STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255272	A. BUILDING _____ B. WING _____	09/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRTLES NURSING CENTER, LLC	1018 ALBERTA AVENUE COLUMBIA, MS 39429

(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 Survey Agency (SA) conducted an annual recertification from 9/11/18 through 9/14/18. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited the regulatory deficiencies F 641, F 656, F 690, F 759 and F 880. At the time of the survey, the census was 93, and the facility held a license for 98 beds.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based record review, facility policy review, and staff interview, the facility failed to ensure that the Minimum Data Set (MDS) was coded for a fracture for one (1) of 18 resident assessment MDS's reviewed: Resident #15 Findings include: A review of a letter provided by the facility, revealed that the facility had no policy for the correct coding of the Resident's MDS. The facility did provide a letter dated 09/14/2018 that documented: "This facility uses the Resident Assessment Instrument (RAI) User Manual for MDS training, references, and coding purposes." The letter was provided and signed by the Director of Nursing (DON), when asked for a policy for coding the MDS correctly.	F 641	F 641 *On 9/27/2018, Resident # 15 Minimum Data Set (MDS) was modified to reflect current status related to fracture by Director of Nursing (DON). *Residents with fractures have the potential to be affected by this alleged deficient practice. The DON reviewed the prior six (6) months of MDS's for residents with fractures on 9/28/2018 with no additional discrepancies noted. *On 10/1/2018, the DON in-serviced three (3) of 3 nurses working in the MDS office, related to the proper coding of the MDS section J1700 subsection C per the Resident Assessment Instrument (RAI). On 10/1/2018 the Quality Assurance Committee (QAC) reviewed the RAI section J1700 with no recommended	10/9/18

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

Electronically Signed | 10/01/2018

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F 641	Continued From page 1 A record review of Resident #15's Significant Change Comprehensive MDS with an Assessment Reference Date (ARD) of 12/31/2017, revealed that Section J1700, sub-section C, was coded "0", indicating that the resident did not have any fractures within six (6) months of this assessment. A record review of the facility's Departmental Notes, revealed an entry into the nursing notes dated 12/16/2017. The Nurse's Notes revealed that Resident #15 had an unobserved fall in the facility and was sent out to the emergency room for an evaluation per an order by Resident #15's physician. A record review of Resident # 15's medical record, revealed a hospital discharge summary, with an admission date of 12/16/2017, and a discharge date of 12/24/17. The discharge summary stated that Resident #15 was given a diagnosis of a Closed Intertrochanteric fracture of the right hip. During an interview on 09/14/2018 at 9:40 AM, LPN # 5/ MDS Coordinator stated that the J1700 section of Resident #15's Significant Change MDS, with the ARD date of 12/31/2017, was not coded correctly for the resident's fracture history. LPN #5 confirmed that Resident #15's MDS documented that the resident had not had any fractures in the last six (6) months. LPN #5 also confirmed that Resident #15 did actually have a fall resulting in a major injury (right hip fracture) on 12/16/2017. During an interview on 09/14/2018 at 1:36 PM, the Director of Nursing (DON) confirmed that Section J1700 of Resident #15's Significant	F 641	changes to facility practices. *The DON will review all MDS assessments to be submitted for transmission for the correct coding of section J1700 subsection C once a week for four (4) weeks and then monthly for two (2) months. The QAC will evaluate the DON assessments monthly for three months and make needed recommendations to ensure ongoing compliance with F tag 641.	

