



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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P.O. Box 83720
Boise, Idaho 83720-0009
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October 4, 2019

Monica Brutsman, Administrator
The Terraces of Boise
5301 E. Warm Springs Ave.
Boise, ID 83716

Provider #: 135141

Dear Ms. Brutsman:

On **September 20, 2019**, a survey was conducted at The Terraces of Boise 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 a widespread deficiency 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.

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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 **October 15, 2019**. Failure to submit an acceptable PoC by **October 15, 2019**, may result in the imposition of penalties by **November 6, 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*.

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 **October 25, 2019 (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 **December 20, 2019**. A change in the seriousness of the deficiencies on **November 4, 2019**, 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 **December 20, 2019** includes the following:

Denial of payment for new admissions effective **December 20, 2019**. [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 **March 20, 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 Chief, 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 **December 20, 2019** 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/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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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 **October 15, 2019**. If your request for informal dispute resolution is received after **October 15, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2019
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NAME OF PROVIDER OR SUPPLIER TERRACES OF BOISE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 5301 E WARM SPRINGS AVE BOISE, ID 83716
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted from September 16, 2019 through September 20, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Cecilia Stockdill, RN, Team Coordinator Brad Perry, LSW Sallie Schwartzkopft, LCSW Kim Saccomando, RN</p> <p>Survey Abbreviations:</p> <p>DON = Director of Nursing LPN = Licensed Practical Nurse mg = milligrams MAR = Medication Administration Record MDS = Minimum Data Set POA = Power of Attorney REM = Rapid Eye Movement (a kind of sleep that occurs at intervals during the night and is characterized by rapid eye movements, more dreaming and bodily movement, and faster pulse and breathing) RN = Registered Nurse</p>	F 000		
F 550 SS=D	<p>Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p>	F 550		10/16/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/14/2019

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 550	<p>Continued From page 1</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, Facility Assessment review, Admission Agreement review, and resident representative and staff interview, it was determined the facility failed to ensure it</p>	F 550	<p>CORRECTION FOR THOSE RESIDENTS AFFECTED: Resident #11 the facility has and will continue to pay for the 1:1 supervision</p>		

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F 550	<p>Continued From page 2</p> <p>established and maintained identical policies and practices regarding a) the provision of supervision necessary to meet the residents' behavioral and safety needs, and b) discharge from the facility, regardless of the residents' payment source. This was true for 1 of 12 residents (Resident #11) reviewed who required increased supervision due to behavioral symptoms. The deficient practice created the potential for Resident #11 to experience ongoing disruptive behaviors and falls due to a lack of supervision, and be discharge from the facility due to the behaviors and falls, should he or his representative, not be able to pay for a 1:1 sitter. Findings include:</p> <p>The facility's Assessment stated the facility reviewed those with disruptive or unsafe behaviors to ensure adequate staff were available to meet their needs. The Assessment documented if a resident required 1:1 supervision and was on Medicare, the facility provided the 1:1 supervision and "If PVT (private payer) then family is notified to be with the resident or hire private agency. We review 24-hour report daily and Social Services reviews behaviors to identify those residents that need extra assistance or supervision." The Assessment also stated the facility had a "...very high staffing ratio PPD (per patient day) that was generous enough to meet special needs without requiring more staff."</p> <p>Resident #11's Nursing Admission Agreement, signed 11/17/18, by his representative, documented the rights and responsibilities of the facility included "nursing care and other personal services as may be determined by the facility to be legally and reasonably required for the health,</p>	F 550	<p>until no longer needed. 10/8/19 the facility assessment and admission agreement were reviewed and updated to include identical policies and practices regarding transfer, discharge, and the provision of services for all residents regardless of payment source.</p> <p>OTHERS WITH THE POTENTIAL TO BE AFFECTED: No other resident is receiving 1:1 supervision</p> <p>SYSTEMIC CHANGES: 10/9/19 staff were educated on the updated facility assessment to state that the same services are to be provided to residents no matter what their payer source. 10/8/19 the facility assessment and admission agreement were reviewed and updated to include to include identical policies and practices regarding transfer, discharge, and the provision of services for all residents regardless of payment source.</p> <p>ON GOING MONITORING: Residents that have interventions for 1:1 will be audited by DNS monthly X 3 months then Quarterly X 2 quarters, and the audits will be reviewed in Monthly QAPI meeting to ensure that the services and billing is correct.</p>		

