STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BRIDGER AVE PINEDALE, WY 82941

(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 A recertification survey was conducted by Healthcare Licensing and Surveys from 3/11/19 to 3/14/19. The following common abbreviations are used throughout this document: BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 604		4/22/19

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

Electronically Signed | 04/03/2019

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F 604	Continued From page 1 §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interviews, the facility failed to ensure restraints were used to treat a medical condition, that the restraint was the least restrictive intervention, and that there was on-going evaluation for 1 of 6 sample residents (#18) with restraints. The findings were: 1. Review of the 2/6/19 quarterly MDS assessment revealed resident #18 had a BIMS score of 14 (intact cognition). Observation on 3/12/19 at 8:50 AM revealed CNA #1 and CNA #2 transferred the resident into a recliner in his/her room. The CNAs used the control for the recliner to recline the chair and elevate the resident's feet. The CNAs then disconnected the control, and placed it in a drawer across the room. During an interview at the time, the CNAs stated they removed the control so the resident would not use it to lower his/her feet and try to walk. During an interview on 3/12/19 at 12:53 PM the resident stated s/he was unable to change his/her position in the recliner if s/he wanted because staff removed the control because they didn't want him/her to use the control to lower the foot of the	F 604	F604: The facility failed to ensure restraints were used to treat a medical condition, that the restraint was the least restrictive intervention, and that there was on-going evaluation for 1 of 6 sample residents (#18) with restraints. 1. The issue for this resident was corrected by doing both a Physical Restraint Elimination Assessment on 03/27/19 and a Pre-Restraint Assessment on 03/29/19, both assessments indicated that the restraint was the least restrictive intervention. 2.Consent form was obtained and recommended the use of a restraint to treat symptoms of specific targeted behaviors and/or a medical condition. 3.All residents who are assisted into recliners had an audit to ensure that recliner use did not impose or restrict movement(position change). For those who were in "a chair that prevents rising", medical records and MDS review were completed to ensure audits, assessments and consents were completed/signed and	

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F 604	Continued From page 2 recliner. During an interview on 3/13/19 at 3:50 PM RN #1 stated staff removed the control for the recliner so the resident could not use it to lower the foot of the recliner and try to get up. The following concerns were identified: a. Review of the medical record showed no documentation of any medical symptoms related to staff removing the control for the recliner, nor was there evidence of on-going assessment to determine the continued need to remove the control for the recliner. d. On 3/13/19 at 4:19 PM the administrator stated that staff removing the control for the recliner would be considered a restraint because it restricted freedom of movement (positional change), and confirmed the facility had not gone through the normal assessment process for restraints.	F 604	that appropriate documentation, including regular review. This review was completed on 04/15/2019. 4. The Director of Nursing held a nurses meeting on 04/01/2019 and CNA manager held a CNA meeting on 04/02/2019 that educated staff on restraint use, what constitutes a restraint, appropriate documentation and consent along with the importance of following the resident's established care plan. 5. The Director of Nursing will audit all residents quarterly to ensure there are no undocumented restraints, alarms, etc... and that those residents with restraints have devices which are the appropriate and least restrictive implemented. DON will audit for appropriate documentation, regular review and MDS accuracy with a goal of reducing restraints where possible. 6. The Director of Nursing will report on facility restraint use as a function of our regularly scheduled QAPI on June 12, 2019.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or	F 623		4/3/19

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discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email),

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and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of

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F 623	Continued From page 5 the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a transfer notice was issued for 3 of 3 sample residents (#1, #8, #20) with hospital transfers. The findings were: 1. Review of the medical record for resident #1 showed s/he was transferred to the hospital on 2/21/19 for an evaluation. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 2. Review of the medical record for resident #8 showed s/he was transferred to the hospital on 7/2/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 3. Review of the medical record for resident #20 showed s/he was transferred to the hospital on 11/16/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 4. Interview with the administrator 3/13/19 2:52 PM revealed the facility had not issued written notices of transfer with all the required information to the residents or the residents' representative.	F 623	F623: The facility failed to ensure a transfer notice was issued for 3 of 3 sample residents (#1, #8, #20) with hospital transfers. The facility will correct this issue by: 1. A notice of transfer/discharge was developed on 03/25/2019. This form includes the specific reason for the transfer/discharge, date, location, explanation of the resident's right to appeal. All medical charts for this facility include a folder specifically for transfers/discharge which currently includes POLST forms and pertinent medical information. The transfer/discharge form has been placed in this folder to assist in reminding staff of its necessity. In the event a resident is not able to sign/understand at the time of transfer/discharge, social services will follow up as soon as practical. 2. An in-service meeting was held with the nursing staff on 04/01/2019 which reviewed the importance of informing residents about their rights with regard to transfers as well as their transfer status. 3. Social services will audit all transfers and discharges for a minimum of the next six months to ensure that documentation was given to the resident or family (as appropriate) upon transfer/discharge and that copy has been filed in the medical	