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F 641	Continued From page 2 Change MDS was miscoded. The DON stated that the guidelines in the RAI manual are the guidelines practiced by the facility. The DON stated that the resident's MDS should have been coded to indicate that the resident had a fracture within the last six (6) months, during the lookback period of the MDS, with and ARD date of 12/31/2017.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 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	F 656		10/9/18

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F 656	Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to follow the comprehensive care plan for four (4) of six (6) care plans reviewed for indwelling urinary catheter care, Resident #54, Resident #60, Resident #87, and Resident #29. Findings include: A review of the facility's policy entitled "Care Plan Process", with an original date of 06/15, and a latest revision date of 08/17, revealed the facility staff shall follow the care plan. Resident #54 The comprehensive care plan for Resident #54, with a revision date of 8/1/18, revealed an intervention to secure the catheter to prevent pulling. The comprehensive care plan with an onset date of 5/9/17, addressed the indwelling urinary catheter with catheter care. On 09/13/18 at 2:19 PM, Resident #54 was lying in bed, awake with an indwelling urinary catheter	F 656	F 656 *On 9/18/2018, the Director of Nursing (DON) assessed Residents #54, #60, #87, and #29 with no new adverse findings noted. *All residents with indwelling urinary catheters have the potential to be affected by this deficient practice. *On 9/27/2018, the DON began in-servicing facility Licensed Practical Nurses (LPN's), Registered Nurses (RN's) and Certified Nurse Assistants (CNA's) related to the facilities "Comprehensive Care Plan" policy as related to indwelling urinary catheter care. In-servicing will continue until all facility direct care nursing staff have been in-serviced. On 10/1/2018, the Quality Assurance Committee (QAC) reviewed the policy, "Care Plan Process", with no recommended changes to the policy. *The DON will review care plans of residents with indwelling urinary catheters weekly for four (4) weeks and then	

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F 656	Continued From page 4 to gravity drainage. Observation revealed Certified Nursing Assistant (CNA) #2 performed catheter care on Resident #54. During catheter care, CNA #2 held the catheter tubing about four (4) inches away from the meatus and wiped towards the meatus. Resident #54 also did not have a catheter securing device in place. On 9/14/18 at 12:20 PM, interview with LPN #5 revealed she would expect the staff to follow the comprehensive care plan. A review of the facility's Face Sheet revealed the facility admitted Resident #54 on 5/12/16, with a diagnosis of Urethral Stricture. Resident #60: Review of Resident #60's comprehensive care plan, with a revision date of 8/1/18, revealed to secure the catheter to prevent pulling. Explain catheter care to resident prior to initiating the care. On 09/13/18 10:40 AM, observation of CNA #1 revealed she set up for incontinence and catheter care on Resident #60. CNA #1 washed her hands, applied gloves, and removed Resident #60's brief, then CNA #1 washed her hands, applied clean gloves and began care. CNA #1 secured Resident #60's catheter tubing about four (4) inches away from the meatus area and wiped towards the meatus three (3) times and dried Resident #60's catheter tubing, holding the catheter tubing at least four (4) inches away from the meatus and dried in a motion towards the meatus once, which caused tugging of the catheter tubing. Record review of the physician's orders, dated	F 656	monthly for two (2) months. The QAC will evaluate the DON assessments monthly for three (3) months and make any needed recommendations to ensure ongoing compliance with F Tag 656	

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F 656	Continued From page 5 September 2018, revealed an order for an indwelling Foley Catheter #18 French with a 30 cubic centimeter (cc) bulb; change catheter monthly. A review of the facility's Face Sheet revealed, Resident #60 was admitted on 10/30/15, with diagnoses of Benign Prostatic Hypertrophy (BPH) and Urinary Retention. Resident #29 A record review of the Comprehensive Care Plan for Resident #29, revealed a problem: Resident has an indwelling catheter and history of hemorrhagic Cystitis. Goal: Measures will be taken to prevent complications related to the catheter through the next review. Interventions: Monitor intake and output, change catheter every month and as needed (prn), position urine catheter bag below bladder, and secure catheter to prevent pulling. Observation of incontinent/catheter care on 09/13/2018 at 02:32 PM, revealed Certified Nursing Assistant (CNA) #3 failed to secure tip of the catheter near the meatus while performing catheter care to prevent trauma to the penis. During an interview on 09/13/18 at 02:38 PM, CNA #3, revealed she forgot to hold the tubing near the meatus. CNA #3 said she knew it would cause trauma by not holding the tubing however she forgot. A review of the facility's face sheet revealed the facility admitted Resident #29 on (01/11/2018) with diagnoses, which included Benign Prostatic Hyperplasia with lower urinary tract symptoms,	F 656		

