STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035225	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUN CITY HEALTH AND REHABILITATION CENTER	9940 WEST UNION HILLS DRIVE SUN CITY, AZ 85373

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F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation, and policy review, the facility failed to implement their abuse policy, by failing to conduct a thorough investigation regarding abuse allegations for one of two sampled residents (#12). The deficient practice could result in further potential abuse. Findings include: -Resident #12 was admitted on (MONTH) 26, (YEAR) with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 24, 2019 revealed a BIMS score of 14, which indicated the resident had intact cognition. The facility's investigative report dated (MONTH) 31, 2019 revealed that on (MONTH) 28, 2019 at 2:00 p.m. the resident had complained to the DON that on the prior evening (January 27, 2019) an LPN (Licensed Practical Nurse/staff #89) had refused to allow her to lay down, told her she must eat in her room, refused to give her medication, and yelled at her to stop using your call light, you get one call a shift and you have called way too much. The report also included the resident felt unsafe with staff #89 working. Continued review of the investigative report revealed that staff #89 refused to provide a statement to the investigator, refused to participate in the investigation and was terminated from employment. However, there was no documented evidence that any additional staff had been interviewed, or that any witness statements had been obtained from additional staff that may have been present at the time of the alleged incident on the evening of (MONTH) 27, 2019. An interview was conducted on (MONTH) 18, 2019 at 12:06 p.m. with the DON (staff #30). The DON stated that allegations of abuse are investigated by the Administrator, social worker, and himself. He stated that he interviews all of the staff who were working at the time of the alleged incident to determine if there were any witnesses. The DON stated that he did not participate in this investigation, that it was completed by a staff member who is no longer at the facility. During an interview conducted on (MONTH) 18, 2019 at 12:25 p.m. with the Administrator (staff #45), she stated that when an allegation of abuse is investigated, they obtain statements from other staff who may have been present at the time of the incident. The administrator stated that without staff statements she could not determine if there were any witnesses to the alleged abuse. The facility's policy and procedure titled Abuse Prohibition included that the facility will prohibit abuse and mistreatment of [REDACTED]. The policy included that the facility will initiate an investigation within 24 hours and the investigation will be thoroughly documented with a statement that read Ensure that documentation of witnessed interviews is included. The policy also included the findings of all completed investigations will be reported to the SA within 5 working days.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation, and policy review, the facility failed to ensure allegations of abuse were thoroughly investigated for one of two sampled residents (#12). The deficient practice could result in the potential for further abuse. Findings include: -Resident #12 was admitted on (MONTH) 26, (YEAR) with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 24, 2019 revealed a BIMS score of 14, which indicated the resident had intact cognition. A social service note dated (MONTH) 28, 2019 at 2:38 p.m. revealed the resident reported an incident that had occurred on the evening of (MONTH) 27, 2019. The resident did not feel safe having a specific staff taking care of her. The note included the resident stated that she would feel safer if she received her medications on time and if other staff members provided her care. The facility's investigative report dated (MONTH) 31, 2019 revealed that on (MONTH) 28, 2019 at 2:00 p.m. the resident had complained to the DON that on the prior evening (January 27, 2019) an LPN (Licensed Practical Nurse/staff #89) had refused to allow her to lay down, told her she must eat in her room, refused to give her medication, and yelled at her to stop using your call light, you get one call a shift and you have called way too much. The report also included the resident felt unsafe with staff #89 working. Continued review of the investigative report revealed that staff #89 refused to provide a statement to the investigator, refused to participate in the investigation and was terminated from employment. However, there was no documented evidence that any additional staff had been interviewed, or that any witness statements had been obtained from additional staff that may have been present at the time of the alleged incident on the evening of (MONTH) 27, 2019. An interview was conducted on (MONTH) 18, 2019 at 12:06 p.m. with the DON (staff #30). The DON stated that allegations of abuse are investigated by the Administrator, social worker, and himself. He stated that he interviews all of the staff who were working at the time of the alleged incident to determine if there were any witnesses. The DON stated that he did not participate in this investigation, that it was completed by a staff member who is no longer at the facility. During an interview conducted on (MONTH) 18, 2019 at 12:25 p.m. with the Administrator (staff #45), she stated that when an allegation of abuse is investigated, they obtain statements from other staff who may have been present at the time of the incident. The administrator stated that without staff statements she could not determine if there were any witnesses to the alleged abuse. The facility's policy and procedure titled Abuse Prohibition included that the facility will prohibit abuse and mistreatment of [REDACTED]. The policy included that the facility will initiate an investigation within 24 hours and the investigation will be thoroughly documented with a statement that read Ensure that documentation of witnessed interviews is included. The policy also included the findings of all completed investigations will be reported to the SA within 5 working days.
