STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255314	A. BUILDING _____ B. WING _____	03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CARE CENTER	1920 LISA DRIVE EXTENDED GREENVILLE, MS 38703

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F 000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the Mississippi State Department of Health from 03/25/19 through 03/28/19. The facility was found to be not in substantial compliance with requirements of participation for Medicare and Medicaid and cited deficiencies at F565, F690, F712, F880, and F908. The facility had a census of 50 residents, and held a license for 60 beds.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the	F 565		5/1/19

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

Electronically Signed | 05/01/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 565	Continued From page 1 facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility grievances, it was determined the facility failed to ensure efforts were made to resolve grievances with the facility incontinent brief practice for nine (9) of 13 Residents (R), R #6, #8, #9, #14, #20 #26, #29, #33, and #34, attending the resident group meeting; and two (2) of 19 sample residents, R #22 and R #47, also reviewed. This deficient practice had the potential to affect the other 46 residents identified by the facility with incontinence out of total census of 50 residents. Findings include: The facility's "Grievances" policy, revised November 2017, documented, " ... Minutes of each Resident Council meeting are recorded ... Future meetings will indicate progress made on each suggestion/recommendation and/or the reasons(s) for rejection ..." The policy documented the facility would make prompt efforts to resolve grievances, and document follow through with the complainant. On 3/26/19, the administrator provided a signed	F 565	Resident Council was held by Administrator and Director of Nursing on 3/27/19 to discuss the fact that residents will be provided briefs as needed and there is no four (4) brief per resident rule. Residents #6, #9 and #47 were present for Resident Council Meeting on 3/27/19. Administrator met with Residents #22 and #29 to address brief issue on 4/30/19. All identified residents were satisfied with resolution to brief issue. Fifty-two (52) of (52) residents in the facility have the potential to be affected by this deficient practice. In-services on brief usage and the fact that there is no four (4) brief per day limit were conducted on 3/25/19, 4/2/19, 4/3/19, 4/4/19, 4/12/19 and 4/29/19 with Nurses, Certified Nursing Assistants and Housekeeping staff by Director of Nursing. Nurses and Certified Nursing Assistants were also in-serviced on 3/25/19, 4/2/19, 4/3/19, 4/4/19, 4/12/19 and 4/29/19 by Director of Nursing on	

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F 565	Continued From page 2 statement that the facility did not have a policy on daily brief usage. Resident #47: On 3/25/19 at 2:44 PM, during a resident interview, R #47 pointed to a stack of three (3) adult briefs laying on top of his dresser and stated, "This is something I don't like. They bring you four (4) diapers a day. That's all you get, and if you ask them to leave more, they won't. I thought Medicaid paid for them, but I guess they just pay for four (4) a day," R #47 stated if he required more than four (4) briefs per day, "My wife must go out and buy them. I try to wait as long as I can before I ask to be changed, because it seems like such a hassle." R #47 stated he and his wife had complained to the facility about this issue, but it was still not resolved. Review of the facility's "Grievance File" documented a 02/20/19, grievance from R #47's family member, upset due to the facility's "diaper shortage," and because she had to buy additional briefs for the resident. The facility's response was documented, "Administrator educated [family member's name] on how the diapers work" and "the facility also has cloth diapers that can be used as well." The "Grievance Form" documented the family member was still upset, so they offered a secure storage area for any additional briefs she purchased. No further resolution was documented for the concern. Resident #22: On 3/25/19 at 3:50 PM, R #22's representative stated, during a family interview, that the facility only supplied four (4) adult briefs per day. R #22's representative stated R #22 usually tried not to	F 565	resident grievances with policy titled "Grievances – Residents " with revision date of 11/17, specifically that residents have the right to file a grievance without fear of reprisal and that there is no (4) brief per day limit. The facility Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director and Department heads, met on 4/30/19 and reviewed policy and procedure titled "Grievances – Residents" with revision date of 11/17 and did not recommend any changes. Residents will be monitored through interviews on brief availability weekly for four (4) weeks and monthly for two (2) months by Administrator beginning 5/6/19. Any concerns will be brought to Administrator and Director of Nursing immediately. The Administrator will present any findings to the Quality Assurance Committee monthly for three (3) months then quarterly thereafter. Quality Assurance Committee will make recommendations or changes as needed.	

