STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	C 12/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	**16411 ROBINSON ROAD GULFPORT, MS 39503**

(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	F 000		

The State Agency (SA) initiated a complaint survey for CI MS #16447, CI MS #16472 and CI MS #16466 on 12/17/19 and completed the survey on 12/31/19.

During the survey, the SA substantiated CI MS #16447 related to an allegation of Quality of Care, related to pain during pressure ulcer care, and Infection Control related to Contact Isolation Precautions, improper placement of soiled/used linen and trash. The SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid and cited F656, F686 and F880. On 12/18/19 at 2:55 PM the facility failed to assess Resident #4's pain prior to and during wound care to a stage III sacral pressure ulcer. Resident #4 expressed pain to the nurse before the wound care began, and during the wound care the resident complained of pain, and also made facial grimaces and moaned at times. The nurse did not stop to assess the resident during the wound care, offer or administer pain medication. Therefore, due to Resident #4's wound care provided with obvious signs of significant pain/discomfort, F656 and F686 were cited at a harm level.

During the survey, the SA substantiated CI MS #00016472 regarding an allegation for Quality of Care, related to supervision related to a fall. On 12/10/19 at 8:00 AM, Resident #7 fell from her wheelchair due the facility's failure to adequately monitor/check her self-release belt as ordered by the physician every 30 minutes for functioning and placement, and release every two (2) hours for positioning. As a result, Resident #7 acquired

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

Electronically Signed | 01/31/2020

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F 000	Continued From page 1 a fractured right hip, and required hospitalization and surgery to repair the fractured hip. Resident did not return to the facility. Resident #7 was assessed as a fall risk, on 3/26/18, due to history of falls prior to admission. The SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA cited F656 and F689 at a harm level due to the facility failed to monitor/check resident #7's self-release belt to ensure it was in place and/or functioning appropriately as ordered by the physician to prevent falls/injury. During the survey, the SA was not able to substantiate CI MS #16466 regarding an allegation of Quality of Care related to Incontinent Care and staffing. The SA did not identify any concerns with incontinent/toileting care provided for five (5) of 13 residents sampled for incontinent care/toileting. The SA did not identify any concerns with staffing, and random interviews with residents did not indicate concerns with staffing. The census at the time of the survey was 91, and the facility was certified for 105 beds.	F 000		
F 656 SS=G	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	F 656		2/28/20

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F 656	Continued From page 2 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 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 Observation, interview, record review, and facility policy review, the facility failed to follow the Care Plan for pain management during wound care for Resident #4 for one (1) of three (3) wound care observations and failed to supervise Resident #7 for one (1) of four (4)	F 656	* On 12/18/19 at approximately 3:15 PM, Resident #4 was given as needed PRN Tylenol by Licensed Practical Nurse (LPN) #3. On 12/18/19 all Time Codes for	

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F 656	Continued From page 3 residents reviewed for falls. Findings include: A review of the facility policy, "Total Care Plan", dated 2/27/19, revealed that it is the policy of the facility that the Interdisciplinary Care Plan will identify problems that affect the resident and his/her needs and identify the interventions related to the specific problems. Resident #4 During a wound care observation on 12/18/19 at 2:55 PM Licensed practical Nurse (LPN) #1 did not assess Resident #4's pain level before performing wound care. Resident #4 told LPN #1 before she started wound care that his wound was hurting. Resident #4 exhibited facial grimacing as verbally complaining of pain. LPN #1 proceeded with the wound care treatment telling Resident #1 that she would be finished soon, and she would tell the Medication Nurse to give him something for pain. Resident #4 moaned several times during wound care and voiced he was hurting. Resident #4 yelled out and flinched when LPN #1 cleaned the sacral wound. LPN #1 continued wound care without offering Resident #4 and pain medication. In a record review of the Comprehensive Care Plan, dated 11/5/19, revealed the problem of a stage III Pressure Ulcer to Resident #4's sacrum, with an intervention of noting any complaints of pain, location and severity, and the effectiveness of medications. In a record review of the Physician Order's dated, December 2019, revealed an order for Tylenol 325mg two (2) tablets by mouth (po) every four (4) hours as needed for pain. During an interview,	F 656	Physician Orders were corrected to prompt for every two hour check and release on the Treatment Administration Record (TAR) for self-release belts. ** All resident with wounds or self-release belts have the potential to be affected by this deficient practice. *** LPN #1 has been counseled on the importance of asking residents if they need pain medication according to the Physician Order before beginning wound care. During wound care, the nurse should watch for signs of pain. If the resident refuses pain medication before beginning but exhibits signs of pain during care, the nurse must again ask if resident would like to be administered pain medication per the Physician Order. Every wound care order now includes a pre-wound care pain scale special requirement that requires the nurse to put in a numerical response before they can sign off on the TAR. This requirement prompts the nurse to offer pain medication to the resident. The Time Codes for the Physician Orders for check and release of self-release belts will automatically transfer to the TAR for the nurse to document every two hours that the nurse has checked and released the belt. Beginning 01/07/20 at 9:30 AM and	