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure 1 of 4 sampled residents (#59) received an adequate number of showers. The census was 65. The deficient practice could result in hygiene needs not being met, Findings include:

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

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Resident #59 was readmitted to the facility on (MONTH) 11, 2019, with [DIAGNOSES REDACTED]. Review of the facility's shower schedule located in the staffing book revealed residents are scheduled at least 2 times a week for showers and to document in the electronic record and on the shower sheet. The quarterly Minimum Data Set assessment dated (MONTH) 17, 2019, revealed a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The assessment included showers did not occur during the 7-day look-back period. Review of the shower sheets for resident #59 revealed no second shower offered as scheduled during the weeks of: (MONTH) 17-23, 2019, (MONTH) 31 to (MONTH) 6, 2019, and (MONTH) 7-14, 2019. Further review of the clinical record did not reveal documentation of any showers provided to the resident or any showered refused by the resident on those dates. Review of the care plan dated (MONTH) 12, 2019 revealed that the resident was at risk for decreased ability to perform Activities of Daily Living (ADL) in bathing related to [MEDICAL CONDITION]. During an interview conducted with the resident on (MONTH) 15, 2019 at 1:36 p.m., she stated that she did not receive her last two showers. An interview was conducted with a Certified Nursing Assistant (CNA/staff #14) on (MONTH) 19, 2019 at 10:55 a.m. She stated that all residents are scheduled to be offered a shower at least two times a week and that the schedule is located in the staffing book. The CNA stated that they use shower sheets to document the shower was given with any noted skin changes. She stated that the nurse and CNA would sign the sheet and the resident would sign the sheet if the resident refused the shower. She stated that if the shower is not documented as given or refused, then it could mean that the resident was not offered the shower. The CNA stated that the expectation is that the showers be offered to the residents as scheduled and that the documentation be completed. During an interview conducted with a Licensed Practical Nurse (LPN/staff #56) on (MONTH) 19, 2019 at 11:09 a.m., she stated that they have a shower schedule and each resident is scheduled for two showers a week. She stated that the CNA is expected to offer the shower as scheduled and to document any skin or other changes on the shower sheet. The LPN stated that the CNA is to notify the nurse if the resident refuses the shower. She stated that if the resident is alert and oriented, the resident will sign the shower sheet if the resident refuses the shower. The LPN stated that if there was no shower sheet, or other documentation, for the scheduled shower, there would be no way to show the shower was offered, given, or refused. An interview was conducted with the Administrator (staff # 45) on (MONTH) 19, 2019 at 11:22 a.m. She stated that she expects staff to offer showers to the resident on their scheduled shower days. She stated that she expects staff to document on the shower sheet which would include if the resident was provided the shower or refused the shower and turn it into the nurse. The Administrator stated that if there is no documentation of the shower in the clinical record and the resident stated that they did not get the shower; then it means the shower was not given, offered, or refused. Review of the facility's policy for Activities of Daily Living (ADL) revealed that the center must ensure that a resident who is unable to carry out ADL's receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The policy included the purpose is to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to ensure one sampled resident (#28) received treatment and care in accordance with professional standards of practice, by failing to schedule an appointment ordered by the physician. The census was 65. The deficient care could affect continuity of care. Findings include: Resident #28 was admitted to the facility on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED]. Review of the recapitulation of physician's orders [REDACTED]. Review of the clinical record revealed no evidence the resident was seen by a gynecologist or no rationale why an appointment not being made. During an interview conducted with a Licensed Practical Nurse (LPN/staff #18) on (MONTH) 17, 2019 at 9:56 AM, the LPN stated that at the time the order was written, there was a different procedure for scheduling appointments. The LPN stated that medical records now schedule appointments. During another interview conducted with the LPN (staff #18) on (MONTH) 18, 2019 at 9:05 AM, she stated that she was unable to locate any information regarding the appointment. In an interview conducted on (MONTH) 18, 2019 at 1:18 PM with the Administrator (staff#45), the Administrator stated her expectation is that if there is a physician's orders [REDACTED]. She further stated that refusals and calls to the physician need to be documented. An interview was conducted on (MONTH) 18, 2019 at 3:20 PM with the Director of Nursing (DON/staff #30). The DON stated that the process for scheduling outside appointments would include receiving a physician order, scheduling the appointment, and setting up transportation. The DON also stated that he could not explain why there seemed to be no information regarding this order for an appointment.