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

PRINTED: 10/24/2019
FORM APPROVED
OMB NO. 0938-0391

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F 550	<p>Continued From page 3</p> <p>safety, and well-being of the Resident. Upon admission and periodically as is reasonable and/or required by law, the facility will assess the Resident's functional capacity and implement a comprehensive care plan for the Resident." The Admission Agreement further documented "The Resident hereby acknowledges that the facility has provided, and the Resident or Responsible Party has read and understands to their satisfaction, the following exhibits." The Exhibit B, Per Diem Charges and Billing Policies stated Private Pay residents would incur an additional charge for "Personal duty personnel."</p> <p>Resident #11 was readmitted to the facility on 1/29/19, with multiple diagnoses including Parkinson's disease, REM sleep behavior disorder (the paralysis that normally occurs during REM sleep is incomplete or absent, allowing the person to "act out" his or her dreams), and generalized muscle weakness. Resident #11 used a wheelchair for mobility. Resident #11's Admission Record facesheet, documented his primary payer source was private pay.</p> <p>An MDS Assessment, dated 8/16/19, documented Resident #11 was severely cognitively impaired, and required extensive physical assistance from one person with bed repositioning and transfers from the bed and wheelchair, and to a standing position.</p> <p>The following describes Resident #11's nighttime behaviors requiring extensive staff supervision, and the progression of actions taken by the facility to require Resident #11 or his representative to pay the for staff supervision:</p>	F 550			

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F 550	Continued From page 4 *A Progress Note, dated 7/7/19 at 7:07 AM, documented the "last" three night shifts Resident #11 had been up and down constantly and his bed alarm sounded when the CNA and nurse were caring for other residents in other areas of the facility. Resident #11 was found self-transferring to the bathroom more than two times. The note stated Resident #11's fall risk was extremely high. The note documented "These behaviors affect care for others and delays getting the work done on time." *A Progress Note, dated 7/12/19 at 3:41 AM, documented Resident #11 was active at the beginning of the shift and did not want to go to bed. When convinced it was time to go to bed Resident #11 would not stay in bed. The note documented Resident #11 was offered two safe options, and chose to lay on the mat by his bed. *A Progress Note, dated 7/17/19 at 12:13 AM, documented Resident #11 was up in the dining room and refused to stop moving. The note documented Resident #11 had started moving about the facility at 10:00 PM on 7/16/19. The note stated one or two staff had been with Resident #11 the entire time. *A Progress Note, dated 7/19/19 at 5:52 AM, documented Resident #11 was awake at 12:00 AM to use the bathroom and then wanted to get dressed in day clothes. He went to the dining room, sat with a nurse, and then wanted to walk. At 1:00 AM he was taken back to bed. The note documented Resident #11 was provided 1:1 supervision for his safety. The note stated Resident #11 was getting up every 10 minutes	F 550			

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F 550	<p>Continued From page 5</p> <p>from 1:20 AM - 3:00 AM. At 3:00 AM Resident #11's bed alarm went off, staff checked on him and he had self-transferred to the mat beside his bed. At 3:30 AM staff checked on Resident #11 and he was crawling on the ground into another resident's room. Resident #11 was assisted to his wheelchair by 3 staff and neurological checks initiated. Resident #11 went to bed at 5:00 AM and was up to use a urinal at 5:30 AM.</p> <p>*A Progress Note, dated 8/2/19 at 3:44 PM, documented the LSW and DNS had a phone conference with Resident #11's daughter to discuss the concern that Resident #11 "is requiring 1:1 care" on the night shift. The note documented due to Resident #11 starting to require 1:1 supervision at night, his daughter would reach out to several agencies for a sitter on the night shift.</p> <p>*A Progress Note, dated 8/7/19 at 5:20 AM, documented Resident #11 was hallucinating and attempted to self-transfer. Resident #11 insisted on getting ready for the day at 3:00 AM. Interventions were ineffective and staff called his daughter at 4:00 AM and she reported she was out of town. The note documented Resident #11 went back to bed at 5:30 AM. The note stated Resident #11 was provided 1:1 supervision most of the night for his safety.</p> <p>*A Progress Note, dated 8/10/19 at 4:44 AM, documented Resident #11 attempted to self-transfer frequently. The note stated around 2:15 AM Resident #11 woke up, was confused, and became combative. The note documented 1:1 supervision was required for Resident #11's safety from 2:15 AM - 4:00 AM.</p>	F 550			

