STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255138	A. BUILDING _____ B. WING _____	11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND HEALTH AND REHABILITATION	16056 BOUNDRY DRIVE ASHLAND, MS 38603

(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 State Agency (SA) conducted an annual recertification survey at the facility from 11/19/23 through 11/21/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F604, F636, F656, and F880. The facility held a license for 60 beds, with a census of 45.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical	F 604		12/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/14/2023

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F 604	Continued From page 1 symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review and facility policy review the facility failed to prevent a resident from being physically restrained by the sound of a chair alarm for one (1) of three (3) residents with chair alarms reviewed. Resident #23. Findings include: Review of the facility policy titled, "Restraint Standards; Physical Restraints" with a revision date of 4/2023 revealed under, "Physical Restraints Standard ...The goal of this facility is to ensure that each resident attains and maintains his/her highest practical level of function and well-being in an environment that limits restraint use to circumstances in which the medical symptoms of the resident warrant the use of the least restrictive restraint". On 11/19/23 at 3:40 PM, an observation and interview revealed a chair alarm on Resident #23's wheelchair that was pinned to the back of her shirt. This observation revealed the resident propels herself with her feet in the wheelchair. During an interview at the same time with Resident #23 revealed that the resident is alert to herself and pleasantly confused on time and place. Resident #23 was asked if she knew what the device was on her wheelchair and she stated, "It's a woolly of a thing, it worries me to death. It's supposed to catch me if I'm about to fall. I ask	F 604	1. Corrective action was completed on Resident #23 by removing clip alarm on 11-20-2023. Resident was re-assessed by Director of Nursing on 11-20-23 after resident interview and resident's request for alarm to be removed. 2. Six of the residents residing at the facility have been assessed at a high risk for falls could be affected by the same practice of utilizing a clip alarm. Clip alarms were removed on Resident #23 and Resident #24 after resident interview, and RN assessment, and discussion of residents with clip alarms during an Interdisciplinary Team (IDT) meeting on 11-19-23. The IDT consists of Nursing Home Administrator,Director of Nursing, Nurse Educator, Medical Records LPN, RN Supervisor, MDS RN. An audit was performed by Director of Nursing (DON) and Nurse Educator (NE) on the six residents that had clip alarms on 11-20-2023. The audit performed noted for MD order, family aware of clip alarm, clip alarm documented on Medication Administration Record (MAR), and resident agrees with placement of clip alarm for safety. If clip alarm is deemed appropriate but resident does not agree then would be deemed a restraint and the Restraint Standard to be followed.	

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F 604	Continued From page 2 them all the time if I can get it off there and they say no ma'am". An interview on 11/20/23 at 9:00 AM with Certified Nurse Assistant (CNA) #1 confirmed that Resident #23 has a chair alarm clipped to her shirt and connected to a box device on her wheelchair. She stated that she thinks they put it on there because the resident kept falling. She stated that the alarm goes off when she tries to get up or when she moves forward enough in her wheelchair that makes it alarm. She stated that the resident really doesn't like the chair alarm and has complained about wanting it removed. She confirmed that she had told Registered Nurse (RN) #2 about the resident's complaint of wanting the clip alarm removed. An interview on 11/20/23 at 9:05 AM with CNA #2 confirmed that Resident #23 had complained several times about not wanting the clip alarm on her wheelchair. On 11/20/23 at 10:30 AM, an interview with RN Minimum Data Set (MDS) nurse confirmed that Resident #23 had a clip alarm on her wheelchair because she kept falling. She revealed that the Interdisciplinary Team (IDT) team decides who gets a clip alarm when they discuss in the morning standup meetings regarding falls. She stated that they do not consider it a restraint because the resident can remove it. She revealed that when a resident has a fall then a fall risk assessment is completed that indicates the use of a clip alarm. She stated that normally they will leave the alarm on for a couple of months then reevaluate with a high risk fall assessment. She stated she has not heard of any resident's complaining but if they did then they would have	F 604	Findings of initial audit noted that clip alarm was not documented on the MAR, and note had not been made that resident agreed with placement of clip alarm for six of the six clip alarms. 3. To ensure that utilizing a physical restraint inappropriately does not reoccur an inservice was begun on 11-19-23 by Nurse Educator and completed on 11-21-23 for nursing staff on proper documentation, appropriate interventions of MD order, resident agreement with placement of clip alarm for safety, family aware of clip alarm, that clip alarm is noted on MAR. Inservice on 11-20-23 included instruction if clip alarm is noted by resident to be a restraint but deemed necessary for resident safety by Interdisplinary Team (IDT), Restraint Standard would be followed. IDT will note all clip alarms on white board during facility morning meetings noting appropriate interventions have been followed and are in place. All new hires for nursing will be inserviced by the Nurse Educator on this process and it will be ongoing. 4. To ensure that the facility has sustained compliance, beginning 11-19-23 the resident's nurse and the resident's certified nurse aide will monitor during every two hour staff rounds and note on the MAR and the CNA Task List that the clip alarms are in place on the four residents with clip alarms. The IDT will audit weekly beginning 11-22-23 and note in the Quality Assurance Performance	