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure 1 of 3 sampled residents (#28) received Restorative Nursing Assistant (RNA) services as recommended and ordered. The deficient practice could result in a reduction in range of motion. Findings include: Resident #28 was admitted to the facility on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED]. A review of physician's orders [REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 26, 2019 revealed a Brief Interview for Mental Status score of 3 which indicated the resident had severe cognitive impairment. The assessment included the resident required extensive to total assistance with all Activities of Daily Living except eating and had impairment of physical mobility of the upper and lower extremities on one side. The assessment also included no RNA services were provided during the 7 day look-back period.Review of the PT notes dated (MONTH) 13, 2019 revealed instructions to provide passive range of motion (PROM) exercises to the right and left ankle and knee, and to provide PROM to all joints of the right upper extremity 3 times a week for two months. The care plan for restorative range of motion care initiated on (MONTH) 13, 2019 included a goal to prevent contractures and maintain skin integrity. Interventions included PROM and providing support above and below the joint. Review of physician's orders [REDACTED]. A review of the RNA documentation for (MONTH) and (MONTH) 2019 revealed the resident did not receive PROM exercises on (MONTH) 1 and (MONTH) 3, 2019. The documentation revealed the RNA worked as a Certified Nursing Assistant (CNA) on those days. On (MONTH) 8, 2019, it was documented the RNA was on vacation. During an interview conducted on (MONTH) 17, 2019 at 1:32 PM with the RNA (staff #4), the RNA stated that she started providing PROM exercises to the resident on (MONTH) 15, 2019. She stated that she is the only RNA and she works three days per week. The RNA stated that sometimes she is assigned to take a CNA assignment and that when that happens, the RNA program is not provided. In an interview conducted on (MONTH) 18, 2019 at 1:18 PM with the Administrator (staff#45), the Administrator stated her expectation is that if there is a physician's orders [REDACTED]. She further stated that refusals and calls to the

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) physician need to be documented. An interview was conducted on (MONTH) 18, 2019 at 3:29 PM with the Director of Nursing (DON/staff #30). The DON stated that the RNA receives guidance from the therapy department. He stated that the RNA is also a CN[NAME] The DON also stated that he does not complete the schedule and is unaware that the RNA was assigned CNA duties at times which resulted in RNA services not being provided. The facility's policy for Restorative Nursing revised (MONTH) 15, (YEAR) revealed it is the policy of the facility to provide restorative programs coordinated by nursing or in collaboration with rehabilitation based on individual patient needs. The policy included a Registered Nurse or Licensed Practical Nurse must supervise the activities in a restorative program. The policy also included the restorative nursing program is to be implemented according to the specifics on the resident's plan of care.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure one of one sampled resident (#51) was provided appropriate treatment and services to restore bladder continence. The deficient practice could result in bladder continence not being restored. Findings include: Resident #51 was admitted to the facility on (MONTH) 15, 2019, with [DIAGNOSES REDACTED]. A care plan dated (MONTH) 15, 2019, revealed the resident was at risk for decreased ability to perform toileting due to limitations in mobility. The goal was to improve the level of function. Interventions included monitoring the conditions that contributed to the decreased ability and referring to rehabilitation therapy. Review of the clinical record revealed no evidence that a bladder assessment had been completed upon admission. The Certified Nursing Assistant (CNA) Flowsheets dated (MONTH) 15, 16, and 17, 2019 revealed the resident had been incontinent of bladder on multiple occasions every day. Review of a physician history and physical dated (MONTH) 17, 2019 revealed the resident was to participate in Occupational Therapy (OT) and Physical Therapy (PT) for strengthening exercises and to decrease weakness. A written summary of the baseline care plan dated (MONTH) 17, 2019 revealed the resident was continent of bladder and required extensive staff assistance for transfers to the toilet. Review of the CNA Flowsheets for (MONTH) 18 - 22, 2019, revealed the resident continued to have frequent episodes of bladder incontinence on multiple occasions every day. The admission Minimum Data Set (MDS) assessment dated (MONTH) 22, 2019 revealed a score of 12 on the Brief Interview for Mental Status, which indicated the resident had mild cognitive impairment. The MDS assessment also revealed the resident was always incontinent of bladder and that a trial of a toileting program had not been attempted since admission. The assessment included the resident required limited to extensive assistance with toileting. The Care Area Assessment (CAA) worksheet for the MDS assessment dated (MONTH) 22, 2019, revealed the resident was always incontinent of bladder, required extensive assistance, and had participated in skilled therapy to increase her mobility and that information was gathered from the CNA Flowsheets. The CAA worksheet included the following modifiable factors that contributed to the incontinence: 1) the resident's restricted mobility, 2) urinary urgency, 3) the need for staff assistance with toileting, and 4) depression. The worksheet also included that a care plan would be developed. Review of the CNA Flowsheets dated (MONTH) 22 through (MONTH) 1, 2019, revealed the resident continued to have frequent episodes of bladder incontinence on multiple occasions every day. A nursing note dated (MONTH) 2, 2019 revealed the resident required extensive assistance with toileting and had expressed to PT and OT staff that she was capable of increasing some independence with some aspects of her activities of daily living. Review of the care plan dated (MONTH) 8, 2019, revealed the resident was always incontinent of bladder and had potential for improved control or management of urinary elimination. The goal was to improve the urinary elimination by experiencing less than 3 episodes of incontinence per day. Interventions included completing an incontinence assessment at intervals according to policy and procedure and encouraging the resident to use the toilet upon awakening, after meals, nightly and as necessary, and continue OT and PT. Review of the CNA Flowsheets