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F 623	Continued From page 6	F 623	chart. Social Services will ensure that the Ombudsman is informed about all transfers/discharges. 4. Social services will report as a function of our regularly scheduled QAPT on June 12th.	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		4/4/19

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F 625	Continued From page 7 by: Based on medical record review and staff interview, the facility failed to provide written information on the bed-hold policy for 3 of 3 sample residents (#1, #8, #20) with hospital transfers. The findings were: 1. Review of the medical record for resident #1 showed s/he was transferred to the hospital on 2/21/19 for an evaluation. Further review showed no evidence the facility issued a written notice of bed-hold policy to the resident or the resident's representative. 2. Review of the medical record for resident #8 showed s/he was transferred to the hospital on 7/2/18. Further review showed no evidence the facility issued a written notice of bed-hold policy to the resident or the resident's representative. 3. Review of the medical record for resident #20 showed s/he was transferred to the hospital on 11/16/18. Further review showed no evidence the facility issued a written notice of bed-hold policy to the resident or the resident's representative. 4. Interview with the administrator on 3/13/19 at 2:52 PM revealed the facility had not issued written notices of the bed-hold policy to the residents or the residents' representative.	F 625	F625: The facility failed to provide written information on the bed-hold policy for 3 of 3 sample residents (#1, #8, #20) with hospital transfers. The facility will correct this deficiency by: 1. The facility bed hold policy was reviewed and amended to be congruent with State Policy on 03/27/2019 and will be provided in writing both at admission and at the time of transfer. All medical charts for this facility include a folder specifically for transfers/discharge which currently includes POLST forms and pertinent medical information. The bed hold policy has been placed in this folder to assist in reminding staff of its importance. In the event a resident is not able to understand the bed hold policy at the time of transfer, social services will follow up with resident or family as soon as practical. 2. An in-service was held with nursing staff on 04/01/2019 to educate them on bed hold policy and procedure. Billing staff will attend an in-service reviewing the same information on 04/04/2019. 3. Social Services will audit all transfers for the next six months to ensure the bed hold policy was given to residents or families at the time of transfer or as soon after transfer as practical. 4. Social Services will report on their findings at the next regularly scheduled QAPI on June 12th.	

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F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any	F 660		4/1/19

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referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to ensure the development and implementation of a discharge

F660: The facility failed to ensure the development and implementation of a discharge plan for 1 of 2 sample residents

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F 660	Continued From page 10 plan for 1 of 2 sample residents (#29) who were discharged. The findings were: 1. Review of the medical record for discharged resident #29 on 3/13/19 10:22 AM showed that a comprehensive discharge plan had not been developed. An "Interdisciplinary Discharge Summary" that was used as documentation was not complete, and did not include elements necessary to prevent unnecessary readmissions such as a reconciliation of pre and post discharge medications. There was no indication of where the resident planned to live, nor was there documentation that pertinent labs, prescriptions, or new home medications had been forwarded to the resident's primary care provider. 2. In an interview on 3/13/19 04:45 PM, the administrator and medical records staff #1 confirmed that the "Interdisciplinary Discharge Summary" was the only documentation in use and acknowledged it did not meet all of the requirements.	F 660	(#29) who were discharged. To correct this deficiency: 1. MDS created a form with nursing and medical records that addresses medications, discharge location, continuing care such as home health or outpatient therapy, follow up appointment or contact information for the resident/family to make appointment independently, future labs such as INR, supplies needed and medical conditions that may be new or changed. This form will be completed in conjunction with the medical provider and copied for patient prior to discharge. 2. Nurses were educated at an in-service on 04/01/2019 regarding new discharge form and education to be provided to residents/families at the time of discharge. 3. MDS will follow up with discharges over the next six months in both chart review and follow up call to ensure the resident/family achieved understanding of future care at the time of discharge. Any misunderstandings will be cleared at this time with a goal of ensuring successful transition to the next location of service or home. 4. MDS nurse will report on her findings as a function of our regularly scheduled QAPI on June 12th.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv)	F 661		4/3/19

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F 661	Continued From page 11 §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide the necessary elements of a discharge summary for 1 of 2 sample residents (#29) discharged. The findings were: 1. Review of the medical record for discharged resident #29 showed that the form with the heading "Interdisciplinary Discharge Summary"	F 661	F661: The facility failed to provide the necessary elements of a discharge summary for 1 of 2 sample residents (#29) discharged. The facility will correct this deficiency by: 1. MDS created a form with nursing and medical records that addresses medications, discharge location,	