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F 656	Continued From page 6 Urinary Retention and Alzheimers Disease. Resident #87 A Record Review of the Comprehensive Care Plan revealed resident has a suprapubic Catheter related to retention of urine. The goal: measures will be in place to prevent complications through the next review. Interventions: intake and output, change catheter every month and PRN, position urine catheter bag below bladder, encourage fluid intake, and secure catheter to prevent pulling. Observation of incontinent/catheter care on 0/9/13/2018 at 01:26 PM, with CNA #4, revealed the CNA failed to secure the tubing while providing catheter care. A review of the facility's face sheet revealed the facility admitted Resident #87 on (01/27/2017) with diagnoses, which included Other Specified disorders of bladder, Overactive Bladder and Cystostomy. During an interview on 09/14/18 at 12:55 PM, RN #2 stated she expect the staff provide care according to the professional standards and to follow the care plan as indicated.	F 656		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		10/9/18

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F 690	Continued From page 7 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review, and record review, the facility failed to provide catheter care in a manner to prevent the possible spread of infection for two (2) of six (6) catheter care observations; Resident #54 and Resident #60; and failed to prevent possible trauma to the urethra for four (4) of six (6) catheter care observations; Resident #54, Resident #60, Resident #87, and Resident #29.	F 690	F 690 *On 9/18/2018, the Director of Nursing (DON) assessed Residents #54, #60, #87, and #29 with no new adverse findings noted. On 9/14/2018, the Staff Development Coordinator (SDC) in-serviced Certified Nurse Assistant (CNA) #1, #2 and #4 related to the correct procedure for indwelling urinary catheter care.	

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F 690	Continued From page 8 Findings include: A review of the facility's policy entitled "Perineal Care", with an original date of 06/94, and a latest revision date of 11/17, revealed: While performing perineal care, secure the catheter tubing to one (1)leg without causing traction of the urethra. Using one (1) hand hold the catheter close to the urethral opening to prevent tension as you wash the tubing. Do no let the tubing cause traction on the urethra at any time. Start at the meatus and wash the tubing in a circular motion away from the body about four (4) to five (5) inches. Resident #54 On 09/13/18 at 2:19 PM, observation revealed Resident #54 lying in bed, awake with an indwelling urinary catheter to gravity drainage. Certified Nursing Assistant (CNA) #2 performed catheter care on Resident #54. CNA #2 held the catheter tubing about four (4) inches away from the meatus and wiped towards the meatus. Resident #54 did not have a securing device in place. On 9/13/18 at 3:15 PM, interview with CNA #2 revealed holding the catheter tubing keeps from pulling the catheter out. CNA #2 also stated, she needed to wipe the catheter tubing away from the penis area to prevent infection. On 9/13/18 at 2:35 PM, interview with the Director of Nurses (DON) revealed training is done on a timed and as needed basis for catheter care. The DON stated wiping towards the meatus is not using proper technique and there is always the potential for complications, you could potentially contaminate the urinary system. The DON also stated, there is nowhere to put a securing device	F 690	*All residents with indwelling urinary catheters have the potential to be affected by this deficient practice. *On 9/27/2018, the SDC began in-servicing CNA's related to the facility's "Perineal Care" policy. In-servicing will continue until all direct care C.N.A.'s have been in-serviced prior to care of residents with an indwelling urinary catheter. On 10/1/2018, the Quality Assurance Committee (QAC) reviewed the policy, "Perineal Care" with no recommended changes to the policy. *The DON and/or SDC will observe Perineal Care of four (4)residents with indwelling urinary catheters per week for 4 weeks and then monthly for two (2) months. The QAC will evaluate the DON and/or SDC assessments monthly for three (3) months and make recommendations as needed to ensure ongoing compliance with F Tag 690.	