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F 604	Continued From page 3 to re-evaluate, educate, and possibly do another alternative to the alarm. On 11/20/23 at 10:40 AM, an interview with the Director of Nurses (DON) and Nurse Educator confirmed that Resident #23 did have a clip alarm on her wheelchair and has had it since her last fall in 8/2023. The Nurse Educator revealed that the resident's fall prior to the one in 8/2023 occurred in 4/2023 and the resident did not have any injuries with either fall. She confirmed that they do not necessarily consider the clip alarm on the wheelchair to be a restraint because the resident can remove it. She stated that they usually leave the clip alarm on the resident for 2 months then reevaluate with a high risk fall evaluation again to determine if the resident still needs the alarm. She confirmed that they would normally discuss this reevaluation in the IDT meetings then remove the alarm and see how the resident does. The DON and the nurse educator confirmed that if a resident complained about the clip alarm and did not want it on, then they would need to reevaluate and remove. The DON stated that if the resident complained about the alarm to staff, then they should notify us so we can reevaluate. An observation and interview on 11/20/23 at 11:00 AM, with the DON, Nurse Educator and Resident #23 the resident confirmed that she did not like the alarm on her chair, that every time she moved it went off, she could not even get her books out of her dresser drawers without it going off and buzzing. She stated she knew it was because she had fallen and she may fall tomorrow, but she wanted it taken off. The DON and the Nurse Educator agreed that they would reassess the residents need for the clip alarm.	F 604	Improvement (QAPI) minutes durng their weekly QAPI meeting that appropriate interventions are in place and will re-evaluate monthly for need for clip alarm. This will be ongoing. On 12-14-23 a report was submitted for discussion by the Director of Nursing to the Quality Assurance Performance Improvement (QAPI) team noting all clip alarms and documentation. THE QAPI team consists of Medical Director,Nursing Home Administrator,Director of Nursing, Medical Records LPN, Social Service, Dietary Manager, Housekeeping Supervisor, Nurse Educator, Human Resource Director, Activity Director, and Maintenance Director. The QAPI team will review and monitor this process until 100% compliance has been obtained for three months. The Director of Nursing is responsible for compliance.	

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F 604	Continued From page 4	F 604		

An interview on 11/20/23 at 3:00PM, with the Administrator revealed that she felt like it was a hard call to make whether the residents need a chair alarm or not. She stated that she would consider the residents diagnoses and cognition when determining if a resident needed the alarm due to falls. She agreed that if a resident was complaining about not wanting the alarm, then they should reassess the need.

An interview on 11/21/23 at 8:44 AM, with the DON confirmed that she understands that assessing the resident for how they feel about the chair alarm should be part of the assessment for its use. She stated that they just really did not consider it a restraint, or they would have done things differently. She revealed that she understood after reading the regulation that it can be considered a restraint. She revealed that they probably need to have an order for any type of alarm use, document the reason for the use of the alarm and the reevaluation documented along with coding it correctly on the MDS and care planning it correctly also. She confirmed that the resident's fall evaluations dated 8/2023 and 9/2023 did not indicate the use of a chair alarm.

Record review of Resident #23's "Incident Investigation" form dated 8/23/23 revealed the resident had an unwitnessed fall with no injuries.

Record review of Resident #23's "Fall Evaluation" form dated 8/23/23 and 9/1/23 revealed under "clinical suggestions" that positioning alarms were not indicated.