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F 661	Continued From page 12 did not include diagnoses, pertinent lab results, a reconciliation of all pre-discharge medications with post-discharge medications, or a post-discharge plan of care indicating where the individual planned to reside. There was no documentation of arrangements for follow up care, ordered lab work, or continued medication oversight. Review of the Medication Administration Record (MAR) showed an order for Coumadin using alternate day dosing had been changed three times since admission in December 2018. These changes and future dosing plans were not addressed in the Interdisciplinary Discharge Summary. 2. Interview with the administrator and medical records staff #1 on 3/13/19 4:45 PM confirmed that the Interdisciplinary Discharge Summary was the only form in use for discharges and they acknowledged it was incomplete.	F 661	continuing care such as home health or outpatient therapy, follow up appointment or contact information for the resident/family to make appointment independently, future labs such as INR, supplies needed and medical conditions that may be new or changed. This form will be completed in conjunction with the medical provider and copied for patient prior to discharge. The contents of the form will be added to the recapitulation of stay currently done by IDT. 2. IDT was educated on 04/03/2019 on the importance of including diagnoses, pertinent lab results, medication reconciliation, and post-discharge plan of care. 3. The Administrator or designee will review closed charts within one week of discharge for the next 20 discharges to ensure proper documentation and that post discharge plan of care was completed with a goal of ensuring successful transition to alternate place of service or home. 4. The Administrator will report as a function of our regularly scheduled QAPI on June 12th.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		4/1/19

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F 755	Continued From page 13 §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure medications available for use were not expired in 1 of 2 medication carts (North medication cart). The findings were: 1. Observation during medication pass on 3/12/19 at 4:25 PM of the North medication cart showed the following concerns: a. One vial of Humulin R 100 units/milliliter	F 755	F755: the facility failed to ensure medications available for use were not expired in 1 of 2 medication carts (North medication cart). The findings were: Observation during medication pass on 3/12/19 at 4:25 PM of the North medication cart showed the following concerns: a. One vial of Humulin R 100 units/milliliter (ml) insulin showed no	

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F 755	Continued From page 14 (ml) insulin showed no written expiration date. b. Three Levemir flex touch insulin pens 100 unit/ml showed no written expiration date. c. One Humalog injection insulin pen 100 unit/ml showed no written expiration date. Interview with RN #2 at that time confirmed the medications had no written date, and were available for use. 2. Interview with the DON on 3/13/19 at 3:58 PM revealed it was the facility expectation that the medications were labeled with expiration dates, and they were to be discarded when expired. 3. Review of the policy named "Administering Medication" established on 4/05 showed "...7. a...Insulin must have expiration date from date of opening labeled on the outside of the bottle."	F 755	written expiration date. b. Three Levemir flex touch insulin pens 100 unit/ml showed no written expiration date. c. One Humalog injection insulin pen 100 unit/ml showed no written expiration date. The facility will correct this deficiency by: 1. The DON audited the medication carts and if insulin bottles or pens in the carts were not labeled then they were disposed of and new insulin bottles and pens were opened and labeled with the date of opening. 2. This deficiency has the potential to effect all IDDM residents who receive insulin. A nurse meeting was held on 4/1/19 and nurses were provided education that insulin bottles and pens are required to be labeled with the date opened and discarded after 30 days. A sign out sheet was created for nurses to sign out insulin and check if they dated the insulin. 3. The DON will audit this sign out sheet as well as both medication carts monthly. 4. The sign out sheet and results of cart audits will be presented by the DON as a function of our regularly scheduled QAPI on June 12th and quarterly thereafter as needed.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		4/26/19

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F 880	Continued From page 15	F 880		

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

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F 880	Continued From page 16 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, medical record review and staff interview, the facility failed to ensure staff utilized infection prevention techniques for 1 of 2 sample residents (#1) with a urinary catheter. The findings were: 1. Observation of resident #1 on 3/12/19 at 5 PM showed the resident was on contact isolation for extended spectrum beta-lactamases (ESBL) in the urine. Continued observation showed the resident's Foley catheter bag was uncovered and lying on the floor. a. Interview on 3/12/19 at 5:14 PM with RN	F 880	F880: The facility failed to ensure staff utilized infection prevention techniques for 1 of 2 sample residents (#1) with a urinary catheter. The findings were: Observation of resident #1 on 3/12/19 at 5 PM showed the resident was on contact isolation for extended spectrum beta-lactamases (ESBL) in the urine. Continued observation showed the resident's Foley catheter bag was uncovered and lying on the floor. 1. Resident's catheter bag was placed in a	

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F 880	Continued From page 17 #2 revealed the Foley bag should always be off the floor and covered. b. During an interview on 3/13/19 at 2 PM the infection control nurse stated the expectation was that catheter bags should be covered and not laying on the ground.	F 880	bath basin and covered with a towel, which will be changed out every three weeks at the same time as this resident's catheter change procedure. The towel will be changed daily and as needed. All other residents in the facility who utilize catheters were audited to ensure compliance with infection control standards. 2. An in-service addressing proper infection control as it pertains to catheter bags, residents rights vs facility need to provide infection control and the importance of following the individualized plan of care is scheduled for April 26th. 3. The infection control nurse will audit residents with catheters monthly to ensure infection control standards are being met. This nurse will also audit the plan of care for residents with indwelling catheters to ensure staff are following the plan of care. 4. The infection control nurse will report findings at the next regularly scheduled QAPI meeting on June 12th.	