dated (MONTH) 8 -15, 2019, revealed the resident continued to have episodes of bladder incontinence on multiple occasions every day. Further review of the clinical record revealed no evidence of a bladder or incontinence assessment or that the resident had been provided a toileting schedule or program to aid in restoring bladder continence. An interview was conducted with the resident on (MONTH) 15, 2019 at 2:02 p.m. The resident stated that she has occasions of bladder incontinence. The resident also stated that she had attended a recent care plan meeting and was told the staff would check on her on a more regular basis, every 2-3 hours. The resident further stated that staff checking on her every 2-3 hours would able her to get to the toilet so that she would not have to urinate in the brief. During an interview conducted on (MONTH) 18, 2019 at 11:22 a.m. with a CNA (staff #44) providing care to the resident, the CNA stated that the resident is not on a scheduled toileting program. The CNA stated that the resident is checked on a regular basis to see if the brief needs to be changed. An interview was conducted with a Licensed Practical Nurse (LPN/staff #31) on (MONTH) 19, 2019 at 11:31 a.m. The LPN stated that the resident is always incontinent of bladder and was not on a toileting program. The LPN further stated that Therapy would make a recommendation to the nursing staff if the resident was a candidate for a training program. Staff #31 stated there is an opportunity every day at the stand-up meeting for information to be communicated between Therapy and the nursing staff. After reviewing the clinical record, the LPN stated that she was not able to find a bladder assessment or a therapy recommendation. An interview was conducted with a LPN (staff #37) on (MONTH) 19, 2019 at 11:50 a.m. Staff #37 stated that the resident is not on a training program. The LPN stated the expectation is that therapy and the nursing staff would have a discussion regarding the incontinence and reach a conclusion or recommendation. The LPN further stated that at this time, it cannot be determined if the resident is appropriate for a training program because a bladder assessment had not been completed. During an interview conducted with social services (#53) on (MONTH) 19, 2019 at 11:55 a.m., staff #53 stated the resident has been anxious and in turmoil regarding her discharge plan. Staff #53 stated the resident wants to resolve the bladder incontinence issue by getting to the toilet timely so that she can return to her former living arrangements. An interview was conducted with the resident on (MONTH) 19, 2019 at 1:22 p.m. The resident stated that she would absolutely love to be on a toileting program and not have to urinate in the brief. The resident stated that it was humiliating to urinate in the brief. The resident stated that she needs staff assistance to the toilet and that staff does not always help her. The resident further stated that she is anxious and nervous about the bladder problem because her prior living arrangements require she be continent before returning. An interview was conducted with the Director of Nursing (DON/staff #30) on (MONTH) 19, 2019 at 1:41 p.m. The DON stated that a bladder assessment is to be completed on admission and reassessed 24 and 72 hours following the admission assessment. The DON stated that the assessments determine what type of training program would be most effective and beneficial for the resident. The DON further stated that he was unsure of why there was no communication between Therapy and the nursing staff regarding this resident's incontinence problem. The facility's policy on Continence Management revealed a urinary incontinence assessment and the Three Day Continence Management Diary will be completed if the resident is incontinent upon admission. The policy included that the purpose is to provide appropriate treatment and services for residents with urinary incontinence to minimize infections and restore as much normal elimination function as possible. The policy also included addressing transient causes for incontinence.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.**

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F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident and staff interviews, and policies, the facility failed to ensure one sampled resident (#11) who had an enteral feeding tube received the appropriate treatment and services to prevent complications. The deficient practice could result in potential enteral feeding tube complications. Findings include: Resident #11 was admitted to the facility on (MONTH) 15, (YEAR), with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. -check the feeding tube for proper placement prior to each feeding, flush, or medication administration by measuring the length of the tube using tape measurement. -flush the feeding tube with 15 milliliters (ml) of water before each medication pass every shift for [DEVICE] care, flush tube with at least 15 ml of water between each medication. -flush the feeding tube with 250 ml of free water every 6 hours for hydration. -change the feeding syringe, date and initial bag every evening shift. Review of the Medication Administration Record (MAR) for (MONTH) 2019 revealed the scheduled times for the every 6 hours feeding tube flush was 12:00 a.m., 6:00 a.m. 12:00 p.m. and 6:00 p.m. Additional review of the MAR for (MONTH) 2019 revealed no documentation that the feeding tube was flushed at 12:00 a.m. on (MONTH) 2, 3, 4, 10, 11, 16, and 17, 2019 and at 6:00 a.m. on (MONTH) 16, 19, 30 and 31, 2019. A significant change Minimum Data Set (MDS) assessment dated (MONTH) 23, 2019, revealed a Brief Interview of Mental Status (BIMS) score or 15, which indicated the resident had intact cognition. The assessment included the resident had a feeding tube. A nursing progress note dated (MONTH) 6, 2019 revealed a skin check was performed and that the following new skin injury/wound was identified: Moisture Associated Skin Damage to the [DEVICE] site with redness. A physician's orders [REDACTED]. Review of the Treatment Administration Record (TAR) for (MONTH) 2019 revealed no documentation that the antibiotic/anti-fungal