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F 656	Continued From page 4 on 12/18/19 at 3:55 PM, (LPN) #1, stated that by not assessing Resident #4 for pain and administering pain medication as needed, she had not followed the care plan. During an interview, on 12/18/19 at 5:12 PM, Registered Nurse (RN) #2 stated that LPN #1 did not follow the Comprehensive care Plan for wound care by not assessing the pain level of Resident #4 during wound care. During an interview, on 12/18/19 at 5:30 PM, LPN #2 stated that the Comprehensive Care Plan for wound care was not followed by LPN #1 when she did not assess the pain level of Resident #4. The facility admitted Resident #4 on 10/22/19 with the diagnosis of End Stage Renal Disease with Dialysis, Peripheral Vascular Disease and Type II Diabetes. Resident #7 In a record review of the Physician Order's for Resident #7 dated December 2019, revealed orders for a self-release alarm belt while in wheelchair, check every 30 minutes for proper functioning and release every two (2) hours and as needed for toileting and repositioning. In a record review of the Comprehensive Care Plan dated 9/3/18, revealed a problem of Risk for Falls, with the intervention of applying the self-release alarm belt while up in wheelchair and check placement every shift. During an interview on 12/31/19 at 12:21 PM, the Director of Nursing (DON) stated that not following the Comprehensive Care Plan regarding falls and the self-release alarm belt monitoring per Physician Orders could contribute to a fall. The DON verified that the Physician's Order for the self-release seat belt monitoring was not	F 656	ending on 01/16/20 at 8:30 AM, 10 Registered Nurses (RNs), 36 LPNs and 46 Certified Nurse Assistants (CNAs) were in-serviced on the Total Care Plan Policy by the Director of Nursing (DON). Beginning 01/07/20 at 9:30 AM and ending on 01/16/20 at 8:30 AM, 10 RNs and 36 LPNs were in-serviced on the Pain Policy by the DON. **** The Quality Assurance (QA) nurse will monitor two wound care treatments per week beginning on 01/30/20 for three months for pain management by reviewing documentation and by conducting resident interviews regarding their pain. The QA nurse will monitor three residents per week beginning on 01/30/20 for a period of three months to ensure that two hour check and release of self-release belts are being done by reviewing documentation and resident interview. The QA nurse will bring these findings to the monthly QA Meeting for review and recommendation.	

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F 656	Continued From page 5 transcribed to the Comprehensive Care Plan or the Treatment Record accurately. The DON stated that the Physician's Order not being transcribed to the Treatment Record accurately and the monitoring not being done as ordered, could have caused the development of a decubitus ulcer, contractures, anxiety, or mental anguish for any resident. During an interview on 12/31/19 at 12:44 PM, LPN #4 revealed that not following the Comprehensive Care Plan regarding falls and the self-release alarm belt monitoring for Resident #7 could have caused an injury to occur as well as skin breakdown and contractures for. LPN #4 stated that not monitoring or releasing the restraints as ordered by the Physician, the same issues could have occurred. LPN #4 verified that the Physician's order for the self-release alarm belt was not transcribed to the Comprehensive Care Plan accurately for Resident #7. During an interview on 12/31/19 at 1:17 PM, LPN #2 stated that the nurses not following the Comprehensive Care Plan for falls and the use and monitoring of a safety belt could cause any resident to get hurt, have skin breakdown in places, as well as to develop contractures. The facility admitted Resident #7 on 3/26/18 with the diagnosis of Repeated Falls, Hypertension (high blood pressure), Unspecified Dementia and Breast Cancer.	F 656		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		2/28/20