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F 565	Continued From page 3 void in the afternoons, so she had plenty of briefs for the evening and night. R #22's representative stated she was not aware of a time when the resident had been denied an extra brief if she needed it but stated, "It's a terrible thing to have to worry about all day. And I know she does worry, because when I visit that's one of the things she always talks about." Resident Group: On 3/26/19 at 10:05 AM, nine (9) of the residents in the resident group stated incontinent residents were given only four (4) adult briefs per day. The residents stated they had never been denied additional briefs if they needed them, but had repeatedly asked the facility to adapt their brief distribution system to reduce resident worry over brief usage. The residents stated the facility had not made any changes, and they felt it had been made clear that no changes would be forthcoming, so they had stopped complaining and made their own adaptations to cope with the lack of response by the facility. The residents reported that staff often chose to borrow briefs from another resident for them. Three (3) residents, who wanted to remain anonymous, stated they started asking for their "allotment" of four (4) briefs per day, so they could share them with other residents. Two (2) residents, who wanted to remain anonymous, stated they paid privately to stay at the facility, and bought their own briefs, but asked their families to supply additional briefs so they could share with others. Two (2) residents, who wanted to remain anonymous, stated they required extra large briefs stated the facility often did not have that size available, so staff would use a large size instead. R #6 stated the briefs had to be pulled so tight to fasten them that he sometimes sustained	F 565		

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F 565	Continued From page 4	F 565		

bruises, and the other stated she frequently stayed in her room when extra large briefs were not available so as not to become embarrassed if she became incontinent in a public setting and her waste leaked out of the smaller brief. R #12 stated when she saw she received extra large briefs for that day, she quickly stuffed them under her mattress, so staff did not see them there and take them for another resident. Seven (7) members of the group stated they started thinking about how to procure additional briefs from the moment staff left their "allotment" of four (4) briefs each morning and did not stop thinking about it all day.

Review of the Resident Council meeting minutes revealed on 01/23/19, "Residents were confused about diaper policy ... Administrator explained the policy on diapers. The facility provides four (4) diapers per day for each resident and we encourage residents to be 'open to air' at night to promote skin integrity. Administrator explained that we would not let residents go without diapers, but that he would work with families to provide extra diapers if the residents/families preferred more than four (4) a day." The Resident Council Minutes for 02/25/19, and 03/21/19, did not document follow-up discussion to confirm the issue had been resolved.

On 3/26/19 at 4:26 PM, the Administrator stated when he first started working in the facility a few months prior, he was informed that residents were allotted four (4) adult briefs per day, although there was no formal policy to that effect. The Administrator stated the facility requested resident families to provide additional briefs if a resident "preferred" more than four (4) briefs per day, regardless of payer source. The

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F 565	Continued From page 5 Administrator stated he had assured residents that if their family members refused to supply extra briefs, the facility could obtain one (1) for them. The Administrator stated the State Agency had recently been in the facility for a complaint investigation, became aware of the resident concerns, and told him the facility could be cited if the practice continued. The Administrator stated after that, he received permission to provide up to six (6) briefs per day if a resident needed them. The administrator stated, "I know it's a problem, and it embarrasses me that it's an issue, but the decision is made far above me or my boss." On 3/28/19 at 12:47 PM, Housekeeper (H) #1 stated she had worked at the facility "for years" and one (1) of her job duties was to distribute briefs to residents each morning. H #1 stated she had been instructed to give each resident four (4) briefs even if they requested more, and she had "never questioned it." H #1 stated she could give four (4) briefs per day to any resident who requested them, and did not know who was continent or incontinent, so if a resident asked she left them four (4)briefs. H #1 stated many residents had requested more than four (4) briefs "from time to time," but she just told them no. H #1 stated she had not been informed she could leave up to six (6) briefs per day after the recent complaint survey.	F 565		
F 690 SS=D	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	F 690		5/1/19