treatment to the GT site was applied at 8:00 a.m. or 8:00 p.m. on (MONTH) 10 and 24, 2019. Review of the MAR for (MONTH) 2019 revealed no documentation that the placement of the feeding tube was checked on (MONTH) 3, 2019, the feeding tube was flushed at 12:00 a.m. and at 6:00 a.m. on (MONTH) 1 and 15, 2019 and the feeding syringe was changed on (MONTH) 4 and 5, 2019. Review of the care plan dated (MONTH) 12, 2019 revealed the resident was at risk for skin breakdown as evidenced by the feeding tube with a goal that the resident would not show signs of skin breakdown. Interventions included evaluating for any localized skin problems including redness and monitoring the skin for sign/symptoms of skin breakdown. A physician's orders [REDACTED]. Review of a change of condition evaluation dated (MONTH) 28, 2019 revealed the resident had a fungal rash around the [DEVICE] site and that an order was obtained for 2% antifungal cream and [MEDICATION NAME] for 3 days. Review of the TAR dated (MONTH) 2019 revealed no documentation that the antibiotic/anti-fungal treatment was applied at 8:00 a.m. on (MONTH) 13 and 14, 2019, at 8:00 p.m. on (MONTH) 11 and 15, 2019, and at 5:00 p.m. on (MONTH) 29, 2019. Review of the MAR for (MONTH) 2019 revealed no documentation that the placement of the feeding tube was checked on the 6:00 a.m. to 2:00 p.m. shift on (MONTH) 6, 13, and 15, 2019, on the 2:00 p.m. to 10:00 p.m. shift on (MONTH) 11, 15, and 29, 2019, and on the 10:00 p.m. to 6:00 a.m. shift on (MONTH) 5, 10, 14, 18, and 20, 2019. The MAR for (MONTH) 2019 included no documentation that the feeding tube was flushed before medication pass and between medications on the 2:00 p.m. to 10:00 p.m. shift on (MONTH) 2, 2019 and on the 10:00 p.m. to 6:00 a.m. shift on (MONTH) 3, 5, 9, and 10, 2019. The MAR for (MONTH) 2019 also revealed no documentation that the feeding tube was flushed at 12:00 a.m. on (MONTH) 1, 2, 3, 4, and 9, 2019 and at 6:00 a.m. on (MONTH) 1, 3, 4, 5, 7, 8, 9, and 10, 2019 or that the feeding syringe was changed on (MONTH) 10, 2019. An observation was conducted on (MONTH) 16, 2019 at 1:41 p.m. of the feeding tube insertion site. The skin surrounding the site was noted to be reddened with crusty exudate. During an interview with the resident on (MONTH) 16, 2019 at 1:41 p.m., he stated that the feeding tube was infected and that he wanted the tube removed. An interview was conducted with a Certified Nursing Assistant (staff #23) on (MONTH) 17, 2019 at 12:28 p.m. The CNA stated that it is her responsibility to clean the outer tube on the feeding tube and to clean any leakage from the tube. She stated that she would tell the nurse if there was any redness or if the tube was coming out. The CNA stated that she cleans around resident #11's feeding tube and that his skin gets kind of crusty and is sometimes red after cleaning. She stated that the nurse applies cream to the skin redness. An interview was conducted with a Licensed Practical Nurse (LPN/staff #2) on (MONTH) 18, 2019 at 12:45 p.m. She stated that for a resident with a feeding tube, she checks for residual each shift and changes the syringe and tubing. The LPN stated that she flushes the tube every shift and before and after medication administration. The LPN also stated that she cleans the tube site at least once a day unless it is ordered more frequent. She stated that if a resident refused the care, she would document the refusal. The LPN also stated that if there are blank spaces on the MAR or TAR, there would be no way to know if the care was provided or not given. She stated that the expectation is that all documentation be complete by the end of the shift. The LPN stated that the physician's orders [REDACTED]. An interview was conducted with the Administrator (staff #45) on (MONTH) 18, 2019 at 1:18 p.m. She stated that the expectation is that the physician's orders [REDACTED]. The Administrator stated that if the resident refuses a medication or treatment, staff should notify the physician and document the refusal and the notification. She stated that if the care is not documented, then it was not done and acknowledged the blank areas on the TAR. The facility's policy for Care of Transabdominal Feeding Tubes revealed that upon admission and for any newly inserted tube, measure the tube from the point of entry into the skin to the end of the tube and to document the length in centimeters; and if at any time during the patient's stay, the length of the tube significantly changes, notify physician/advanced practice provider. The policy further included to examine the skin around the tube, look for redness, signs of skin breakdown, [MEDICAL CONDITION], or the presence of purulent drainage. Review of the policy for Medication/Treatment Administration Records (MAR/TAR) revealed that whenever a medication or treatment is started, given, refused, or discontinued, including those ordered to be administered as needed, the medication or treatment shall be documented on the MAR/TAR with the initials of the administering individual. The policy for Medication Administration revealed to document administration of medication on the Medication Administration Record (MAR). The policy also included that for a medication refused by a resident, circle your initials in the date and time space where that medication is ordered and document the resident's refusal of medication on the back of the MAR (for electronic order management centers, document refusal by entering the refusal code on the MAR).
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, facility documentation, and policy review, the facility failed to ensure that two of two medication refrigerators containing medications and biologicals for multiple residents were monitored for safe and recommended temperature ranges and failed to ensure that two expired medications were not available for use on one of two sampled carts. The deficient practice could result in medications and biologicals not being stored at the accepted temperature and in expired medications being administered to residents. The census was 65. Findings include: Regarding the medication room refrigerators:

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) -An observation was conducted of the medication storage room on Station 1 with the Unit Manager/Licensed Practical Nurse (LPN/staff #37) on (MONTH) 16, 2019 at 8:47 a.m. Review of the medication room refrigerator temperature log for (MONTH) 2019 included instructions for staff to record the temperature twice a day. However, further review of the log revealed no documentation of temperatures until (MONTH) 15, 2010 in the a.m. During this observation, an observation was conducted of the refrigerator. The medication refrigerator temperature was observed to be 40 degrees and the refrigerator was observed to contain medications for 13 residents. These medications included the following: -one [MEDICATION NAME] (nerve pain and anticonvulsant) 250 milligrams (mg)/5 milliliters (ml). -two [MEDICATION NAME] (HCl) (antibiotic) 250 mg/50ml. -one [MEDICATION NAME] (insulin) 100 units (U)/ml insulin pen. -three Humalog (insulin) vials 100u/ml. -one [MEDICATION NAME] (insulin) mix 70/30 vial. -four Cathflo [MEDICATION NAME] ([MEDICAL CONDITION]) 2 m vials. -four [MEDICATION NAME] (sedative) oral concentrate bottles 2 mg/ml. -six [MEDICATION NAME] (antibiotic) in sodium/[MEDICATION NAME] 2 mg/100 ml IV solution. An interview was conducted with the Unit Manager (staff #37) following this observation. She stated that up until (MONTH) 15, 2019, the medication refrigerator temperatures were not being monitored. The unit manager stated that she did not know when the medication refrigerator temperature was last checked before that. During a later interview with staff #37 at 10:30 a.m., the Unit Manager (staff #37) stated the expectation is that the medication refrigerator temperature be checked and documented daily. She stated that the risk of not checking the temperature could result in the temperature being out of range which could adversely affect the medications stored in the refrigerator. -An observation was conducted of the medication storage room on Station 2 with the Unit Manager/LPN (staff #18) on (MONTH) 16, 2019 at 9:33 a.m. Review of the medication room refrigerator temperature log for (MONTH) 2019 included instructions for staff to record the temperature twice a day. However, further review of the log revealed no documentation of temperatures until (MONTH) 15, 2010 in the p.m. During this observation, an observation was conducted of the refrigerator. The medication refrigerator temperature was observed to be 40 degrees and the refrigerator was observed to contain medications for 8 residents. These medications included the following: -three [MEDICATION NAME] pre-filled syringes 100u/3ml. -two [MEDICATION NAME] (insulin) 100u/ml. -one [MEDICATION NAME] (sedative) oral concentrate bottle 2 mg/ml. -29 [MEDICATION NAME] (sedative) 2 mg/ml pre-filled syringes. -one [MEDICATION NAME] (insulin) 250 mg/5 ml in sodium chloride 0.9% IV -one Levimir Flextouch (insulin) 100u/Ml - one Firvanq [MEDICATION NAME] (antibiotic) 50 mg/ml. -one unopened vial of [MEDICATION NAME] (vaccination) 23 -and one vial of influenza. An interview was conducted with the Unit Manager (LPN/staff #18) on (MONTH) 16, 2019 at 10:26 a.m. She stated that the medication refrigerator temperature should be checked one time on the 6 a.m. to 2 p.m. shift and one time on the 2 p.m. to 10 p.m. shift and documented on the temperature log. The Unit Manger stated that she did not know how long it had been since the medication refrigerator temperature was last checked before (MONTH) 15, 2019. She stated that monitoring the temperature of the medication refrigerators was important because the medications in the refrigerator need to be kept at the proper temperature and they need to know that the refrigerator is working properly. An interview was conducted with the Director of Nursing (DON/staff #30) on (MONTH) 16, 2019 at 10:34 a.m. He stated the expectation is that the medication room refrigerators temperature be checked and logged on the flow sheet daily by staff. The DON stated that the risk of not monitoring the temperature of the medication refrigerators could result in medications not being stored at the proper temperature and being unable to be administered. Regarding the expired medications: [REDACTED] During an observation conducted of the #1 medication cart on station 2 with the Unit Manager (staff #18) on (MONTH) 16, 2019 at 11:10 a.m., Zinc (supplement) 220 milligram (mg) capsules was observed with a use by date of (MONTH) (YEAR) and [MEDICATION NAME] (cholesterol medication and vitamin) 500 mg tablets was observed with a use by date of (MONTH) 2019. Following this observation, an interview was conducted with the Station 2 Unit Manager (staff #18). She stated that the nurses check for expired medications on their cart frequently and that they discard and replace expired medications. She stated that there should not be any expired medications on the cart. The Unit Manager stated that she did not think the expired medications observed on cart #1 would pose a risk to the residents, because the nurses are expected to check the expiration date of each medication before administering the medication to the resident. Another interview was conducted with the DON on (MONTH) 16, 2019 at 11:13 a.m. The DON stated that staff is expected to discard any expired medications in the medication cart and that expired medications should not be available for use in the medication cart. During an interview conducted with the Administrator (staff# 45) on (MONTH) 18, 2019 at 8:22 a.m., the Administrator stated that no other medication refrigerator temperature logs were able to be located and that all available logs had been provided. Review of the facility's policy for Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles revealed that medications and biologicals shall be stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges, and that staff should monitor the temperature of vaccines twice a day. The policy included the accepted refrigeration temperature range was 36 degrees to 46 degrees Fahrenheit. The policy stated that the staff should ensure medications and biologicals that have an expired date on the label are stored separate from other medications until destroyed or returned to the pharmacy or supplier.