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F 686	Continued From page 6 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to assess Resident #4's level prior to providing wound care and during the wound care provided by Licensed Practical Nurse (LPN) #1. The failure to assess Resident #4's pain levels resulted in the resident expressing signs of pain during the treatment with facial grimacing, moaning, and verbalization of pain. This was identified for one of three (1 of 3) resident wound care observations. Findings include: A review of the facility policy titled, "Clean Dressing Change" not dated, revealed the following procedure to perform a clean dressing change included: Explain to Resident that you are about to perform a dressing change on them, explain the procedure and evaluate pain level, administer pain medication if needed. During a wound care observation, on 12/18/19 at 2:55 PM, Licensed Practical Nurse (LPN) #1 and Certified Nursing Assistant (CNA) #1 entered Resident #4's room to provide wound care to a Stage III pressure ulcer to the Sacrum. Licensed practical Nurse (LPN) #1 did not assess Resident	F 686	* On 12/18/19 at approximately 3:15 PM, Resident #4 was given as needed PRN Tylenol by Licensed Practical Nurse (LPN) #3. ** All residents with wounds have the potential to be affected by this same deficient practice. *** Beginning 01/07/20 at 9:30 AM and ending on 01/16/20 at 8:30 AM, 10 Registered Nurses (RNs) and 36 LPNs were in-serviced on the Pain Policy by the Director of Nursing (DON). Beginning 01/24/20 at 6:00 PM and ending on 01/31/20 at 5:00 PM, all 10 RNs and 36 LPNs have been educated with documentation by a Certified Wound Care RN from an outside vendor. All nurses will be given a skills assessment by this Certified Wound Care RN by February 7, 2020. All new hire LPNs and RNs will be educated the Pain Policy and on wound care upon hire and will be required to pass a skills assessment within 30 days of	

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F 686	Continued From page 7 #4's pain level before performing wound care. Resident #4 told LPN #1 before she started the wound care that his wound was hurting. Resident #4 exhibited facial grimacing as well as verbally complaining of pain. LPN #1 proceeded with the wound care treatment telling Resident #1 that she would be finished soon and she would tell the Medication Nurse to give him something for pain. Resident #4 moaned several times during the wound care and voiced he was hurting. Resident #4 yelled out and flinched when LPN #1 cleaned the sacral wound. LPN #1 continued wound care without any pain assessment or pain medication. Review of December 2019 Physician's Orders revealed an order, dated 12/13/19, to clean the sacral ulcer with Normal Saline, Pat dry, Apply Hydrogel and Collagen mix to wound bed and cover with silicone foam border every 48 hours and as needed. Review of the December 2019 Medication Administration Record (MAR) revealed no Tylenol was administered on December 18th before, during or after the wound care. The last dose of Tylenol was documented on 12/13/19 at 6:45 AM. Review of the December 2019 Physician's Orders revealed an order, dated 11/7/19, for Acetaminophen (Tylenol) 325 milligrams (mg), two (2) tabs by mouth (po) every four (4) hours as needed (PRN) for pain. During an interview, on 12/18/19 at 3:55 PM, LPN #1 revealed she should have waited to do the wound care and offered him some pain medication. She stated she normally would any other time, but she got nervous.	F 686	date of hire. Every wound care order now includes a pre-wound care pain scale special requirement that requires the nurse to put in a numerical response before they can sign off on the Treatment Administration Record (TAR). This requirement prompts the nurse to offer pain medication to the resident. **** The Quality Assurance Nurse (QA) nurse will monitor two wound care treatments per week beginning on 01/30/20 for three months for pain management by reviewing documentation and by conducting resident interviews regarding their pain. They will bring their findings to the monthly QA meeting for review and recommendations.	

