between meals. Further description including stage, length, width, and color of the wound and surrounding area were not documented. Treatment applied to the area was not documented.</p> <p>A Nursing Progress Note, dated 8/26/19 at 2:18 AM, documented to continue to monitor Resident #6's "Coccyx area", she was turned every two hours, and ointment to her buttocks was applied at every change of her incontinence brief. Further description of the wound and surrounding area was not documented.</p> <p>A Nursing Progress Note, dated 8/28/19 at 3:51 PM, documented Resident #6 had an open area on the right side of her coccyx, barrier cream was applied, she was laid down between meals, and repositioned from side to side. Further description including stage, length, width, depth, and color of the wound and surrounding area were not documented.</p> <p>A Nursing Progress Note, dated 8/29/19 at 12:58 AM, documented Resident #6 was sleeping on her side off the "thinning scar" of her coccyx and staff repositioned her side to side between incontinent brief changes. Further description including stage, length, width, and color of the wound and surrounding area were not documented.</p> <p>A Nursing Progress Note, dated 8/29/19 at 1:30 PM, documented continued monitoring of Resident #6's coccyx area, she was laid down after breakfast, and barrier cream was applied to</p>	F 686			

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F 686	<p>Continued From page 15</p> <p>her buttocks at every incontinence brief change. Further description including stage, length, width, and color of the wound and surrounding area were not documented.</p> <p>A Nursing Progress Note, dated 8/29/19 at 11:50 PM, documented Resident #6 was sleeping on her side off her buttocks, she was kept clean and dry between bedtime rounds, "good" peri care was provided, and zinc was applied to her buttocks and "resolving" open site of "old scar". Further description including stage, length, width, depth, location, and color of the wound and surrounding area were not documented.</p> <p>A Nursing Progress Note, dated 8/30/19 at 1:20 AM, documented an "open" site. Her incontinence briefs were changed every 2 hours and peri care was provided, she was repositioned side to side, and zinc ointment was applied. Further description including stage, length, width, depth, color, and progress of the open sore and the surrounding area were not documented.</p> <p>A Skin Observation Tool, dated 8/30/19 at 8:31 AM, documented Resident #6 had a .5 x 1.5 cm purplish red area to her right inner buttock, with no drainage from the area, it was cleansed, and barrier cream applied. The type, depth, and the stage of the observed wound were not documented. A description of the surrounding area was not documented.</p> <p>A Nursing Progress Note, dated 8/31/19 at 12:29 AM, documented Resident #6 was turned side to side every 2 hours with continence brief changes, peri care was provided, and zinc was applied to</p>	F 686			

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F 686	<p>Continued From page 16</p> <p>her "closing" right buttock "old open scar site". Further description including stage, length, width, depth, color, progress and location of the open sore and the surrounding area were not documented.</p> <p>A Nursing Progress Note, dated 9/1/19 at 4:40 PM, documented purplish open skin at Resident #6's right inner buttock, with barrier cream applied. Further description of the wound and surrounding area was not documented.</p> <p>A Nursing Progress Note, dated 9/3/19 at 2:08 PM, documented Resident #6 had an open skin area in her coccyx area which was cleansed, and cream applied. Further description of the open sore and the surrounding area were not documented.</p> <p>A Nursing Progress Note, dated 9/4/19 at 5:38 PM, documented an open skin area on Resident #6's coccyx area, the area was cleansed, cream was applied, and she was repositioned every 2 hours. Further description including stage, length, width, depth, color, and progress of the open sore and of the surrounding area were not documented.</p> <p>Resident #6's record, including the above Nursing Progress Notes and Skin Observation Tools, did not include documentation her physician was notified of the pressure wound on her right buttock area.</p> <p>Resident #6's wounds were not described and staged per the facility's policy to ensure objective data upon which to assess progress toward healing and the effectiveness of treatment.</p>	F 686			