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F 690	Continued From page 6 condition is or becomes such that continence is not possible to maintain. §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 record review, interview, and policy review, the facility failed to ensure an individual toileting plan was developed for one (1) of 20 residents, Resident (R) #22, reviewed for incontinence. This deficient practice had the potential to affect the other 46 residents identified by the facility with incontinence out of a total census of 50 residents.	F 690	Resident #22 was started on three (3) day bladder/bowel continence pattern observation by Medical Records Nurse on 4/26/19. The completed bladder/bowel continence pattern was reviewed by the Nurse Case Manager and Director of Nursing on 4/30/19. Resident #22 was placed on a toileting plan based on the	

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F 690	Continued From page 7 Findings include: The facility's "Bowel and Bladder Retraining" policy, revised September 2018, documented the facility would complete a Nursing Data Collection tool upon admission and with each Minimum Data Set (MDS) to determine a resident's candidacy for a retraining program, and use the data collected to develop an individualized toileting plan. The facility did not use the data collected, per their policy, and develop an individualized toileting plan for Resident #22. Resident #22's quarterly MDS assessment with an Assessment Reference Date (ARD) of 01/22/19, documented she was admitted to the facility on 08/28/18, with diagnoses including Hypertension and Dementia. The MDS documented R #22 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderate cognitive impairment, required extensive assistance of one (1) person for toileting, was always incontinent of urine and frequently incontinent of bowel, and had not been tried on a toileting program. On 01/22/19, R #22's "Nursing Data Collection" tool documented a section for a Bowel and Bladder assessment. The form documented she was not on a toileting program and had not been tried on a program. The form documented a bowel and bladder retraining program overall score of 6, which indicated she was a "good candidate" for a retraining program. Review of R #22's "Care Plan" for Activities of Daily Living (ADL), initiated 08/28/18, documented she had a Foley [indwelling urinary]	F 690	reviewed pattern on 5/1/19 by the Director of Nursing. Three (3) of (52) residents were identified by the Director of Nursing on 4/30/19 as having the potential to be affected by the deficient practice. Three (3) of (3) residents were screened for bowel/bladder retraining which included the need for a toileting plan and one (1) of (3) residents were placed on an individualized toileting plan as a result of these screenings on 5/1/19 by the Director of Nursing. In-service on the policy titled "Bowel and Bladder Retraining" with a revision date of 9/18, was conducted on 5/1/19 with nine (9) of (9) Licensed Practical Nurses and two (2) of (2) Registered Nurses by the Director of Nursing. The in-service included that residents admitted with catheters will be screened for retraining when the catheter is discontinued and toileting plans initiated as indicated. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director and Department Heads, reviewed the policy titled "Bowel and Bladder Retraining" on 4/30/19 and did not recommend any changes. Bowel and Bladder screenings of residents completed by nurses will be monitored beginning 5/6/19 by the Director of Nursing and/or Medical Records Nurse weekly for four (4) weeks and monthly for two (2) months. Monitoring will include implementation of	