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F 550	<p>Continued From page 6</p> <p>*Resident #11's Care Conference Note, dated 8/14/19, documented a sitter was to start at night with the goal of cutting back on hours as need decreases; the goal was to keep Resident #11 safe considering his history of poor safety awareness and falls.</p> <p>*A Progress Note, dated 8/16/19 at 3:48 PM, signed by the Administrator, documented a meeting with Resident #11's daughter and a representative from the agency the family chose to provide 1:1 supervision at night. The note documented the 1:1 sitter was not a CNA and could not provide care and would provide supervision from 10:00 PM to 6:30 AM. The note stated the main purpose of the sitter was to redirect Resident #11 when he was trying to get up at night or needed to use the bathroom, because he did not use his call light. The note stated if care was needed the sitter was to call facility staff to provide the care. The note documented the bill from the sitter agency would "come to the facility and be passed on to the resident's monthly bill.</p> <p>Resident #11's care plan documented a 1:1 non-clinical caregiver was provided on the night shift (10:00 PM to 6:00 AM) by an outside agency, initiated 8/16/19.</p> <p>On 9/16/19 at 10:30 AM, Resident #11's representative said Resident #11 had Parkinson's disease, delirium, paranoia, agitation, and was limited in what he could do; he did not use the call light consistently; and he had a history of falls of which the representative was notified every time. Resident #11's representative said he had</p>	F 550			

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F 550	<p>Continued From page 7</p> <p>REM sleep disorder and currently had a sitter after the facility's care team initiated a care conference and the family agreed to provide one on a trial basis.</p> <p>On 9/19/19 at 2:05 PM, the DON said an outside agency provided a nightly companion from 10:00 PM to 6:00 AM and the outside agency billed the facility. The DON said in a care conference on 8/15/19, the facility and family discussed having a sitter for Resident #11 during the night shift with the goal of keeping him safe and to prevent falls considering his history of poor safety awareness.</p> <p>On 9/19/19 at 2:22 PM, the MDS Coordinator said the facility care team identified and suggested a 1:1 sitter for Resident #11 because he was hard to manage at night. The MDS Coordinator said the facility reached out to his financial POA and invited the family to a care conference on 8/15/19 with the care team. The MDS Coordinator said she was present at the care conference on 8/15/19 where the family discussed trying other interventions first, but agreed to hire the sitter, and the decision was made to hire a 1:1 sitter at night. The MDS Coordinator said the family covered the cost of the sitter.</p> <p>On 9/19/19 at 2:37 PM, the Administrator said Resident #11 was a private pay resident, had REM sleep behavior disorder and his disruption occurred mostly at night. She said the facility suggested a 1:1 sitter for safety because he was unpredictable and disoriented, and a sitter would provide reassurance. She said the facility informed the family that the family had the option to sit with the resident at night, but the family</p>	F 550			

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F 550	Continued From page 8 could not; they discussed hiring a sitter at night and reduce the hours if not needed. The Administrator said the family agreed to find sitters and the facility would pay the bill and the family would reimburse the facility. The Administrator said, as documented in the facility assessment, the facility did not provide 1:1 care, and it was not in the facility's agreement with Resident #11's family. The Administrator said Resident #11 slept better with the sitter present. The Administrator said they discussed other options, including placing Resident #11 in another facility, and if the family did not want to provide the 1:1 sitter, then most likely a 30-day notice of discharge would have been the final option. The facility failed to ensure Resident #11 was provided with the same level of facility staff supervision necessary for his safety, as residents with other payer sources; and he was not at risk of discharge from the facility if he could not pay for the staff supervision.	F 550			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, it was determined the facility failed to provide showers consistent with the care plan. This was true for 1 of 12 residents (Resident #8) reviewed for showers. This failure placed the residents at risk of psychosocial distress related to embarrassment and/or isolation from not	F 677	CORRECTION FOR THOSE RESIDENTS AFFECTED: Resident #8 <input type="checkbox"/> Resident was interviewed regarding shower schedule and would like to continue with current schedule. Resident was showered on 9/23/19 and 9/26/19.	10/16/19	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 677	<p>Continued From page 9 receiving showers. Findings include:</p> <p>Resident #8 was admitted to the facility on 1/24/2018, with multiple diagnoses including weakness, fibromyalgia (a disorder characterized by widespread muscle pain), and polyneuropathy (disease affecting limb nerves featuring weakness, numbness and burning pain), and mild cognitive impairment.</p> <p>On 9/16/19 at 10:36 AM, Resident #8 said he was provided a shower once a week and he wanted to have a shower three times a week.</p> <p>Resident #8's care plan documented he required extensive 2-person staff participation with bathing/showers on Wednesday and Saturday evenings, and as needed.</p> <p>The facility's shower schedule documented Resident #8 was to receive showers on Wednesday and Saturday nights with Sunday being a "make-up" day.</p> <p>The Documentation Survey Report for bathing/showering for July - 2019, provided by the DON on 9/19/19, documented Resident #8 was scheduled for assistance with bathing/showering on Mondays, Thursdays, and as needed. The Report documented Resident #8 was provided a shower every third or fourth day with a total of 8 showers up until 7/29/19 when Resident #8 refused. Resident #8 went 6 days between showers provided on 7/29/19 and 8/1/19.</p> <p>The Documentation Survey Report for bathing/showering for August - 2019, provided by</p>	F 677	<p>Starting 10/9/19, licensed staff and CNA's will document in the medical record if the resident refused a shower and include alternatives or interventions that were offered. Frequent refusal of shower/bathing and interventions for refusals will be added to the plan of care.</p> <p>OTHERS WITH POTENTIAL TO BE AFFECTED: All residents that reside in the Redwood Village that are dependent on staff for showering/bathing.</p> <p>SYSTEMIC CHANGES: The nurse on the floor will document resident refusal of showers as well as interventions tried in a progress note. The nurse on the floor will review resident showers for the previous week in the scheduled weekly assessment and if the resident has not had a shower for the week the LSW will be notified. L.S. were educated on 10/9/19 to review bathing history during their weekly assessment. C.N.A's were reeducated on 9/24/19 to notify the primary nurse when a resident refuses bathing so that the L.S. can approach and help identify reason for refusal and offer alternatives.</p> <p>ON GOING MONITORING- Starting 10/9/19, the ADON will audit 5 random residents weekly showers received and weekly nurse's assessment to ensure that attempts to resolve a refusal for bathing are</p>		