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F 686	<p>Continued From page 17</p> <p>On 9/5/19 at 10:00 AM, CNA #1 and CNA #2 were observed providing incontinent care to Resident #6. CNA #1 and CNA #2 washed their hands and applied gloves and assisted Resident #6 into her bed to lay down. Resident #6 had an open wound in the upper part of the right gluteal cleft area (right buttock near the central crease) which measured 2 cm x 3.5 cm. The wound was red in the center with peeling skin around the right side. CNA #1 cleaned stool from Resident #6's peri-area with wipes, tucked the dirty brief under Resident #6 and placed clean briefs under her without changing her gloves after cleaning the per-area. CNA #1 then picked up the tube of barrier cream, squeezed cream onto her dirty gloves and applied the barrier cream to Resident #6's buttocks. CNA #1 did not change her gloves or perform hand hygiene after providing incontinent care to Resident #6 and before handling the clean briefs and applying the barrier cream.</p> <p>On 9/5/19 at 10:10 AM, CNA #1 and CNA #2 stated the wound was checked by the nurse once a week. When asked if there were any other treatments for the wound they stated no, just the barrier cream.</p> <p>On 9/5/19 at 10:30 AM, CNA #1 stated she should have removed her gloves, performed hand hygiene, and replaced with clean gloves before applying the barrier cream to Resident #6's buttocks and before handling new, clean briefs.</p> <p>On 9/6/19 at 10:53 AM, RN #1, the facility's designated wound care nurse, said she</p>	F 686			

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F 686	Continued From page 18 documented measurements in the progress notes or on the Skin Observation Tool. She stated she measured wounds weekly and said she did not document the measurements and she should be. RN #1 said she did not know how to describe the wounds using the correct terminology, or what to document. She stated she did not number the wounds when they were identified. She stated she did not notify Resident #6's physician about the right buttock wound.  Nursing Progress Notes and Skin Observation Tools documented the skin on Resident #6's right buttock area opened and closed, as follows:  6/21/19 - 6/29/19, closed or thin-skinned 6/30/19 7/8/19, open sore or scab 7/9/19 - 7/11/19, closed or thin-skinned 7/12/19 - 7/18/19 at 1:17 AM, open sore 7/18/19 at 7:00 AM through 7/27/19, closed or thin-skinned 7/28/19 - 8/22/19, no documentation of the right buttock area 8/23/19 - 8/27/19, closed or thin-skinned 8/28/19 - 9/5/19, open sore  Resident #6 was harmed when:  *She developed an avoidable recurrent pressure ulcer to her right buttock. *Her physician was not notified of the pressure ulcer on her right buttock and wound care was provided to the pressure ulcer without a physician's order and involvement.	F 686			
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)  §483.20(f)(5) Resident-identifiable information.	F 842		10/30/19	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135066</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/06/2019</b>
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F 842	<p>Continued From page 19</p> <p>(i) A facility may not release information that is resident-identifiable to the public.</p> <p>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(i) Medical records.</p> <p>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete;</p> <p>(ii) Accurately documented;</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR</p>	F 842			

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F 842	<p>Continued From page 20 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <ul style="list-style-type: none"> <li>(i) The period of time required by State law; or</li> <li>(ii) Five years from the date of discharge when there is no requirement in State law; or</li> <li>(iii) For a minor, 3 years after a resident reaches legal age under State law.</li> </ul> <p>§483.70(i)(5) The medical record must contain-</p> <ul style="list-style-type: none"> <li>(i) Sufficient information to identify the resident;</li> <li>(ii) A record of the resident's assessments;</li> <li>(iii) The comprehensive plan of care and services provided;</li> <li>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</li> <li>(v) Physician's, nurse's, and other licensed professional's progress notes; and</li> <li>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</li> </ul> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to consistently document restorative nursing care in the residents' record. This was true for 1 of 5 residents (Resident #3) reviewed for restorative services. This deficient practice created the potential for harm when clinical information was not accurate and complete. Findings include:</p> <p>The tools used to document restorative care</p>	F 842	<p>F842 SS=D CFR(s) 483.20(f)(5), 483.7(i)(1)-(5) Resident records identifiable information</p> <p>What corrective actions will be accomplished for residents found to be affected by the deficient practice. Resident #3 was affected by the inconsistent restorative service documentation. The restorative care</p>		