F 0770 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide timely, quality laboratory services/tests to meet the needs of residents.** Based on facility documentation, staff interviews, policy review, and the manufacturer's instructions, the facility failed to ensure that quality control solution testing was consistently completed on multi-use glucometers. The deficient practice could result in not being aware of glucometers that were not functioning properly and therefore providing inaccurate glucose level results for residents with diabetes. Findings include: Review of the Blood Glucose Monitoring System Daily Quality Control Record for (MONTH) 2019 revealed sections for staff to complete the station/shift, operator initials/shift, meter cleaned Y/N, Test Strip Lot number, Code number, Test Strip Expiration Date, Level 1 lot number, Level 1 Expiration date, Level 1 control range, Level 1 control result, Level 2 lot number, Level 2 Expiration date, Level 2 control range, Level 2 control result, and corrective action. However, there was no documentation that the daily glucometer control testing for accuracy was completed on one of the two glucometers on station 1 after (MONTH) 14, 2019. There was no documentation that the other glucometer on station 1 was tested for accuracy on (MONTH) 6 and 7, 2019 and no documentation that testing for accuracy was performed after (MONTH) 11, 2019. Review of the records dated (MONTH) 2019 for the two glucometers on station 2 revealed no documentation that one of the glucometers was tested for accuracy for (MONTH) 2019. There was no documentation that the other glucometer on station 2 was tested for accuracy on (MONTH) 3, 15, 18, 19, 24, 25, and 26, 2019. Review of the records dated (MONTH) 2019 for the two glucometers on station1 and the two glucometers on station 2, revealed one record for one of the two glucometers on station 2. The one glucometer on station 2 was only tested for accuracy on (MONTH) 1, 2019. There were no records for the other glucometer on station 2 and no records for the two glucometers on station 1. Review of the records for (MONTH) 2019 revealed no documentation that the two glucometers on station 1 and the two

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F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) glucometers on station 2 had been tested for accuracy from (MONTH) 1-14, 2019. An interview was conducted with station 1 Unit Manager (staff #37) on (MONTH) 16, 2019 at 9:30 a.m. She stated that they stopped checking the glucometers for accuracy when they ran out of the testing control solution. The Unit Manager also stated they started using a different pharmacy in (MONTH) 2019 and were provided new glucometers but that they were not checking the glucometers for accuracy. During an interview conducted with the Director of Nursing (DON/staff #30) on (MONTH) 16, 2019 at 9:33 a.m., the DON stated that the two glucometers on station 1 had not been tested for accuracy since they changed to a different pharmacy. An interview was conducted with station 2 Unit Manager (staff #18) on (MONTH) 16, 2019 at 10:26 a.m. She stated that the staff are to test the glucometers daily for accuracy and document the results on the monitoring record. The Unit Manager stated that if the glucometers are not checked for accuracy, there is a potential for inaccurate blood sugar results which could result in residents not being medicated appropriately. Another interview was conducted with station 1 Unit Manager (staff #37) on (MONTH) 16, 2019 at 10:30 a.m. She stated that the night shift staff are expected to test the glucometers for accuracy daily and document the results on the monitoring record. The Unit Manager stated that if the glucometers are not tested for accuracy, the accuchecks could be inaccurate and the wrong dose of insulin could be administered to the resident. Another interview was conducted with the DON (staff #30) on (MONTH) 16, 2019 at 10:34 a.m. He stated that the glucometer machines are to be tested for accuracy daily and the results documented on the monitoring record. The DON stated that if the glucometers are not tested for accuracy, it could result in wrong readings and staff could administer the wrong dose of insulin. An interview was conducted with the Administrator (staff #45) on (MONTH) 18, 2019 at 8:45 a.m. She stated that there were no other glucometer monitoring records and that all of the glucometer monitoring records had been provided. Review of the facility's policy titled Glucose Meter revealed that to ensure the accuracy and validity of blood glucose monitoring, glucose meters will be tested daily for quality control according to the manufacturer's guidelines. The policy included that the Nurse Executive or designee will assign nursing staff on a specific shift to perform the daily meter maintenance to maintain the equipment at the optimal level of functioning. The manufacturer's instructions for the glucometers instructs to perform the control solution testing when using the meter for the first time, using a new bottle of test strips, to make sure the test strips and the meter are working together properly, and when the blood glucose test results do not reflect how the resident feels.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations, staff interviews and review of policies, the facility failed to provide evidence that two nutrition refrigerator temperatures were being monitored to ensure the temperatures were within safe and recommended temperature ranges. By not monitoring the refrigerator temperatures, staff would not be aware if the temperatures ever increased above the recommended ranges, therefore, exposing residents to the potential for food borne illnesses. Findings include: An observation was conducted on (MONTH) 19, 2019 at 11:25 a.m. of the nutrition refrigerator on unit 1. The refrigerator temperature was 32 degree Fahrenheit (F) and was observed to contain resident snacks and personal food items. However, there was no documented evidence, such as a refrigerator temperature log, that the temperature was being monitored on a daily basis. During this observation, an interview was conducted with the Dietary Manager (staff #74). She stated that the dietary staff do not monitor the nutrition refrigerator temperature that it is the nursing staff responsibility to monitor and document the refrigerator temperatures. The Dietary Manager was unable to find refrigerator logs that contain documented evidence the temperatures were being monitored. During an interview conducted on (MONTH) 19, 2019 at 11:30 a.m. with the Unit Manager (staff #37) for unit 1, she stated that there were no temperature logs for the nutrition refrigerators. The Unit Manager stated that the dietary staff are supposed to maintain the temperature logs for the nutrition refrigerators, not the nursing staff. An observation was conducted on (MONTH) 19, 2019 at 11:35 a.m. of the nutrition refrigerator on unit 2. The refrigerator temperature was 40 degrees F and was observed to contain resident snacks and personal food items. Further observation revealed no documented evidence that the refrigerator temperature was being monitored on a daily basis. Following this observation, an interview was conducted with staff #74. The Dietary Manager stated that there is no refrigerator temperature log for this refrigerator. She stated that she checks the nutrition refrigerator temperatures each morning but that she has no way of writing down the temperatures. Review of the facility's policy and procedure titled Pantry/Nourishment Room Sanitation included that Pantry/Nourishment rooms are maintained in a sanitary manner and Refrigerator/Freezer temperatures are maintained within acceptable ranges. The policy also included the Director of Dining Services or designee will observe and record the temperature of the refrigerator and freezer daily on the Refrigerator/Freezer Temperature Log. The facility's policy and procedure titled Food Storage: Cold Foods included that all Temperature Control for Safety (TCS) foods frozen and refrigerated will be appropriately stored, and a written record of daily temperatures will be recorded.