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F 689	<p>Continued From page 11</p> <p>supervision to meet residents' needs. This was true for 1 of 5 residents (Resident #11) reviewed for supervision and falls. This created the potential for harm if residents experienced injuries from falls. Findings include:</p> <p>The facility's standards and guidelines for Falls and Fall Risk Management, undated, documented the following: Staff were directed to identify appropriate interventions to reduce the risk of falls. If falling recurred despite initial interventions, staff implemented additional or different interventions, or indicated why the current approach remained relevant. If underlying causes could not be readily identified or corrected, staff tried various interventions, based on the assessment of the nature of the falls, until falling was reduced or stopped, or until the reason for the continuation of the falling was identified as unavoidable.</p> <p>Resident #11 was readmitted to the facility on 1/29/19, with multiple diagnoses including Parkinson's disease (a progressive nervous system disorder that affects movement), REM sleep behavior disorder (the paralysis that normally occurs during REM sleep is incomplete or absent, allowing the person to "act out" his or her dreams), and generalized muscle weakness. Resident #11 used a wheelchair for mobility.</p> <p>Resident #11's Fall Risk Assessments, dated 7/19/19, 8/6/19, 8/14/19, 9/5/19, and 9/16/19, documented he was at high risk for falls.</p> <p>Resident #11's quarterly MDS Assessment, dated 8/16/19, documented he was severely cognitively impaired, and required extensive assistance from</p>	F 689	<p>have been changed to a new documentation system. While resident is awake staff will keep him within line of sight at all times.</p> <p>Staff were educated on 10/9/19 that when resident is laying down that checks will remain hourly but a silent bed alarm will be placed for use when resident is lying in bed, to alert the staff.</p> <p>Resident will continue with 1:1 caregiver nightly from 10p- 630am when resident is experiencing REM sleep disorder behaviors and confusion.</p> <p>OTHERS WITH THE POTENTIAL TO BE AFFECTED: Residents that are care planned for hourly monitoring have the potential to be affected. Those residents have new hourly documentation system in place.</p> <p>SYSTEMIC CHANGES: Nursing staff were educated on 9/24/19 and 10/9/19 on hourly documentation process to ensure that the hourly checks that are being completed, are documented to reflect that the hourly checks have been completed. Staff were educated 10/9/19 that increased supervision is a potential option for fall intervention. And must notify the DNS if the intervention is initiated.</p> <p>ON GOING MONITORING: DNS or designee will audit the daily hourly check documentation times 2weeks, and then weekly times 4 weeks. Results of these audits will be reported</p>		