Record review of Resident #23's progress notes revealed there was a note dated 9/14/23 that

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F 604	Continued From page 5 indicated the resident was being evaluated for a chair clip alarm. This review revealed no other documentation regarding the alarm. Record review of Resident #23's "Admission Record" revealed the resident was admitted to the facility on 8/31/22 with medical diagnoses that included Type 2 Diabetes Mellitus without Complications. Record review of Resident #23's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/1/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 02, which indicated the resident is severely cognitively impaired and in Section P that the resident had a chair alarm in use at all times.	F 604		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns.	F 636		12/15/23

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(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization

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F 636	Continued From page 7 or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, record review and facility policy review, the facility failed to identify and analyze information obtained from a Minimum Data Set assessment for a chair alarm restraint prior to developing the comprehensive care plan for one (1) of three (3) residents with a chair alarm, Resident #23. Findings include: Review of the typed statement on facility letterhead dated 11/21/23 revealed the facility did not have a policy regarding MDS assessment. The facility uses the current RAI (Resident Assessment Instrument) Manual and was signed by the Administrator. During an observation and interview on 11/19/23 at 3:40 PM, revealed a chair alarm on Resident #23's wheelchair that was pinned to the back of the resident's shirt. This observation revealed the resident propels herself with her feet in the wheelchair. An interview at the same time with Resident #23 revealed that the resident is alert to herself and pleasantly confused on time and place. The resident was asked if she knew what the device was on her wheelchair and she stated, "It's a woolly of a thing, it worries me to death. It's supposed to catch me if I'm about to fall. I ask them if I can get it off there and they say no ma'am". During an interview on 11/20/23 at 10:30 AM, with Registered Nurse (RN) Minimum Data Set (MDS)	F 636	1. Corrective action was completed on Resident #23 by removing clip alarm on 11-20-2023. Resident was re-assessed by Director of Nursing on 11-20-23 after resident interview and resident's request for alarm to be removed. 2. Six residents residing in the facility utilizing a clip alarm that are assessed as high risk for falls could be affected by not having a correct Comprehensive and Timely Assessment on their Minimum Data Set (MDS). An audit was performed by the Director of Nursing and Nurse Educator on 11-20-23 on charts of the six residents with clip alarms. All had been noted as alarms and none as restraints. 3. To ensure that the omitted information on MDS assessment in regards to clip alarms does not reoccur, inservices were provided on criteria that alarms and restraints must be utilized according to the RAI Manual to MDS RN, Interdisciplinary Team (IDT) on 11-20-23, by the Nurse Educator. The IDT consists of Director of Nursing, Nurse Educator, MDS RN, Medical Records LPN, and Nursing Home Administrator. Inservice included that Minimum Data Set (MDS) must reflect residents that have a clip alarm either "restraint" or "alarm" but must be coded utilizing the information noted in Resident Assessment Instrument (RAI) manual for restraints or alarms.	

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F 636	Continued From page 8 nurse confirmed that Resident #23 had a chair alarm clipped to her shirt that was connect to a box device on her wheelchair "because she kept falling." She stated that they do not consider it a restraint because the resident can remove it and we do not code it on the MDS because of that. During an interview on 11/20/23 at 10:40 AM, with the Director of Nurses (DON) and the Nurse Educator confirmed that Resident #23 did have a clip alarm on her wheelchair, and it been on there since her last fall in 8/2023. They confirmed that they do not consider the clip alarm on the wheelchair to be a restraint since the resident can remove it. An observation on 11/20/23 at 11:00 AM revealed Resident #23 stated she did not like the alarm on her chair, that every time she moved it went off, she could not even get her books out of her dresser drawers without it going off. During an interview on 11/20/23 at 3:35 PM with RN MDS Nurse revealed the reason the personal alarm was not care planned as a restraint was because they were not aware that a bed or chair alarm could be a restraint. Record review of Resident #23 care plan titled, "The resident is at risk for falls," date initiated 09/02/22, revealed that the care plan does not mention a chair alarm in use. Record review of Resident #23's "Fall Evaluation" form dated 8/23/23 and 9/1/23 revealed under "clinical suggestions" that positioning alarms were not indicated. Record review of Resident #23's "Admission	F 636	All new hires for MDS will be inserviced on this process and will be ongoing. 4. To ensure that the facility has sustained compliance, the Interdisiplinary Team (IDT) beginning 11-22-23 will monitor the Care Plan or Resident Assessment during the weekly at Quality Assurance Performance Improvement meeting (QAPI) meeting in the QAPI minutes that correct Resident Assessment Interventions (RAI) criteria in regards to clip alarms is coded correctly in the MDS and appropiate interventions have been followed. This will be ongoing for the IDT. A report will be submitted monthly for discussion beginning 12-14-23 by the Director of Nursing to the monthly Quality Assurance Performance Improvement (QAPI) team noting the criteria for all clip alarms has been met. THE QAPI team consists of Medical Director,Nursing Home Administrator,Director of Nursing, Medical Records LPN, Social Service, Dietary Manager, Housekeeping Supervisor, Nurse Educator, Human Resource Director, Activity Director, and Maintenance Director. The QAPI team will monitor this process monthly until 100% compliance has been obtained for three months. The Director of Nursing is responsible for compliance.	