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F 690	Continued From page 8 catheter. The care plan intervention had not been discontinued or revised. An additional intervention to toilet the resident upon rising, before and after meals, at bedtime, and as needed was added on 12/23/18. On 3/25/19 at 3:44 PM, R #22's representative was interviewed with R #22 present. The representative stated prior to admission to the facility R #22 was continent but had become incontinent since admission to the facility. She stated R #22 had a catheter when first admitted to the facility, but it had been discontinued within a few days. R #22 stated, "I sit here in the afternoon and wonder when they are going to come in and take me to the toilet. I worry about it all the time." On 3/28/19 at 8:28 AM, the Director of Nursing (DON) stated R #22 had a catheter upon admission, but it had been discontinued as soon as the resident arrived. The DON stated the toileting times documented on R #22's care plan were designed to train her body to void at those times, as it was easier on staff if all residents had the same voiding schedule. The DON stated that R #22's care plan was not reflective of an individualized retraining program, or plan of care, and stated she was not aware whether R #22 had been continent prior to her admission and could not tell from looking at the documentation in her record.	F 690	toileting plan as indicated on the completed bowel and bladder screenings. Any findings are recorded on the medical record audit form and maintained by the Director of Nursing. The Director of Nursing will present findings to the Quality Assurance committee. The Quality Assurance Committee will address concerns and evaluate monitoring monthly for three (3) months then quarterly thereafter. Quality Assurance Committee will make recommendations or changes as needed.	
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first	F 712		5/1/19

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F 712	Continued From page 9 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on policy review, interview and record review it was determined the facility failed to ensure physician visits were conducted at least once every 60 days by their physician for two (2) of 18 sampled residents, Resident (R) #3 and R #44. This deficient practice had the potential to affect the total census of 50 residents in the facility. Findings include: The facility's "Physician Visit Tracking" policy, revised January 2015, documented residents would be seen by their physician every 30 days for the first 90 days of admission, then every 60 days thereafter. The facility failed to ensure physician visits with residents were conducting per the facility policy. The "Progress Notes" documented R #44 was	F 712	Physician for Resident #3 visited resident and wrote progress note on 4/30/19. Physician for Resident #44 visited on 3/9/19, Resident #44 expired on 4/13/19. Fifty-two (52) of (52) residents could have been affected by this deficient practice. As of 4/30/19, all physicians are compliant with visits. Medical Records sent letters to seven (7) of (7) facility physicians on 4/17/19 reminding them of the federal regulation regarding physician visits. In-service with Medical Records on 4/30/19 by Director of Nursing on policy titled "Physician Visit Tracking" with revision date of 1/15. The in-service included that the facility Medical Director can see residents if primary physician cannot and that the facility will	

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F 712	Continued From page 10 seen by her physician on 08/29/18, 11/3/18, and 03/9/19. The EMR did not document other physician's visits in R #44's electronic or paper medical record. The quarterly Minimum Data Set (MDS) found in R #44's electronic medical record (EMR) with an Assessment Reference Date (ARD), of 02/25/19, documented an original admission to the facility on 08/29/18, and readmission on 02/22/19. On 3/28/19 at 8:50 AM, Director of Nursing (DON) stated R #44 was followed by the facility's Medical Director (MD) #1. The DON stated she was not sure of the process the facility used to track the frequency of MD #1's visits, but suggested the Health Information Manager (HIM) may have more information. On 3/28/19 at 9:16 AM, the Health Information Manager (HIM) reviewed R #44's record and stated she was responsible for filing progress notes into the paper medical record. The HIM stated notes are left in her office and then she is responsible to file them in a resident's record. The HIM said she did not know how the facility tracked the frequency of MD #1's visits. Resident #3: Resident #3's record documented "Physician Progress Notes" on 7/31/18, 11/3/18, and 3/9/19. There were no further "Physician Progress Notes" documented in R #3's electronic or paper medical record. The MDS found in R #3's EMR with an ARD of 12/24/18, documented she was admitted to the facility on 08/02/17, with diagnoses of Diabetes mellitus and Bipolar disorder.	F 712	mail letters to physicians up to one (1) week prior to required visit. Facility Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director and Department heads, met on 4/30/19 and reviewed policy titled "Physician Visit Tracking" and did not recommend any changes. Beginning 5/6/19, facility Administrator, Director of Nursing and Medical Records will monitor the timeliness of physician visits weekly for (4) weeks and monthly for (2) months with findings recorded on Physician Visit Log. Director of Nursing will present findings to Quality Assurance Committee monthly for (3) months then quarterly thereafter. Quality Assurance Committee will make recommendations or changes as needed.	