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F 689	<p>Continued From page 12</p> <p>one person with bed repositioning and transfers from bed to a wheelchair and to a standing position.</p> <p>Resident #11's record documented he fell on 2/7/19, 2/22/19, 4/6/19, 4/8/19, and had 7 more falls from 7/4/19 to 9/16/19 as described below:</p> <p>* A Fall Scene Investigation Report, dated 7/4/19, documented Resident #11 was found at 2:45 PM kneeling on the floor in his room next to his bed. He had no injury. The falls team recommended no additional changes to the care plan on 7/8/19.</p> <p>Resident #11's care plan, initiated on 2/6/19 and revised 7/4/19, directed staff to place Resident #11's bed in the lowest position when he was in bed.</p> <p>* A Fall Scene Investigation Report, dated 7/19/19, documented Resident #11 was found at 3:30 AM on the floor in an adjacent resident's room. He placed himself onto the fall mat and crawled to the adjacent room. No injuries were noted. The falls team documented the plan was to schedule a care conference with Resident #11's daughter to discuss having a companion for Resident #11 during the night time hours.</p> <p>Resident #11's care plan directed staff to provide 1:1 supervision if Resident #11 showed he was going to continue to transfer himself, initiated on 7/21/19.</p> <p>* A Fall Scene Investigation Report, dated 8/6/19, documented Resident #11 was found at 10:15 AM in his room on the fall mat next to his bed. No injuries were noted. The falls team did not</p>	F 689	<p>and reviewed in the monthly QAPI meeting for concerns or trends. DNS will be responsible for ongoing compliance</p>		

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F 689	<p>Continued From page 13 document additional care plan updates.</p> <p>Resident #11's care plan did not document interventions were updated after the fall on 8/6/19, and before the next fall on 8/14/19.</p> <p>* A Fall Scene Investigation Report, dated 8/14/19, documented Resident #11 was found at 11:45 AM on the floor in his room next to his bed. No injuries were noted, and it was not documented the care plan was updated. The falls team documented social services requested a care conference with Resident #11's family to discuss having a sitter during the night shift (10:00 PM to 6:00 AM).</p> <p>Resident #11's Care Conference Note, dated 8/14/19, documented his history of poor safety awareness and falls, and a sitter was to start at night. The goals included keeping Resident #11 safe and cutting back on hours as the need decreased.</p> <p>Resident #11's care plan documented a 1:1 non-clinical caregiver was provided on the night shift (10:00 PM to 6:00 AM) by an outside agency, initiated 8/16/19.</p> <p>* A Fall Scene Investigation Report, dated 9/5/19, documented Resident #11 was found at 8:30 AM in his room on his fall mat next to his bed. No injuries were noted. The falls team documented "N/A" (not applicable) for additional care plan updates.</p> <p>Resident #11's care plan did not document interventions were updated after the fall on 9/5/19 and before the next fall on 9/11/19.</p>	F 689			

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F 689	<p>Continued From page 14</p> <p>* A Fall Scene Investigation Report, dated 9/11/19, documented Resident #11 fell at 8:15 AM in the dining room when he tried to stand from his wheelchair. The wheelchair rolled to the left, and Resident #11 fell backward to the right, and was "intercepted" by a nurse from behind. No injuries were noted. The falls team documented it was suggested and agreed that Resident #11 was to have some occupation available at the table, including food/drink and other residents to socialize with. The care plan was updated and monitoring at the table continued.</p> <p>Resident #11's care plan directed staff to have Resident #11 sit at a dining table with others for socialization and to distract him from impulsive behaviors, and to offer Resident #11 food/drink or an activity as soon as he sat at the dining table to distract him from impulsive behaviors. Both interventions were initiated on 9/12/19.</p> <p>* On 9/16/19 at 8:21 AM, Resident #11 was observed laying on his side on the floor in the dining room. He appeared to be asleep and slightly shaking. RN #2 was talking to Resident #11 and he was not verbally responding. At 8:34 AM, CNA #1 arrived and assisted RN #2 with lifting and placing Resident #11 in his wheelchair and taking him to his room.</p> <p>A Fall Scene Investigation Report, dated 9/16/19, documented at 8:00 AM Resident #11 was assisted from his wheelchair to the floor twice as he "slid to the edge of his wheelchair" in the dining room. No injuries were noted, and the care plan update was documented as "N/A". The falls</p>	F 689			

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F 689	<p>Continued From page 15</p> <p>team recommended placing a piece of non-skid fabric to Resident #11's wheelchair seat and to have staff offer to take Resident #11 to his room when he wanted to be on the floor and stay by him while he was on the floor to ensure safety. The care plan was updated.</p> <p>Resident #11's care plan documented the following interventions:</p> <ul style="list-style-type: none"> - Resident #11 was to sit at a table with others to socialize and distract him from impulsive behaviors, initiated on 9/12/19 and revised on 9/17/19. - Resident #11's bed was to be placed in the lowest position, and if he did not allow the bed to be in the lowest position while he occupied it, staff monitored him closely to ensure safety, initiated on 2/6/19 and revised on 9/17/19. - Staff were to check on Resident #11 every hour to ensure safety, initiated 2/6/19. - Staff were to provide "increased supervision" and "frequent visual checks" on Resident #11, initiated on 3/26/19 and revised on 9/17/19. <p>On 9/16/19 at 12:30 PM, Resident #11 was observed in the dining room at the table, pushing his wheelchair back and trying to stand up. A staff member spoke to Resident #11 and pushed his wheelchair closer to the table. Soup was provided to Resident #11, and when he finished eating he pushed his wheelchair back from the table and tried to stand up. Another staff member stopped him and spoke with him. Resident #11's meal was placed in front of him, when he finished eating he tried to stand up. A staff member assisted him from the table by pushing him in his wheelchair out of the dining area.</p>	F 689			