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F 842	<p>Continued From page 21</p> <p>services provided by the facility were the Point of Care (POC) Response History (a tool in the electronic record which documented when and how long restorative services were completed daily) and the Restorative Progress Note (a summary of the week's services provided). The POC consisted of a chart with the daily service dates down the side and 4 columns/options across the top; the provider checked the appropriate column. The 4 columns/options were: the number of minutes the resident was provided restorative services, the resident was not available, the resident refused, and not applicable (NA). The Restorative Progress Note was documentation written by the restorative nurse in the electronic record.</p> <p>Resident #3 was admitted to the facility on 7/8/19, with multiple diagnoses including generalized muscle weakness and mild cognitive impairment. Resident #3 used a motorized wheelchair.</p> <p>The Restorative Progress Note, dated 8/30/19 at 10:23 AM, documented the week of 8/24/19 through 8/30/19, Resident #3 participated in restorative exercises on 3 days, and the restorative aide was unable to provide the exercises on the other days because she helped residents with activities of daily living instead. The POC documented from 8/24/19 thru 8/30/19, Resident #3 participated 5 days for 15 minutes and the remaining 2 days were NA. The information found on the two documentation tools for that week were inconsistent.</p> <p>The Restorative Progress Note, dated 8/23/19 at 9:01 AM, documented the week of 8/17/19</p>	F 842	<p>staffs were educated on documenting restorative services in the EMR for better consistency.</p> <p>Identify other resident(s) with potential to be affected and what corrective action(s) will be taken.</p> <p>All residents receiving restorative care have the potential to be affected. The DON met with restorative care staff to discuss restorative documentation. The EMR vendor was contacted to remove the <input type="checkbox"/>not applicable<input type="checkbox"/> NA button from the POC Response History for restorative care to avoid confusion with documentation, but it cannot be changed or removed. The DON and restorative staffs will define the <input type="checkbox"/>not applicable<input type="checkbox"/> NA options and train with staff on documentation in the EMR for better clarification of restorative services.</p> <p>What measures will be put in place to ensure the deficient practice does not recur.</p> <p>The DON and restorative RN updated the policy and procedure Restorative Care Range of Motion and it is compliant with current regulations. A copy of the updated policy was distributed to the restorative staffs for review on 9/30/19. The updated policy also has definitions for the POC Response History options in the EMR and the <input type="checkbox"/>not applicable<input type="checkbox"/> category will only be used for days when no restorative aide services are provided or if a restorative aide was unable to work with a resident due to time constraints . The restorative</p>		

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F 842	Continued From page 22 through 8/23/19, Resident #3 participated in restorative exercises on 6 days. The POC documented from 8/17/19 thru 8/23/19, Resident #3 participated in exercises on 5 days for 15 minutes each, 1 day was NA, and 1 day the resident refused. The information found on the two documentation tools for that week were inconsistent.  On 9/5/19 at 2:09 PM, the DON said during the week of 8/24/19 through 8/30/19, the facility was short staffed. The DON said staff was directed to provide restorative care 5-7 days a week in the hope of providing services at least 5 days, if the staff attempted all 7 days. The DON said the restorative nurse wrote a weekly summation of restorative services provided after reviewing the POC Response History for the nursing rehabilitation/restorative task. The DON stated the documentation was inconsistent.	F 842	aide will also write a note in the nurse's notes reflecting the time constraints.  The restorative RN will also be reviewing the documentation in the POC for daily details before interviewing restorative staff. This will provide more consistent and matching documentation of services in the Restorative Progress Notes and POC in the EMR.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Beginning 10/1/19, the DON will monitor the restorative documentation weekly for the next 3 months, and then monthly thereafter for 9 months as part of the facility QAPI program. A report on the findings will be submitted monthly to the QAPI Committee and discussed with the restorative staff at monthly staff meetings for continued process improvement suggestions if necessary.  Date corrective action completed: 10/30/19		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		10/30/19	

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F 880	<p>Continued From page 23</p> <p>§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:</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility</p>	F 880			

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F 880	<p>Continued From page 24</p> <p>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.</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 and staff interview, it was determined the facility failed to ensure staff handled, processed, and transported residents' personal clothes in a sanitary manner, and staff providing personal cares in a manner that would prevent the spread of infection. This was true for 9 of 9 residents (#2, #3, #4, #6, #8, #10, #14, #15, and #16) reviewed for infection control and had the potential to impact the other 7 residents residing in the facility. These failures created the potential for the residents to develop infection from cross-contamination of linens and lack of appropriate infection control practices during personal cares. Findings include:</p> <p>1. On 9/6/19 at 10:33 AM, the DON stated the facility had a washer and dryer and all nursing</p>	F 880	<p>F880 SS= F CFR(s) 483.80(a)(1)(2)(4) (e) (f) Infection Prevention and Control</p> <p>What corrective actions will be accomplished for residents found to be affected by the deficient practice. All residents have potential to be affected by deficient infection control practices in the facility. A new policy for resident linen handling and further training for staffs has been conducted on handwashing and gloving to enforce better infection control practices.</p> <p>Identify other resident(s) with potential to be affected and what corrective action(s) will be taken.</p>		