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	255314	A. BUILDING _____ B. WING _____	03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CARE CENTER	1920 LISA DRIVE EXTENDED GREENVILLE, MS 38703

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F 712	Continued From page 11 On 3/28/19 at 1:47 PM, the Administrator stated he was not aware MD #1 had not been completing compliance visits as required, and the facility would work with him to resolve the issue.	F 712		
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 persons in the facility;	F 880		5/1/19

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F 880	Continued From page 12 (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, interview, record review, and policy review, the facility failed to follow infection control practices to prevent the spread of infection throughout the facility. Specifically, the	F 880	Antibiotic Stewardship utilization reports, which included a letter explaining antibiotic utilization for the first quarter of 2019, were mailed to seven (7) of (7)	

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F 880	Continued From page 13 facility failed to: 1. Ensure infection control monitoring of hospital acquired infections and antibiotic stewardship data were analyzed to determine a cause and effect for infection prevention purposes, set goals, and determine any trending; 2. Ensure transmission-based precautions were followed when providing care to residents in the facility; 3. Ensure the facility's staff reviewed the infection control policy annually; and 4. Ensure a proper sanitary environment was maintained in the clean and soiled laundry rooms. This deficient practice had the potential to affect 50 of 50 residents in the facility. Findings include: 1. The facility's policy titled, "Antibiotic Stewardship" revised 10/18, documented, "The drug name, dose, frequency of administration, duration of treatment, route of administration, and indications for use shall be specified by the prescriber for each course of antibiotics ... Monthly reports utilizing infection Control/Antibiotic Stewardship Monthly Report NS-650 shall be reported internally in conjunction with the monthly Infection Control meeting. Reports shall be communicated to physicians utilizing the Letter to MD NS-877 and the Antibiotic Utilization Report in AHT (Quality Assurance > Infection Control > Antibiotic Utilization Report) in conjunction with the QA meeting." The facility's policy did not address the trending of data and the analysis monitoring, setting goals or expectations, using benchmarks as guidelines, or implementing performance actions to effect change.	F 880	attending physicians by the Director of Nursing on 4/12/19. Whirlpool tub seat cushions were replaced by Maintenance and Administrator on 3/28/19. Infection Control and Prevention Manual was reviewed by the Quality Assurance Committee. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director and Department Heads, approved and adopted the manual on 4/30/19 with no changes recommended. The laundry department was cleaned on 4/2/19 by Maintenance. Fifty-two (52) of (52) residents were identified by the Director of Nursing on 4/30/19 as having the potential to be affected by the deficient practice. None of the (52) residents reviewed were affected by the deficient practice. In-service was conducted on 5/1/19 with nine (9) of (9) Licensed Practical Nurses and two (2) of (2) Registered Nurses by the Director of Nursing on the policy titled "Antibiotic Stewardship," with a revision date of 10/18, and included proper use of antibiotics. In-service was conducted by the Director of Nursing on 5/1/19 with Maintenance and Nurse Case Manager on policy titled "Environmental Rounds in Infection Control," with an original date of 6/14 and included reporting any fault with equipment. In-service was conducted by the Director of Nursing on 5/1/19 with Laundry Department on policy titled "Infection Control Laundry Department," with an original date of 6/14, and included	