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

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F 689	Continued From page 16 Resident #11's record documented the hourly safety checks were not completed, as follows: * The safety monitoring task report for Resident #11, dated July 2019, documented the hourly safety checks were not completed for 27 out of 31 days, 306 out of 744 opportunities. Examples include: - 2 days had 1 of 24 safety checks incomplete - 1 day had 2 safety checks incomplete - 3 days had 4 safety checks incomplete - 1 day had 5 safety checks incomplete - 1 day had 6 safety checks incomplete - 8 days had 8 safety checks incomplete - 2 days had 11 safety checks incomplete - 2 days had 13 safety checks incomplete - 3 days had 16 safety checks incomplete - 1 day had 17 safety checks incomplete - 2 days had 21 safety checks incomplete - 2 days had 24 safety checks incomplete * The safety monitoring task report for Resident #11, dated August 2019, documented the hourly safety checks were not completed on 21 out of 31 days, 56 of 744 opportunities. Examples include: - 3 days had 1 of 24 safety checks incomplete - 12 days had 2 safety checks incomplete - 3 days had 4 safety checks incomplete - 2 days had 5 safety checks incomplete - 1 day had 7 safety checks incomplete * The safety monitoring task report for Resident #1, dated September 2019, up to 9/17/19, documented the hourly safety checks were not	F 689			

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F 689	<p>Continued From page 17</p> <p>completed on 12 days out of 17, 41 of 421 opportunities. Examples include:</p> <ul style="list-style-type: none"> - 2 days with 1 of 24 safety checks incomplete - 4 days with 2 safety checks incomplete - 3 days with 4 safety checks incomplete - 2 days with 5 safety checks incomplete - 1 day with 7 safety checks incomplete. <p>On 9/18/19 at 10:08 AM, CNA #2, said if Resident #11 was anxious in the dining area staff took him to his room and did room checks every 2 hours. CNA #2 said when Resident #11 was in the dining room, all the staff knew to keep an eye on him. CNA #2 said if Resident #11 was dining at a table with an eating assistant, the assistant would cue Resident #11, and if Resident #11 was at a table without an assistant, then no one would provide 1:1 supervision.</p> <p>On 9/19/19 at 7:24 AM and 1:18 PM, LPN #1, said Resident #11's bed was placed in the low position and he had a fall mat. LPN #1 said Resident #11 had a 1:1 sitter during night shift to inform staff when he was stirring. LPN #1 said the 1:1 sitter was from an outside source, and the family paid for it. LPN #1 said the care staff was aware Resident #11 was a high risk for falls, and they observed him while performing their tasks. LPN #1 said in the evenings she brought Resident #11 along with her because there was no sitter and had him wait for her in the hall while she went into residents' rooms.</p> <p>On 9/19/19 at 1:26 PM, CNA #3 said Resident #11 was a fall risk, he had dementia, and was forgetful and confused. CNA #3 said Resident #3 got up on his own, so they kept "an eye on him"</p>	F 689			

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F 689	<p>Continued From page 18</p> <p>and he had a bed alarm. CNA #3 said there was one CNA on duty at night, and Resident #11 had a 1:1 sitter at night who kept Resident #11 distracted until the CNA could get to him.</p> <p>On 9/19/19 at 1:39 PM, the DON said Resident #11 was a high fall risk and his fall prevention interventions included a pressure alarm, placing his bed in the low position with the left side against the wall and a fall mat on the right. The DON said when dining Resident #11 was placed with someone for socialization and was given a drink to keep him occupied. The DON said electronic and hand-documented 24-hour hourly safety checks were implemented. The DON said there was incomplete documentation in Resident #11's electronic record due to not charting effectively and it was not documented elsewhere. The DON said Resident #11's hourly checks were sometimes effective and a 1:1 caregiver was brought in. The DON said the 1:1 caregiver was present on night shift (10:00 PM to 6:00 AM), to sit next to Resident #11, reassure him if he woke up and notify the CNA if he needed to get up, and document what was observed. The DON said the night 1:1 supervision was effective to keep Resident #11 from falling but he did not receive 1:1 supervision 24 hours a day because it was a financial burden on the family. The DON said Resident #11 was assisted by facility staff mostly when he was in bed during the day. The DON said when Resident #11 was in bed and the bed alarm sounded, and they could not redirect him, the facility staff provided 1:1 supervision. The DON said if Resident #11 was in the common area and tried to stand repeatedly, the staff would take him on a walk. The DON said after a 1:1 caregiver had been discussed with</p>	F 689			