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F 686	Continued From page 8	F 686		

During an interview, on 12/18/19 at 5:12 PM, Registered Nurse (RN) #2/Assistant Director Of Nurses (ADON) stated LPN #1 should have stopped the wound care and offered Resident #4 some pain medication.

During an interview, on 12/18/19 at 3:25 PM, LPN #3 revealed she was Resident #4's medication nurse and LPN #1 did not tell her that Resident #4 needed pain medication.

During an interview, on 12/18/19 at 5:15 PM, the Medical Director stated Resident #4 had an as needed pain medication available to him when needed. The Medical Director stated the nurses could always call him when needed to address Resident #4's pain level. He stated he was always concerned with controlling the pain level of his residents.

Review of the Face Sheet revealed the facility admitted Resident #4 to the facility 10/22/19 with a diagnosis of End Stage Renal Disease with Dialysis, Peripheral Vascular Disease and Type II Diabetes.

Review of Resident #4's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/24/19, revealed the resident was assessed a high risk for developing pressure ulcers. Resident #4 was admitted with one (1) stage I, two (2) stage II, and two (2) unstagable pressure ulcers. The pain assessment revealed Resident #4 was receiving as needed pain medication. Resident #4's Basic Interview for Mental Status (BIMS) score was 12, which indicated mild cognitive impairment.

Review of Resident #4's 5-Day MDS, with an

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F 686	Continued From page 9 ARD of 11/12/19, revealed the resident was still assessed as high risk for developing pressure ulcers, and was re-admitted with a stage III pressure ulcer. Resident #4 received as needed pain medications. The BIMS score was 9, which indicated moderate cognitive impairment.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, and the facility investigation review, the facility failed to provide adequate supervision to monitor/check Resident #7's self-release safety belt and as a result Resident #7 fell and sustained a fractured right hip. This concern was identified for for one (1) of four (4) residents with self-release belts observed. Findings include: A review of facility policy titled "Accident and Supervision Policy", not dated, revealed that each resident is to receive adequate supervision and assistive devices to prevent accidents which includes implementing interventions to reduce hazards and risks. Specific interventions will be implemented to try and reduce a resident's risk from hazards including documenting interventions	F 689	* On 12/18/19 all Time Codes for Physician Orders were corrected to prompt for every two hour check and release on the Treatment Administration Record (TAR) for self-release belts. ** All residents with self release belts have the potential to be affected by this deficient practice. *** Time Codes for Physician Orders for check and release of self-release belts will automatically transfer to the TAR for the nurse to document every two hours that they have checked and released the belt. Beginning 01/07/20 at 9:30 AM and ending on 01/16/20 at 8:30 AM, 10 Registered Nurses (RNs), 36 Licensed	2/28/20