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F 690	Continued From page 9 for Resident #54, because of the belly bag. A review of the facility's Face Sheet revealed, Resident #54 was admitted on 5/12/16, with a diagnosis of Urethral Stricture. The physician's orders revealed, Foley Catheter 16 FR (French) 10 Cubic Centimeter (CC) bulb for Urinary Retention. Resident #60: On 09/13/18 10:40 AM, CNA #1 performed catheter care on Resident #60. CNA #1 held Resident #60's catheter tubing about four (4) inches away from the meatus area and wiped towards the meatus three (3) times and dried the catheter tubing holding the catheter tubing at least four (4) inches away from the meatus wiping in a motion towards the meatus once, which caused tugging of the catheter tubing. This CNA did not wipe around the head of the penis area at all and stated she had finished catheter care. On 9/13/18 at 3:10 PM, interview with CNA #1 revealed she should have held the catheter tubing close to the penis area and wiped in an outward motion, away from the penis. CNA #1 stated that would keep from pulling the catheter out and keep the resident from getting an infection. On 9/13/18 at 2:55 PM, interview with Registered Nurse (RN) #1 revealed the CNAs complete a skilled evaluation once a year. RN #1 also stated she does random observations throughout the year. RN #1 stated there is a problem with holding the catheter tubing about four (4) inches away from the meatus and wiping towards the meatus. This nurse stated, "They (referring to the CNAs) are supposed to hold it at the meatus and wipe outwards about four (4) inches, to prevent	F 690		

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F 690	Continued From page 10 pulling the tubing and also to prevent infection. RN #1 stated, the catheter tubing need to be secured somehow, so it does not pull. Record review of the physician's orders, dated September 2018, revealed an order for an indwelling Foley Catheter 18 French with 30 cubic centimeter (cc) bulb, and change catheter monthly. Resident has a diagnosis of Benign Prostate Hypertrophy (BPH) and Urinary Retention. Resident #29 Observation of incontinent/catheter care on 09/13/2018 at 2:32 PM, revealed Certified Nursing Assistant (CNA) #3 failed to secure tip of the catheter near the meatus while performing catheter care to prevent trauma to the penis. During an interview on 09/13/18 at 2:38 PM, CNA #3, revealed she forgot to hold the tubing near the meatus. CNA #3 said she knew it would cause trauma by not holding the tubing however she forgot. During an interview on 09/13/18 at 2:45 PM, Registered Nurse (RN) #1 stated that the CNA's are trained to secure the catheter while providing care to the resident. RN #1 said the CNA's are suppose to hold the tubing near the meatus and clean four (4) inches away from the meatus. During an interview on 09/13/18 at 2:52 PM, The Director of Nursing (DON) confirmed the staff failed to prevent trauma by not securing the tubing of the catheter while providing catheter care. Record Review of the facility's Inservice training, dated 7/16/2018, revealed CNA #3 was educated	F 690		

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F 690	Continued From page 11 on Urinary tract Prevention and Perineal Care. A review of the facility's face sheet revealed the facility admitted Resident #29 on (01/11/2018) with diagnoses, which included BPH with lower urinary tract symptoms, Urinary Retention and Alzheimer's Disease. Resident #87 Observation of incontinent/catheter care on 09/13/2018 at 01:26 PM, with CNA #4, revealed the CNA failed to secure the tubing while providing catheter care. During an interview on 09/13/18 at 2:38 PM, CNA #4 stated she forgot to hold the tubing near the bladder while performing catheter care for Resident #87. CNA #4 said she knew it would cause trauma by not holding the tubing however she forgot. During an interview on 09/13/18 at 2:52 PM, with the DON confirmed the staff failed to prevent possible trauma by not securing the tubing of the catheter for Resident #87, while providing catheter care. A review of the facility's face sheet revealed the facility admitted Resident #87 on (01/27/2017) with diagnoses, which included Other Specified disorders of bladder, Overactive Bladder and Cystostomy.	F 690		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		10/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255272	A. BUILDING _____ B. WING _____	09/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRTLES NURSING CENTER, LLC	1018 ALBERTA AVENUE COLUMBIA, MS 39429