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F 636	Continued From page 9 Record" revealed the resident was admitted to the facility on 8/31/22 with medical diagnoses that included Type 2 Diabetes Mellitus without Complications. Record review of Resident #23's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/1/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 02, which indicated the resident is severely cognitively impaired and in Section P that the resident had a chair alarm in use daily.	F 636		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		12/15/23

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F 656	Continued From page 10 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, record review and facility policy review, the facility failed to identify and properly care plan a restraint for a resident with a chair alarm for one (1) of three (3) residents with a chair alarm reviewed. Resident #23 Findings Include Review of the facility policy titled, "Care Planning Management" with a revision date of 04/2019 revealed under "Process for Completing the ...Care Plans ...Standard; It is the practice of this facility to conduct a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Objective ...#1. To	F 656	1. Corrective action was completed on Resident #23 by re-evaluating resident for need of clip alarm and interviewing resident by Director of Nursing. Clip alarm was removed on 11-20-2023. Documentation was provided in medical record for criteria for removal by the Director of Nursing. Resident Plan of Care corrected on 11-20-23 by MDS RN. 2. Six of the residents at the facility assessed as high risk for falls utilizing a clip alarm could be affected by the Resident Comprehensive Care Plan not reflecting a clip alarm as a restraint. 100%	

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ASHLAND HEALTH AND REHABILITATION	16056 BOUNDRY DRIVE ASHLAND, MS 38603

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F 656	Continued From page 11 identify resident's individual needs and care requirements, #2. To assure that an interdisciplinary team assesses the emotional, psychosocial, mental, and physical needs of each resident. Care Conference Protocol ...After the team reviews the triggered areas of concern, a care plan decision will be made. Problems will be identified and written in an interdisciplinary, CAA (Care Area Assessment) integrated format. Goals will be resident specific, measurable, and realistic. Interventions will be action verb directed and specific to each resident..." Record review of Resident #23's care plans revealed there was no restraint care plan. An observation and interview on 11/19/23 at 3:40 PM, revealed Resident #23's had a chair alarm hooked to the back of her wheelchair and was pinned to the back of her shirt. An interview at the same time with Resident #23 revealed that the resident is alert to herself and pleasantly confused on time and place. The resident was asked if she knew what the device was on her wheelchair and she stated, "It's a woolly of a thing, it worries me to death. It's supposed to catch me if I'm about to fall. I ask them if I can get it off there and they say no ma'am". An interview on 11/20/23 at 10:30 AM, with Registered Nurse (RN) Minimum Data Set (MDS) nurse confirmed that Resident #23 had a clip alarm on her wheelchair "because she kept falling." An interview on 11/20/ 23 at 3:35 PM with RN MDS Nurse revealed the purpose of the care plan was to give a guide to help take care of the resident. She revealed the reason the personal	F 656	audit was performed by Director of Nursing (DON) and Nurse Educator (NE) on the six residents utilizing the clip alarms on 11-20-2023. That Audit performed noted for MD order, family was made aware of clip alarm, clip alarm was on Care Plan and Care Guide and if needed consent obtained for restraint. 3. To ensure that omitted information on Resident Care Plan in regards to clip alarms does not reoccur, inservices by the Nurse Educator on utilization of criteria utilizing the Resident Assessment Instrument (RAI) manual for alarms or restraints was provided to MDS RN and also Interdisciplinary Team (IDT) on 11-20-23. The IDT consists of Director of Nursing, Nurse Educator, MDS RN, Medical Records LPN, and Nursing Home Administrator. Inservice included that if clip alarm is utilized the Resident Care Plan must reflect either" alarm" or "restraint" utilizing criteria from the Resident Assessment Instrument (RAI) manual on restraints or alarms.The Nurse Educator began on 11-21-23 on inservicing and completed on 12-6-23 nursing staff on criteria needed for MDS RN to code either alarm or restraint on Resident Care Plan. All nursing new hires will be inserviced on this process and will be ongoing. 4. To ensure that the facility has sustained compliance, the Interdisciplinary Team (IDT) beginning 11-22-23 will note in QAPI minutes during weekly Quality Assurance Performance Improvement meeting	