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F 689	Continued From page 10 and ensuring that the interventions are put into action. A review of facility policy titled "Policy for Restraints", not dated, revealed that applying a restraint for patient safety requires additional care, observation and management by the medical staff to ensure patient safety. Resident's with restraints should be checked every 30 minutes and have the restraint removed and the resident repositioned every two (2) hours. Review of the facility's incident Investigation, dated 12/20/19 at 8 AM, revealed resident was observed by Activity Staff pulling on her catheter tubing. Activity Aide stayed with resident and took her to her assigned nurse, who transported the resident to her room, left her in the doorway to go get someone to assist putting the resident to bed. When the nurse returned, the resident was on the floor on her left side in front of the bathroom door with her feet up in the wheelchair. The resident was assisted to bed with the help of the nurse and aide. The Charge Nurse assessed the resident for injuries. The injuries observed were skin tears to the left elbow and hand, and the right knee. The Responsible Representative (RR) and Medical Doctor (MD) were notified. The Assistant Director of Nurses (ADON) was also notified. The resident's catheter was changed. The resident was out of bed and propelling self in wheelchair around the facility the remainder of the day. On 12/11/10 7 on the 7 AM to 3 PM shift, the resident complained of pain in right knee. The Charge Nurse and MD were notified, and a new order was received for an xray of the right knee and hip. Received the xray report stating a fracture to the right hip. Resident was sent to the hospital for further evaluation.	F 689	Practical Nurses (LPNs) and 46 Certified Nurses Aides (CNAs) were in-serviced on the Accidents and Supervision Policy and the Resident Alarms Policy by the Director of Nursing (DON). Beginning 01/07/20 at 9:30 AM and ending on 01/16/20 at 8:30 AM, 10 RNs, 36 LPNs and 46 CNAs were in-serviced on the Total Care Plan Policy by the DON. Beginning 01/07/20 at 9:30 AM and ending on 01/16/20 at 8:30 AM, 10 RNs and 36 LPNs were in-serviced on the Following Physician's Orders Policy by the DON. **** The Quality Assurance (QA) nurse will monitor three residents per week beginning on 01/30/19 for two hour check and release of restraints by reviewing documentation and resident interview. The QA nurse will bring these findings to the monthly QA Meeting for review and recommendation.	

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Review of the facility's Neurological Flow Sheet revealed neuro checks were started on 12/20/19 at 8:15 AM and completed on 12/11/19 at 3 PM.

Review of the hospital's Emergency Department (ED) Physician Note, dated 12/11/19 at 4:46 PM, revealed Resident #7 presented to the Emergency Room (ER) today after a fall out a wheelchair last night. Patient does not ambulate. The right complete hip xray, on 12/11/19 at 5:39 PM, revealed a Displaced, Angulated Right Femoral Introtrochanteric Fracture. Resident #7 required a Right Open Reduction Internal Fixation surgery to repair the hip during her hospital stay.

During an interview, on 12/30/19 at 6:22 AM, Licensed Practical Nurse/LPN #2/Quality Assurance (QA) Nurse stated Resident #7 could not undo her safety belt on command, but she could undo it when she felt like it. LPN #2 stated during their investigation she discovered Registered Nurse (RN) #2/Assistant Director of Nurses (ADON) told her when she got to work at 7AM that morning she checked Resident #7's self-release belt and it was on and functioning properly. LPN #2 stated RN #2 told her Resident #7 was agitated in the dining room and the Activity Director took her to LPN #5 and LPN #5 stated she pushed Resident #7 in her wheelchair just inside the door of her room and left her to go get someone to assist her to place the resident in her bed. When she returned, she found Resident #7 lying on her left side in front of the door. LPN #2 stated LPN #5 revealed to her that she did not check the belt when she placed Resident #7 by the door.

During an interview, on 12/30/19 at 7:41 AM,

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Licensed Practical Nurse (LPN) #5 stated the Activity person brought the Resident #7 to her on the morning she fell stating that Resident #7 seemed agitated and was pulling at her catheter. She stated she pushed Resident #7 down to her room and placed Resident #7 in the doorway of her room. LPN #5 stated she just pushed her inside the doorway of her room and did not check to see if her seat belt was on or even if it was working. LPN #5 stated that she just assumed it was on Resident #7. LPN #5 stated she walked out of the room to go get help to lay Resident #7 down in the bed and when she went back into Resident #7's room, she was lying on the floor on her left side. LPN #5 stated the belt was suppose to alarm if it was unhooked and she didn't hear it alarm. LPN #5 stated the seat belt was not hooked on Resident #7. LPN #5 stated she didn't know Resident #7 well enough to know if she could take the belt off by herself or not.

Review of the December 2019 Physician's Order for Resident #7 revealed an order for a self-release alarm belt while in the wheelchair. Check every 30 minutes for proper functioning and release every 2 hours and as needed (PRN) for toileting and repositioning. The Physician's Orders revealed Resident #7 with diagnoses of repeated falls and Dementia.