(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 759	Continued From page 12 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review, Resident interview, and record review, the facility failed to ensure it is free of a medication error rate less than five (5) percent for three (3) of 27 opportunities for errors; Resident #18 and Resident #92. Findings Include: Record Review of the facilities policy title, Metered Dose Inhalers-Inhaled Medications, with a revised date of 10/17, revealed to instruct resident to rinse mouth following steroid inhalers. Resident #92 Observation of medication administration on 09/11/18 at 4:00 PM, revealed Licensed Practical Nurse (LPN) #2 gave Resident #92 Spiriva Respimat two (2) puffs and told her, "Make sure you drink all the water." LPN #2 did not instruct the resident to rinse her mouth with the water and spit it out. Observation of medication administration on 09/12/18 at 4:00 PM, revealed LPN #3 gave Resident #92 Spiriva Respimat two (2) puffs and a glass of water. Resident #92 drank all the water. LPN #3 did not instruct Resident #92 to rinse her mouth with the water and spit it out. Record Review of Resident #92 Physician's Order, dated 9/13/2018, revealed to make sure the resident rinsed the mouth after inhaler use. Resident #18	F 759	F759 *On 9/18/2018, the Director of Nursing (DON) assessed Residents #18 and #92 with no adverse findings noted. *All residents receiving inhaled steroid medications have the potential to be affected by this alleged deficient practice. *On 09/14/2018, the DON began in-servicing Licensed Practical Nurses (LPN's) and Registered Nurses (RN's) on "Metered Dose Inhalers-Inhaled Medications", with 100% of LPN's and RN's in-serviced by 09/27/2018. On 10/01/2018, the Quality Assurance Committee (QAC) reviewed the policy "Metered Dose Inhalers-Inhaled Medications" with no recommended changes to the policy. *The DON and/or Staff Development Coordinator (SDC) will observe medication administration of inhaled steroid medication twice a week for four (4) weeks and then monthly times two (2) months. The QAC will evaluate the DON and/or SDC assessments monthly times three (3) months and make recommendations as needed to ensure ongoing compliance with F Tag 759.	

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F 759	Continued From page 13 Observation of medication administration on 09/13/18 at 4:00 PM, revealed LPN #4 gave Resident #18 Symbicort Inhaler two (2) puffs. LPN #4 did not instruct the resident to rinse her mouth. Record Review of Resident #18 Physicians Order revealed to offer resident to rinse mouth after inhaler use. During an interview on 09/13/18 at 11:43 AM, LPN #2 confirmed she forgot to ask Resident #92 to rinse her mouth out with water. LPN #2 stated the resident needs to rinse her mouth out after inhaling a steroid because of the taste. During an interview on 09/13/18 at 11:48 AM, LPN #3 confirmed she failed to ask Resident #92 to rinse her mouth out with water. During an interview on 09/13/18 at 11:50 AM, LPN #4 revealed she failed to ask Resident #18 to rinse her mouth out with water. LPN #4 said the reason the resident rinse their mouth out with water is because of the taste. During interview on 09/14/18 at 11:52 AM, the Director of Nursing (DON) revealed the staff failed to prevent a less than five (5) percent medication error rate by not asking the residents to rinse their mouth out with water after inhaling a steroid. The DON stated the staff should rinse the resident's mouth out to prevent thrush in the resident's mouth.	F 759		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		10/9/18