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F 656	Continued From page 12 alarm was not care planned as a restraint was because they were not aware that a bed or chair alarm could be a restraint. She acknowledged that a bed or chair alarm could prevent freedom of movement. An interview on 11/21/23 at 8:44 AM with the DON confirmed that they just really did not consider it a restraint, or they would have done things differently. She stated that she understands after reading the regulation that a chair alarm can be considered a restraint and confirmed that it was not care planned. An interview on 11/21/23 at 10:40 AM with RN #2 revealed that the purpose of the care plan was to have person centered developed care provided to the resident. Record review of Resident #23's "Admission Record" revealed the resident was admitted to the facility on 8/31/22 with medical diagnoses that included Type 2 Diabetes Mellitus without Complications. Record review of Resident #23's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/1/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 02, which indicated the resident is severely cognitively impaired and in Section P that the resident had a chair alarm in use daily.	F 656	(QAPI) meeting that Resident Care Plan and Care guide are current and correct in regards to clip alarms and will re-evaluate weekly the need for clip alarm. This will be ongoing. A report will be submitted monthly for discussion by the Director of Nursing beginning 12-14-23 to the Quality Assurance Performance Improvement (QAPI) team noting the findings of the documentation on Resident Care Plan and Care Giver Guide. THE QAPI team consists of Medical Director,Nursing Home Administrator, Director of Nursing, Medical Records LPN, Social Service, Dietary Manager, Housekeeping Supervisor, Nurse Educator, Human Resource Director, Activity Director, and Maintenance Director. The QAPI team will monitor this process until 100% compliance has been obtained for three months. The Director of Nursing is responsible for compliance.	
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	F 880		12/15/23

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F 880	Continued From page 13	F 880		

designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

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

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F 880	Continued From page 14 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and facility policy reviews the facility failed to clean and disinfect a multi-use glucometer with the approved disinfecting wipe for two (2) of two (2) medication carts reviewed. Findings Include: Record review of the policy titled, "Diabetic Management," dated 04/2019, revealed, "Cleaning and disinfecting your EvenCare G2 Meter: ...4. To disinfect your meter, clean the meter surface with one of the following disinfecting wipes: Dispatch Hospital Cleaner	F 880	1. Corrective action was completed by Nurse Educator inservicing on 11-19-23 LPN #3 and LPN #4 on immediately cleaning multi-use glucometer with Micro-Kill Bleach Germicidal wipes and by cleaning multi-use glucometer with Bleach germicidal wipes. On 11-19-23 Nurse Educator provided additional information with return demonstration of LPNs' #3 and #4 on proper technique of disinfecting multi-use glucometer. 2. All residents at the facility that utilize a multi-use glucometer have the potential for transmission of communicable disease	