Record review of a facility Consent For Use Of Physical Restraints Or Enabling Device, dated 4/23/18, revealed a self-release alarm belt was ordered for confusion, poor safety and hx of falls.

Review of the Treatment Administration Record (TAR), dated December 2019, revealed self-release alarm belt while in wheelchair, check every 30 minutes for proper functioning and

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release every two (2) hours and as needed for toileting and repositioning. On 12/9/19 and 12/10/19, the 7 AM to 3 PM shift columns for monitoring/checking the belt every 30 minutes and releasing the belt every two (2) hours was blank.

During an interview with RN #2, on 12/31/19 at approximately 10:00 AM, she revealed she checked the resident's seat belt on arrival to work on 12/10/19 at 7AM and it was on and functioning properly. However, she stated she did not document the belt was checked on the Treatment Administration Record (TAR).

During an interview, on 12/30/19 on 8:10 AM, LPN #1 revealed she saw the Activities Director coming down the hallway with Resident #7 and the Activity Aide told her that Resident #7 was pulling at her catheter and the resident seemed a little agitated. The Activities Director handed her off to LPN #5 and she took Resident #7 to her room and left her at the door to go look for somebody to help her put Resident #7 in her bed. LPN #1 stated she didn't think to look for the safety belt because she was just passing Resident #7 in the hallway. LPN #1 stated the day Resident #7 fell, she was doing treatments and it would have been her responsibility to sign the TAR off that the self-release alarm belt was checked. LPN #1 stated she didn't remember checking the safety seat belt at all on the morning that Resident #7 fell.

During an interview, on 12/30/19 at 10:55 AM, the Activity Director stated to be honest and thinking back on it, she didn't remember seeing the safety belt on Resident #7 that morning.

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During an interview, on 12/31/19 at 10:39 AM, the Administrator stated the monitoring of the self-release seat belt was not being done correctly according to the Physician's Order and the TAR for Resident #7 and that she was having the monitoring of the belt corrected immediately.

During an interview, on 12/31/19 at 12:21 PM, the Director of Nursing (DON) stated the Medication Nurses are responsible for monitoring the self-release alarm belt and documenting that they have been checked according to physician's orders. The Don stated according to the TAR, the monitoring of the self-release alarm belt was not being monitored per the Physician's Order. The self-release alarm belt not being monitored correctly could have contributed to a fall for Resident #7.

During an interview, on 12/31/19 at 12:44 PM, LPN #4/Care Plan Nurse revealed the Medication Nurses are responsible to check for the release of the self-release alarm belt and document accordingly. LPN #4 stated after reviewing the TAR, the physician's order for monitoring the self-release alarm belt was not being followed.

During an interview, on 12/31/19 at 1:17 PM, LPN #2 stated the Medication Nurses or Treatment Nurses on the hall are responsible to document and check the self-release alarm belt. LPN #2 verified that according to the TAR, the self-release belt was not being monitored following the physician's order.

Review of the facility's Incident Log revealed Resident #7 had a fall with injury on 12/10/19 at 8:46 AM. The Type of Injury was a skin tear

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F 689	Continued From page 15 Review of the Face Sheet revealed Resident #7 was admitted by the facility, on 3/26/18, and discharged on 12/16/19. Resident #7 was admitted with the included diagnoses of Hypertension (High Blood Pressure), Unspecified Dementia and Breast Cancer.	F 689		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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	F 880		2/28/20

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F 880	Continued From page 16 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 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, record review, staff interview, and facility policy review, the facility failed to ensure measures were implemented to	F 880	* On 12/18/19 a sign was placed on Resident #3's door stating "See Nurse Before Entering." The Personal Protective	