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F 880	Continued From page 14 Review on 03/27/19 at 9:00 AM, of the antibiotic stewardship data identified raw numbers were gathered related to the facility policy. The documentation lacked evidence that trends, facility goals were set, specific analysis or trending was conducted. The documentation identified only who ordered the antibiotic. In an interview on 03/27/19 at 11:15 AM, the Nurse Case Manager (NCM) said that she was only acting as the Infection Control Preventionist (ICP) because the former ICP was let go the previous week. The NCM stated the documentation reviewed was from the former ICP's data gathering and antibiotic stewardship program. The NCM confirmed the information did not include documentation of analysis, trending and goal setting. On 03/27/19 at 11:30 AM, the Quality Improvement Nurse said that the quality department did not monitor infection control measures. 2. The facility's policy titled, "Environmental Rounds in Infection Control" dated 07/11, documented, "It is the policy of this facility that the Infection Preventionist or other appropriate designee completes environmental rounds on a regular basis. Environmental rounds will be an integral part of the daily routine and also will be performed regularly throughout the entire facility. The Infection Preventionist will report areas of noncompliance. This report and a corrective action form will be distributed to the supervisors of each area. The corrective action plan will be completed by the supervisor and will outline the corrective actions to be taken and the anticipated completion dates." The facility's staff was not	F 880	cleanliness of the laundry department. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director and Department Heads, reviewed the policies titled "Antibiotic Stewardship," "Environmental Rounds in Infection Control," and "Infection Control Laundry Department." The Quality Assurance Committee did not recommend any changes. Beginning 5/13/19, antibiotic utilization reports completed by the Staff Development Nurse will be printed monthly for three (3) months and sent to the physicians by the Director of Nursing, Nurse Case Manager and/or Staff Development Nurse. Copies will be maintained in the infection control binder by the Director of Nursing. Beginning 5/6/19, environmental rounds will be made weekly for four (4) weeks and monthly for two (2) months by the Staff Development Nurse, Maintenance, Nurse Case Manager, and/or Director of Nursing. Inspection of whirlpool and laundry department will be recorded on the rounds flow record and maintained by the Administrator. The Administrator and/or Director of Nursing will submit findings to the Quality Assurance Committee. The Quality Assurance Committee will address concerns and evaluate monitoring monthly for three (3) months then quarterly thereafter. Quality Assurance Committee will make recommendations or changes as needed.	

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F 880	Continued From page 15 following the policy by inspecting for breaches of infection control. Observation on 03/26/19 at 10:20 AM, of the bath room, revealed the whirlpool tub chair had a vinyl seat that was cracked and open on all edges and three (3) long cracks in the middle of the pad. This was a breach in the integrity of the vinyl where micro-organism's grow and can cause a risk of infection or bacterial growth. In an observation and interview on 03/27/19 at 11:35 AM, with the Director of Nursing (DON), held in the bath room, the whirlpool tub seat was discussed. The DON was not aware the seat was cracked. The DON stated to the Administrator that they probably had some other seat pads in the storage building. In an interview on 03/27/19 at 11:40 AM, with the Administrator, held in the bath room, the Administrator confirmed he was not aware of the condition of the seat on the whirlpool tub, but stated they would get it replaced. 3. The facility's manual titled, "Infection Control and Prevention Manual" dated 07/11, documented, "This policy and procedure manual was reviewed, approved and adopted by the Quality Assessment and Improvement Committee as dated below." [Medical Director 8/4/17, Administrator 8/4/17, Director of Nursing 8/4/17]" The area for signatures documented, "Annual Review" that had no signatures in the area. The facility's staff was not following their policy to review the Infection Control Manual or policy annually. In an interview on 03/27/19 at 11:10 AM, the	F 880		

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F 880	Continued From page 16 Nurse Case Manager (NCM) said she was only acting as the Infection Control Preventionist (ICP). The former ICP was let go on the previous week because the duties for the infection control program were not being completed. 4. The facility's policy titled, "Infection Control Laundry Department" dated 06/14, documented, "It is important to maintain a clean, safe and sanitary environment for our residents. This is accomplished by appropriate cleaning of the facility and resident linen ... Laundry area must be kept clean with routine mopping of floors with disinfectant material." The facility's staff did not follow their policy to keep the laundry areas clean. On 03/26/19 at 11:10 AM, observation of the laundry areas of the facility revealed dirty walls and floors in the soiled laundry room. The room was very cluttered and appeared to be used as storage for buckets, mops, and crates, all where the washing machines were stored. In the clean laundry room there were two (2) long table tops used for folding clean laundry. The tile floors were dirty with stain and debris. Observation identified the laundry aide dropped a wash cloth on the floor, picked it up and placed it on the tabletop with other clean towels. On 03/27/19 at 12:00 PM, an interview was conducted with the Administrator in the soiled and clean laundry rooms. On opening the door, the clutter from 03/26/19, had been removed, but the room was still dirty. The clean laundry room was in the same condition as observed on 03/26/19. The Administrator confirmed the rooms needed to be cleaned and he planned to clean and polish the floors the coming weekend.	F 880		