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F 880	Continued From page 14 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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F 880	Continued From page 15 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to store a nebulizer mask in a manner to prevent to possible spread of infection for one (1) of nine (9) residents with nebulizer masks observed, Resident #25; and failed to provide Gastric Tube site care in a manner to prevent the possible spread of infection for one (1) of three (3) residents with Gastric Tubes, Resident #58. Findings include: A review of the facility's policy entitled, "Infection	F 880	F 880 *On 9/18/2018, the Director of Nursing (DON) assessed Residents #25 and #58 with no adverse findings noted. Staff Development Coordinator (SDC) replaced and properly stored the nebulizer mask of Resident #25 on 9/13/2018. The Treatment Nurse was in-serviced on 9/18/2018 by DON related to proper technique in gastric tube site care. *All residents with Nebulizer treatments or Gastric Tubes have the potential to be affected by this deficient practice.	

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F 880	Continued From page 16 Prevention and Control Program", with an original date of 06/14, revealed: The facility has developed and maintains an infection prevention and control program that provides a safe, sanitary, and comfortable environment to help prevent the development and transmission of infections. This program will develop specific policies and procedures governing such activities as aseptic technique, outbreak investigation wound care, catheter care, etc. A review of the facility's policy entitled, "Nebulizer", with an original date of 06/94, and a latest revision date of 10/17, revealed: When cleaning nebulizers, store in a clean plastic bag. Resident #25 Observations of Resident #25 on 9/11/18 at 10:55 AM, and 9/12/18 at 11:20 AM, revealed his nebulizer mask was not in use and was not bagged. On 9/13/18 at 9:45 AM, Resident #25 was observed sitting in his wheelchair in his room and his nebulizer mask was not bagged. On 9/13/18 2:50 PM, interview with the Director of Nurses (DON) revealed, "Our policy states it's (referring to the nebulizer mask) to be cleaned and placed in a zip lock bag at the bedside." On 9/13/18 at 3:00 PM, interview with Registered Nurse (RN) #1 revealed the nebulizer mask should be covered when not in use to prevent germs. A review of the facility's Face Sheet revealed, Resident #25 was admitted on 8/20/15, with a diagnosis of Pneumonia. Resident #58 Observation on 9/13/18 at 11:40 AM, revealed Licensed Practical Nurse (LPN) #1 used Alcohol	F 880	*On 9/27/2018, the DON began in-servicing facility Licensed Practical Nurses (LPN's) and Registered Nurses (RN's)related to proper storage of nebulizer masks and proper technique in gastric tube site care. On 10/1/2018, the Quality Assurance Committee (QAC) reviewed the " Dressing Change" policy and procedure and " Nebulizer " policy with no recommended changes to the policies. *The DON and/or Charge Nurse will observe the proper storage of Nebulizer masks twice weekly for four (4) weeks and then monthly for two (2) months. The DON and/or Staff Development Coordinator (SDC)will observe Gastric Tube Site care of two of four residents twice weekly for four weeks and then monthly for two months. The QAC will review the assessments monthly for three months and make recommendations as needed to ensure ongoing compliance with F Tag 880.	

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F 880	Continued From page 17 Based Hand Gel (ABHG) and set up supplies, with ungloved hands, during which time she placed a 4 x 4 gauze dressing into a 30 cubic centimeter (cc) plastic cup with normal saline, then took her ungloved right index finger and pushed the gauze into the cup of normal saline. During an interview on 9/13/18 at 11:50 AM, LPN #1 stated, "I used my hand sanitizer before I started, did I still need gloves on?" On /13/18 at 2:35 PM, interview with the DON revealed training is done on a timed basis and an as needed basis for and Gastric Tube care. On 9/13/18 at 2:45 PM, the DON stated it was not a good infection control technique to use an ungloved index finger to stuff 4 x 4 gauze into a cup of normal saline. A review of the facility's Face Sheet revealed, Resident #58 was admitted on 4/16/14, with a diagnosis of Dysphagia.	F 880		

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	255272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/12/2018**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 10/01/2018

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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E 000	Initial Comments Survey conducted on 9/12/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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