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F 880	<p>Continued From page 25</p> <p>staff provided laundry services for the residents personal clothing. The DON stated she had completed the laundry for the residents several times. The DON stated when she washed the residents' clothing she applied gloves and sorted the clothing, separating the dark colors from the white, and transported the dirty laundry into the washer. She stated she then removed her gloves and washed her hands. The DON stated while the laundry was in the washer, the staff or herself provided personal care for the residents. After the wash cycle was completed, she returned to the laundry area and stated she transferred the washed laundry from the washer to the dryer and stated she did not wear gloves or a gown when transferring the laundry from the washer to the dryer, then returned to provide personal care to the residents. After the dryer cycle was completed, she stated she transferred the laundry from the dryer to the folding area without wearing gloves and a gown. The DON stated she hung up the personal clothing on an uncovered rack and delivered the cleaned clothing to the residents' rooms.</p> <p>On 9/6/19 at 10:45 AM, the DON stated she understood by not wearing a gown, gloves, or covering the clean clothing with a clean barrier during the transferring of laundry, the staff and herself were at risk of cross contaminating the personal laundry.</p> <p>2. On 9/5/19 at 10:00 AM, CNA #1 and CNA #2 were observed providing incontinent care to Resident #6. CNA #1 and CNA #2 washed their hands and applied gloves and assisted Resident #6 into her bed to lay down. CNA #1 cleaned stool from Resident #6's peri-area with wipes,</p>	F 880	<p>The DON reviewed the State Operations Manual and created a new Resident Linen policy and procedure that reflects the needs of our residents and fulfills the infection control linen requirements. The new policy was discussed at the 9/18/19 and 9/19/19 staff meetings so staffs are aware of the new procedures to process resident linens. The DON also reviewed handwashing and gloving procedures for patient cares at the meeting.</p> <p>The DON installed hooks to be used for clean and dirty disposable gowns on each side of the laundry room. Gowns and gloves kept on the dirty side of the laundry room are to be worn while putting laundry in the washing machine. Gowns and gloves kept on the clean side of the laundry room are to be worn to fold and put away clean laundry. The DON also obtained marked separators for resident laundry for the clean laundry rack. Staffs have been instructed to cover the laundry with a sheet and wear a gown when collecting or distributing the laundry. A dirty laundry cart for each hall has been ordered for better efficiency and infection control to be used to transport dirty laundry for residents as well.</p> <p>What measures will be put in place to ensure the deficient practice does not recur. The DON and Infection Control Preventionist will conduct an annual review of the infection control policies for compliance with all infection control</p>		

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F 880	<p>Continued From page 26</p> <p>tucked the dirty brief under Resident #6 and placed clean briefs under her without changing her gloves after cleaning the per-area. CNA #1 then picked up the tube of barrier cream, squeezed cream onto her dirty gloves and applied the barrier cream to Resident #6's buttocks. CNA #1 did not change her gloves or perform hand hygiene after providing incontinent care to Resident #6 and before handling the clean briefs and applying the barrier cream.</p> <p>On 9/5/19 at 10:30 AM, CNA #1 stated she should have removed her gloves, performed hand hygiene, and replaced with clean gloves before applying the barrier cream to Resident #6's buttocks and before handling new, clean briefs.</p>	F 880	<p>regulations found in the State Operations Manual. The Infection Control Preventionist will continue to come to monthly staff meetings to review infection control policies and best practices, with particular training and reminders on handwashing and gloving.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Beginning 10/1/19, the DON will monitor the aide staff with random spot checks for compliance with the new linen policy and infection control practices; and handwashing and gloving procedures as part of the facility QAPI program. These checks will be done twice a week for 2 months, and then weekly for 2 months, and monthly thereafter for a year. A report on the findings will be submitted monthly to the QAPI Committee. Deficiencies will be discussed with the Infection Control Preventionist for continued process improvement suggestions if necessary.</p> <p>Date corrective action completed: 10/30/19</p>		