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F 812	<p>Continued From page 20</p> <p>12 of 14 residents (#3, #5, #6, #8, #9, #10, #11, #112, #213, #114, #115, and #212) who received food from the kitchen of Redwood Village, 1 of 2 facility kitchens. This placed residents at risk for potential contamination of food and adverse health outcomes. Findings include:</p> <p>On 9/16/19 at 12:06 PM, Cook #1 was observed standing in front of the tray line when he lifted a spaghetti noodle off the surface of the serving counter with his bare hand, and then dropped the noodle into the warming bin with the other spaghetti noodles.</p> <p>On 9/16/19 at 12:10 PM, Cook #1 said he picked up the noodle with his bare hand, and he placed it back in the warming tray.</p> <p>On 9/19/19 at 10:38 AM, the Dietary Manager said he expected food to be placed in the trash if it was touched with a bare hand, and no ungloved hand should touch food to be served.</p>	F 812	<p>Redwood Village SNF, were reeducated on proper food handling procedures by the CDM.</p> <p>All residents were monitored 9/16/19, 9/17/19, and 9/18/19 for any symptoms of food borne related illness and no residents were identified with any symptoms.</p> <p>OTHERS WITH POTENTIAL TO BE AFFECTED:</p> <p>All residents were monitored 9/16/19, 9/17/19, and 9/18/19 for any symptoms of food borne related illness and no residents were identified with any symptoms.</p> <p>SYSTEMIC CHANGES:</p> <p>By 9/27/19 all cooks for Redwood Village SNF have been reeducated on proper food handling procedures by the CDM.</p> <p>ON GOING MONITORING;</p> <p>CDM will monitor the cooks during meal prep daily in Redwood five times a week times 2 weeks, then weekly times 2 weeks then randomly for 2 weeks, to ensure proper food handling occurs. Dietician will monitor meal preparation and food handling in Redwood Village monthly during routine visit and observations.</p> <p>CDM and Dietician audits will be reported to Monthly QAPI for review to identify any concerns or trends.</p> <p>CDM will be responsible for ongoing compliance</p>		
F 838	Facility Assessment	F 838		10/16/19	

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F 838 SS=D	Continued From page 21 CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to,	F 838			

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F 838	<p>Continued From page 22</p> <p>(i) All buildings and/or other physical structures and vehicles;</p> <p>(ii) Equipment (medical and non- medical);</p> <p>(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;</p> <p>(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;</p> <p>(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and</p> <p>(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.</p> <p>§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, Facility Assessment review, Admission Agreement review, and staff interview, it was determined the Facility Assessment failed to ensure residents were provided with the level of facility staff supervision necessary to meet their behavioral and safety needs. This was true for 1 of 12 (Resident #11) residents reviewed who required increased supervision due to behavioral symptoms. This created the potential for residents to experience falls and other adverse events if the facility did not provide the staff resources necessary to appropriately supervise residents. Findings include:</p>	F 838	<p>CORRECTION FOR THOSE RESIDENTS AFFECTED: All caregiver/sitter expenses have been paid by the facility for 1:1 services provided to resident #11.</p> <p>OTHERS WITH POTENTIAL TO BE AFFECTED: No other residents are receiving 1:1 supervision.</p> <p>SYSTEMIC CHANGES: The facility assessment was reviewed and updated 10/8/19, to include wording</p>		