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F 880	Continued From page 17 prevent the possible spread of infection and/or contamination, for three (3) of 11 resident rooms observed, as evidenced by: (1) A Contact Isolation Precautions sign was not posted on the door to notify the nurse before entering Resident #3's room and the Personal Protective Equipment (PPE) container was not stocked with PPE supplies and was not stationed on the outside of Resident #3's door. (2) Dirty linen and garbage was placed on the floor in Resident #9 and Resident #10's room. Findings include: A review of facility policy titled, "Contact Isolation Policy", dated 2/4/13, revealed the procedure for establishing Contact Isolation begins with labeling the residents door with a sign, "See Nurse before entering". Healthcare personnel caring for residents on Contact Precautions always wear gloves and may need gowns for interactions that involve contact with the resident or potentially contaminated areas in the resident's environment. All personnel entering the room should wear gloves if they are going to come in contact with contaminated surfaces or have direct contact with the resident. Gowns may be required when caring for the individual if there is excessive drainage that may potentially contaminate the caregiver. A review of facility policy titled, "Infection Prevention and Control Program", dated 12/26/19, revealed soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom.	F 880	Equipment (PPE) equipment bag was hung on the outside of Resident #3's door and filled with the proper equipment. On 12/30/19 dirty linen and garbage was picked up and placed in designated receptacles. ** All residents have the potential to be affected by this deficient practice. *** Certified Nursing Assistants (CNA's) #2 and #3 have been counseled on the proper disposal of dirty linen and trash. Beginning on 02/03/20, when a resident is placed on contact precautions, a Nursing Medical Intervention is added to the Medication Administration Record (MAR) to check placement of the sign on the door, check for proper placement of the PPE equipment and check placement and use of biohazard containers each shift. Beginning 01/07/20 at 9:30 AM and ending on 01/16/20 at 8:35 AM, all nursing staff, 10 Registered Nurses (RN's), 36 Licensed Practical Nurses (LPN's) and 46 CNA's have been in-serviced on "Soiled Linen and Trash Containers Policy" and "Dirty Linen and Storage Policy" by the Director of Nursing (DON). **** The Quality Assurance (QA) nurse will check the Infection Control Log daily beginning on 01/30/20 to see that proper equipment is correctly placed and in use and will monitor two shifts per week for	

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F 880	Continued From page 18 Review of Resident #3's Physician's Order, dated 10/30/19, revealed Resident #3 was placed on contact Precautions. Further review of the order revealed Resident #3 was diagnosed with Methicillin Resistant Staphylococcus Aureus to the left heel, and to start Vacomycin 500 milligrams (mg) every 12 hours. During an observation, on 12/18/19 at 4:30 PM, Licensed Practical Nurse (LPN) #1 entered Resident #3's room to perform wound care to a Stage III pressure wound to the left heel. Resident #3 had a Physician's order for contact precautions and there was no sign identifying Contact Precautions or to see the nurse before entering Resident #3's room. The Personal Protective Equipment (PPE) bag was hanging inside of Resident #3's room on the back of the door. There were no gloves, gowns or face shields in the PPE designated bag. LPN #1 exited Resident #3's room and gathered PPE supplies before wound care could be performed. During an interview, on 12/18/18 at 4:50 PM, LPN #1 revealed there was no reason for the contact isolation supplies to not be on the outside of Resident #3's door. LPN #1 stated there was no excuse for a Contact Precaution sign or to see the nurse before entering the room sign not to be posted on Resident #3's door. During an interview, on 12/18/19 at 5:30 PM, LPN #2/Quality Assurance (QA) Nurse/Infection Control Nurse revealed there should have been a sign on the door identifying Contact Precautions or to talk to a nurse before entering Resident #3's room, and the PPE bag with the supplies should have been located on the outside of the door.	F 880	proper handling of dirty linen and trash removal for a period of three months. The QA nurse will bring the findings to the monthly QA meeting for review and recommendations.	

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During an interview, on 12/18/19 at 5:40 PM, Registered Nurse (RN) #1 stated there should have been a Contact Precaution sign on Resident #3's door. The Contact Isolation bag with the gloves and gowns should have been on the outside of the door and stocked with supplies.

During an interview, on 12/18/19 at 5:12 PM, RN #2 revealed the PPE bag should have been on the outside of Resident #3's door. The PPE bag should have contained all the supplies needed for that room such as gloves and gowns. There should have been a sign on the door to see the nurse before entering the room or displaying Contact Precautions.