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F 880	Continued From page 15 Disinfectant Towel with Bleach (1 minute). Medline Micro-Kill Disinfecting, Deodorizing, cleaning wipes with Alcohol (30 seconds). Clorox Healthcare Bleach Germicidal and Disinfectant Wipes (1 minute). Medline Micro-Kill Bleach Germicidal Bleach Wipes (2 minutes)..." An observation and interview on 11/19/23 at 4:10 PM, with Licensed Practical Nurse (LPN) #4, the LPN used the glucometer to check finger stick blood sugar (FSBS) of a resident and upon return to the B hall medication cart LPN#4 retrieved a pack of 75% alcohol disinfecting wipes and wiped the glucometer with the alcohol wipe for about 15 seconds and laid the glucometer down on a napkin with the wipe still wrapped around the glucometer. An interview with the LPN at this time stated that she usually uses the purple top wipes but there weren't any on her med cart for the last two days and stated, "I think we are out of them. I looked for them yesterday and couldn't find any." An observation and interview on 11/19/23 at 4:15 PM, with LPN #3 on A hall med cart revealed that she was out of the purple top wipes as well and stated, "I told the Registered Nurse (RN) supervisor to bring me some wipes and he brought me these," holding up a container of 75% alcohol disinfecting wipes. LPN #3 confirmed that she works every other weekend and has not had any purple top wipes on her med cart yesterday or today, but did have some the last time she worked. Interview on 11/19/23 at 4:18 PM, with the CNA Staffing Coordinator confirmed that she ordered supplies and stated, "I think they (purple top wipes) are on back order, let me check the supply closet." Observation of the supply closet with	F 880	or infection. 100% audit was performed by Nursing Home Administrator of resident with diagnosis on 11-19-21,documentation determined no resident currently residing in facility had a communicable blood borne pathogen diagnosis. On 11-19-23 bleach wipes were placed on LPN's #3 and #4 medication cart, Supply Room, and additional bleach wipes placed in Med Room by Director of Nursing. On 11-19-23 additional nurses at facility were inserviced by Nurse Educator regarding proper technique for sanitizing multiuse glucometer. Beginning 11-19-23 nurses and Supply clerk were inserviced that germicidal wipes should be on medication cart, in Med Room and Supply Room, and if nurse cannot locate wipes, they are to immediately notify Director of Nursing or the Nursing Home Administrator. 3. To ensure that proper technique for sanitizing multi-use glucometer occurs, inservices were completed on 11-19-23 by Nurse Educator or Director of Nursing for LPN #3 and LPN #4. Inservices by the Nurse Educator beginning on 11-19-23 and completed by 11-21-23 for all nurses that are employed by facility on proper disinfecting technique of multi-use glucometer as noted by successful return demonstration. LPN #3 and LPN #4 will perform return demonstration of proper disinfecting technique of multi-use glucometer weekly beginning 11-19-23 with return demonstration observed for next 4 weeks to the Nurse Educator. Beginning 11-20-23 Central Supply Clerk will note that germicidal wipes are in	

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F 880	Continued From page 16 CNA staffing coordinator confirmed that there were no purple top wipes in the supply closet. An interview with the Director of Nursing (DON) on 11/19/23 at 4:20 PM, confirmed that she had the disinfecting wipes for the glucometers in her office and that they had just come in and she had placed them in her office, not knowing that the nurses on the med carts were out and that there were none available in the supply closet. The DON confirmed that her office is locked and that weekend staff would not have had access to her office to retrieve the wipes. Record review of in-services transcript for LPN #4 revealed that she had "Diabetic Management" and "Infection Control," on 10/30/23 and LPN #3 completed her in-service titled, "Glucometer Disinfection" on 10/26/23. An interview with the DON on 11/20/23 at 2:35 PM, confirmed that these three inservices that were attended by LPN #3 and LPN #4 would have taught them that they have to use a germicidal wipe instead of an alcohol wipe on the glucometers. Interview on 11/20/23 at 2:40 PM, with the Nurse Educator confirmed that the in-services titled "Glucometer Disinfection" and "Diabetic Management," is the same in-service and training on how to clean the meter with the appropriate wipe.	F 880	medication carts, available in Med room and Supply room during the week and adequate supplies for the weekend are noted on Fridays. Central Supply clerk to notify Director of Nursing or Nursing Home Administrator immediately if there is any type of supply issue. All nurses will be educated by the Nurse Educator upon hire and ongoing in regards to supplies needed for work. 4. To ensure that the facility has sustained compliance, beginning 11-21-23 audits of supplies will be performed by the Central Supply clerk biweekly for six weeks,then weekly and then ongoing. Any issues with germicidal wipes will be immediately reported to the Director of Nursing or Nursing Home Administrator. Results of supply audit will be reported by the Director of Nursing for discussion at the Quality Assurance Performance Improvement (QAPI) team beginning 12-14-23 and then monthly until 100% compliance has been obtained for three months. The QAPI team consists of Medical Director,Nursing Home Administrator,Director of Nursing, Medical Records LPN, Social Service, Dietary Manager, Housekeeping Supervisor, Nurse Educator, Human Resource Director, Activity Director, and Maintenance Director. The Nurse Educator will audit proper cleaning technique of multi-use glucometer with germicdal wipes beginning 11-21-23 weekly times four weeks for LPN #3 and LPN #4 and will be ongoing for nurses newly hired. Results	

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F 880	Continued From page 17	F 880	of proper cleaning technique of multi-use glucometer audit will be reported by the Director of Nursing to the Quality Assurance Performance Improvement (QAPI) team for discussion beginning 12-14-23 and monthly until 100% compliance has been obtained for three months. The Director of Nursing is responsible for compliance.	