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F 908	Continued From page 17	F 908		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on policy review, observation, and staff interview, the facility failed to maintain the whirlpool tub chair in safe and clean operating condition. This deficient practice had the potential to affect all 50 residents in the facility. Findings include: A facility policy titled, "Typical Duties of the Infection Preventionist" dated 06/14, documented, "Conduct periodic rounds address/find areas of concern. Identify areas of new or excess concern." The facility's Infection Control Preventionist was not following the policy for periodic rounds in the bath room to check equipment for breaches in infection control and the need for repair. Observation on 03/26/19 at 10:20 AM, of the bath room, revealed the whirlpool tub chair had sharp edges along each side of the chair. There were cut and scratch marks in the slightly raised areas on each side. On 03/27/19 at 11:35 AM, the Director of Nursing (DON) observed the whirlpool tub chair and said she was not aware of the sharp edges on the chair. The DON confirmed the edges were sharp and could be a risk to residents. In an interview on 03/27/19 at 11:40 AM, the	F 908	Whirlpool tub seat cushions were replaced by Maintenance and Administrator on 3/28/19. Rough edges on whirlpool tub were caulked on 3/27/19 by Maintenance. Fifty (50) of (52) residents have the potential to be effected by these deficient practices. No residents were affected. Infection Control in-service was conducted by Director of Nursing on 4/2/19 with bath aides. In-service included reporting any fault with equipment to Director of Nursing, Administrator and/or Charge Nurse. Facility Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director and Department Heads, met on 4/30/19 and discussed policy titled "Typical Duties of the Infection Preventionist," with revision date of 6/14 and did not recommend any changes. Administrator, Maintenance and/or Director of Nursing will monitor whirlpool equipment through observations weekly for four (4) weeks starting 5/6/19 and monthly for two (2) months. Any concerns will be reported to facility Quality Assurance Committee by the	5/1/19

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F 908	Continued From page 18 Administrator observed the whirlpool tub chair's sharp edges. The Administrator said he was not aware the whirlpool tub chair had sharp edges, but stated the facility would repair the chair by putting some epoxy on the edges.	F 908	Administrator, Director of Nursing and/or Maintenance monthly for three (3) months and quarterly thereafter. Quality Assurance Committee will make recommendations or changes as needed.	

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain a complete manual fire alarm system as directed by NFPA 72 code 1-5.4.6, and NFPA 101 section 9.6. The deficient practice affected two (2) of two (2) smoke compartments in facility on the day of survey. Findings include: On April 2, 2019 at 11:10 AM, observation revealed a "smoke detector" trouble signal on the fire alarm system panel of the facility. It was also revealed the Maintenance Supervisor was unable to reset the fire alarm system to normal status, but the fire alarm system was functioning properly.	K 345	Administrator notified fire alarm servicing company on 4/2/19 that fire panel was indicating a trouble signal. Fire panel servicing company came and corrected issue on 4/3/19. This deficient practice had the ability to affect 52 of 52 residents. Administrator in-serviced Maintenance Director on 4/29/19 to notify Administrator if there is an issue with fire alarm panel. Fire alarm panel will be monitored weekly for (4) weeks and monthly for (2) months by Administrator. Any concerns will be corrected immediately and reported to	5/1/19

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

Electronically Signed | 05/01/2019

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K 345	Continued From page 1 The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on April 2, 2019.	K 345	facility Quality Assurance Committee monthly for (3) months and quarterly thereafter. This will be completed by 5/3/19	

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 4/2/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

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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.