Review of the Face Sheet revealed the facility admitted Resident #3, on 6/1/19, with the included diagnoses of Urinary Tract Infection, Sepsis, Acute Kidney Failure, Pressure Ulcer of Right Heel.

Resident #9

During an observation, on 12/30/19 at 520 AM, Certified Nursing Assistant (CNA) #2 entered Resident #9's room to provide incontinent care. A bag of dirty linen and a bag of garbage containing a soiled brief was bagged and placed on the floor in Resident #9's room. CNA #2 had placed an open bag on the floor by Resident #9's bed. CNA #2 removed Resident #9's brief and tossed the brief onto the top of the open bag on the floor. CNA #2 continued to provide incontinent care to Resident #9 using a towel to wipe the perineal area tossing the dirty towels on top of the open bag lying on the floor. CNA #2 completed the incontinent care for Resident #9, gathered the

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dirty brief and the soiled towel, and placed them down into the bag in which they were tossed. CNA #2 closed the bag and then placed the bag back onto the floor while she cleaned the area up.

During an interview, on 12/30/19 at 5:25 AM, CNA #2 revealed she thought as long as the dirty linen was in a bag it could sit on the floor.

During an interview, on 12/30/19 at 5:27 AM, Licensed Practical Nurse (LPN) #6 revealed he too saw the bags of dirty linen and garbage on the floor of Resident #9's room. LPN #6 stated it was not acceptable for it to be placed on the floor, and CNA #2 should have taken it to the rolling bin at the end of the hall to be destroyed before going to another resident's room.

During an interview, on 12/31/19 at 11:00 AM, LPN #2 stated that bagged dirty linen and garbage should not be left on the floor. When it is bagged, it should be taken to the dirty linen bin down the hall and then taken out. Linen bags should not be on the floor. LPN #2 stated it could be a definite infection control issue. LPN #2 stated the bags of dirty linen and garbage being placed on the floor could allow for germs to be transmitted from room to room.

During an interview, on 12/31/19 at 11:12 AM, the Director of Nursing (DON) stated the bags containing the dirty linen and garbage should not be placed on the floor. The bag that was being used by CNA #2 to discard the dirty linen should have been placed on the foot of Resident #9's bed and not on the floor. The bags of linens and the bags of trash should be removed immediately from the room when a CNA gets done. It is an infection control issue with the bags of dirty linen

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and garbage being left on the floor.

Resident #10

An observation during the general rounds, on 12/30/19 at 5:20 AM, revealed one bag of dirty linen and one bag of garbage on the floor of Resident #10's room. No staff was present in the room.

During an interview, on 12/30/19 at 5:30 AM, Certified Nursing Assistant (CNA) #3 stated she was assigned to Resident #10. CNA #3 stated she put the bag of dirty linen and the bag of garbage on the floor when she was finished providing care for Resident #10 and she should not have put them on the floor. CNA #3 stated she should have taken it to the bin to be destroyed.

During an interview, on 12/30/19 at 5:27 AM, LPN #6 revealed he saw the bags of dirty linen and garbage on the floor of Resident #10's room. LPN #6 stated it was not acceptable for it to be placed on the floor and CNA #3 should have taken it to the rolling bin at the end of the hall and destroyed it before going to another resident room.

During an interview, on 12/31/19 at 11:00 AM, Licensed Practical Nurse (LPN) #2/QA/Infection Control Nurse stated bagged dirty linen and bags of garbage should not be left on Resident #10's floor. When it is bagged, it should be taken to the dirty linen bin down the hall and then taken out. Dirty linen bags should never be placed on the floor. LPN #2 stated it could be a definite infection control issue. LPN #2 stated the bags of dirty linen and garbage being placed on the floor could allow for germs to be transmitted from room to

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F 880	Continued From page 22 room. During an interview, on 12/31/19 at 11:12 AM, the Director of Nursing (DON) stated if a resident has an infection of some type, the dirty linen or garbage bags being placed on the floor could allow those germs to be carried down the hall and into other resident's room.	F 880		