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F 838	<p>Continued From page 23</p> <p>The facility's admission agreement, dated 6/2016, documented residents with private pay status were provided 24-hour nursing services and were charged an additional fee for private duty personnel.</p> <p>The Facility's Assessment, dated 1/1/19, documented: * All residents with unsafe behaviors were provided with adequate staffing, assistance, and supervision to meet their needs. * For residents with Medicare status who required 1:1 supervision, the supervision it was provided by the facility. * For residents with private pay status who required 1:1 supervision, the resident's family could stay with them or could hire a private sitter at their expense.</p> <p>On 9/19/19 at 2:37 PM, the Administrator said Resident #11 currently required 1:1 supervision and received it at night. Resident #11's family paid for the 1:1 sitter. The Administrator said normally the facility would not provide 1:1 care, and it was not in the facility's Admission Agreement to provide 1:1 supervision.</p> <p>The facility's Admission Agreement, Assessment, and practices failed to ensure residents or their representatives were not required to arrange for, and pay for, supervision necessary to meet the residents' behavioral and safety needs.</p> <p>Refer to F550 as it relates to the failure of the facility to ensure it established and maintained identical policies and practices related to supervision and discharge of residents,</p>	F 838	<p>that 1:1 care will be provided at the facility cost, no matter the resident payer source.</p> <p>ON GOING MONITORING: Administrator and DNS will review facility assessment quarterly to identify any changes or updates that may be required and will be discussed in monthly QAPI. Administrator will be responsible for ongoing compliance.</p>		

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F 838	Continued From page 24 regardless of payer source.	F 838			
F 880 SS=D	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§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.</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: (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;</p>	F 880		10/16/19	

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F 880	<p>Continued From page 25</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 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, record review, policy review, and staff interview, it was determined the facility failed to ensure appropriate hand hygiene was performed. This was true for 1 of 12 residents (Resident #6) reviewed for infection</p>	F 880	<p>CORRECTION FOR THOSE RESIDENTS AFFECTED: For Resident #6 the staff who apply leg wraps per MD order were reeducated on performing hand hygiene after removing</p>		

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F 880	<p>Continued From page 26</p> <p>control practices, and created the potential for harm should residents experience infections from cross contamination. Findings include:</p> <p>The facility's policy for Hand Hygiene, undated, directed staff to use alcohol based hand rub for routine decontamination of hands "in all clinical situations other than those listed under "Handwashing..."</p> <p>The Center for Disease Control and Prevention's website, accessed 9/23/19, documented hand hygiene should be performed after touching a patient or their immediate environment and immediately after glove removal.</p> <p>Resident #6 was admitted to the facility on 8/25/17, with multiple diagnoses including venous insufficiency (improper functioning of the vein valves in the leg, causing swelling and skin changes), and lymphedema (swelling in an arm or leg caused by a lymphatic system blockage).</p> <p>Resident #6's physician orders documented an order to apply Velcro wraps and double layer Tubigrip (an elastic bandage to provide compression and support) to the left leg once per day. The order started on 8/20/19.</p> <p>On 9/16/19 at 10:47 AM, Resident #6 was in his room sitting up in his wheelchair. The Tubigrip and Velcro wraps were in place to his left leg.</p> <p>On 9/19/19 at 7:00 AM, LPN #1 entered Resident #6's room and was applying the Tubigrip to his left leg when she said she needed to go get a longer Tubigrip. She then removed her gloves and left the room without performing hand</p>	F 880	<p>gloves.</p> <p>OTHER RESIDENTS AFFECTED: Residents requiring leg wraps have been audited by the infection control nurse to ensure proper hand hygiene has been performed.</p> <p>SYSTEMIC CHANGES: On 10/9/19 nursing staff providing cares that require hand hygiene after removing gloves were re in serviced on proper hand hygiene. ADON will complete random audits 5 times a week for 2 weeks, then weekly times 4 weeks, of hand hygiene being performed by direct care staff in Redwood Village. Results of the ADON audits will be reported in the monthly QAPI meeting for review and to identify and concerns or trends. ADON responsible for ongoing compliance.</p>		

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

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F 880	<p>Continued From page 27</p> <p>hygiene. LPN #1 walked down the hall and entered a supply room. LPN #1 returned to Resident #6's room and she performed hand hygiene prior to entering. LPN #1 began applying the Tubigrip to Resident #6's left leg, then said it was still wet and needed to be dried. LPN #1 removed her gloves and left the room without performing hand hygiene. LPN #1 stopped in the hall and spoke to the Administrator, continued walking down the hall without performing hand hygiene. LPN #1 returned several minutes later and performed hand hygiene prior to entering Resident #6's room. LPN #1 applied the first layer of Tubigrip to Resident #6's left leg, then said she was going to go check on the other layer of Tubigrip. LPN #1 removed her gloves and left the room without performing hand hygiene.</p> <p>On 9/19/19 at 7:44 AM, LPN #1 said hand hygiene should be performed before and after touching residents and before and after entering or exiting their room. LPN #1 said hand hygiene should be performed after removing gloves, and she thought she did that when applying the Tubigrip and Velcro wraps to Resident #6's leg.</p> <p>On 9/19/19 at 8:42 AM, the DON said hand hygiene should be performed before and after entering a resident's room, and before applying and after removing gloves.</p>	F 880			