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff and resident interviews, facility documentation, review of the Center for Disease Control (CDC) guidelines and policies and procedures, the facility failed to maintain an effective infection control program, by failing to ensure that contact precautions were initiated and implemented for one resident (#170) with suspected [MEDICAL CONDITIONS] infection. As a result, the Condition of Immediate Jeopardy (IJ) was identified. The resident census was 65. The deficient practice could result in the spread of infection to residents and staff. Findings include: On (MONTH) 22, 2019 at 1:00 p.m., the Condition of Immediate Jeopardy was identified. The Administrator was informed of the facility's failure to initiate and follow infection control procedures for one resident (#170), with suspected [MEDICAL CONDITION] infection. A stool specimen for [MEDICAL CONDITION] had been sent out on (MONTH) 21, 2019 and the resident had not been placed on contact precautions, pending the laboratory results. Therapy staff had been observed in the resident's room providing care without the use of PPE (personal protective equipment) and the resident had been observed in the therapy gym receiving therapy, with another resident and two staff present. The Administrator presented a plan of correction on (MONTH) 22, 2019 at 3:45 p.m. The Administrator was informed that the plan of correction needed to be revised to include that all facility staff need to receive in-service education regarding infection control precautions for [MEDICAL CONDITION]. A revised plan of correction was presented on (MONTH) 22, 2019 at 4:25 p.m. and was accepted. The plan of correction included the following corrective actions: The therapy gym was cleaned and two residents who were in the therapy gym at the time that resident #170 was receiving therapy were placed on change of condition observations for any signs of loose/watery stools for 48 hours; all residents who resided on unit 1 were to be assessed and placed on observation for loose/watery stools for 48 hours; all staff members were to be provided in-services which would include transmission based precautions and control measures, and placing residents on contact precautions while awaiting results of stool culture testing for [MEDICAL CONDITION]; staff designee will monitor laboratory orders for stool culture orders or reports of residents with loose watery stools and then verify that they have been placed on contact precautions, pending stool culture results. Multiple observations were conducted on (MONTH) 22, and 23, 2019 of the facility implementing their plan of correction. Staff in-services were being completed and staff interviewed were knowledgeable regarding infection control procedures, including that residents were to be placed on contact precautions when they are suspected to have [MEDICAL CONDITION] and are to remain on contact precautions, pending the results of the stool culture testing. In addition, resident #170 was placed on contact precautions, pending the results of the stool culture test. As the facility was implementing their plan

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) of correction and there were no additional concerns identified, the Condition of Immediate Jeopardy was abated on (MONTH) 23, 2019 at 11:00 a.m. Specifics regarding resident #170: Resident #170 was admitted on (MONTH) 6, 2019, with [DIAGNOSES REDACTED]. Review of the hospital records dated prior to admission revealed that resident #170 received IV (intravenous) antibiotics, which included [MEDICATION NAME] 750 mg (milligrams) on (MONTH) 3, 2019 and [MEDICATION NAME] 1 gm (gram) on (MONTH) 5, 2019. Physician transfer orders from the hospital dated (MONTH) 6, 2019 included that resident #170 had received [MEDICATION NAME] 1 gm IV on (MONTH) 6, and that the next dose was scheduled to be received (at the facility) on (MONTH) 7. Review of the facility physician orders [REDACTED]. A nurses note dated (MONTH) 6, 2019 at 9:00 p.m. included that a possible allergy to Ceftraxone had been identified and review of the physician orders [REDACTED]. A baseline care plan completed on (MONTH) 8, 2019 included that resident #170 was confused, received physical and occupational therapy, used a wheelchair, was totally dependent on staff assistance for toileting and hygiene, was incontinent of bowel and received [MEDICATION NAME] 1 gm for two days. An Admission MDS (Minimum Data Set) assessment dated (MONTH) 12, 2019 included that resident #170 had a BIMS (Brief Interview for Mental Status) score of 15, which indicated the resident was cognitively intact. Per the MDS, resident #170 was frequently incontinent of bowel, required extensive assistance from two staff with transfers and extensive assistance from one staff for toileting and personal hygiene. The MDS also included that resident #170 used a walker and a wheelchair and had received antibiotics on a regular basis. A physician's orders [REDACTED]. A nurses note dated (MONTH) 21, 2019 at 2:36 p.m. included that a stool specimen had been collected at 1:35 p.m. and the lab had been notified to pick up the specimen. Review of the clinical record revealed there was no documentation that the resident was having diarrhea/loose stools from admission through (MONTH) 21, 2019. A physician's progress note dated (MONTH) 22, 2019 included documentation that resident #170's chief complaint was follow-up for diarrhea. The resident complained of having loose stools 2-3 times for the past several days. The resident denied rectal bleeding, abdominal pain, nausea, vomiting or fever. Per the note, the resident had a history of [REDACTED]. Review of systems included that all systems were negative except for diarrhea, and that the resident had acute diarrhea and to rule out [MEDICAL CONDITIONS]. On (MONTH) 22, 2019 at 11:35 a.m., an observation was conducted of the resident lying on his bed. At this time, a therapy staff member (staff #70) was observed inside of the room. The therapy staff member was assisting the resident with maneuvering on the bed and was not wearing a gown or gloves. In addition, there was no indication that resident #170 was on contact precautions for suspected [MEDICAL CONDITION] infection, such as an isolation cart with PPE outside of the resident's room. An interview was conducted on (MONTH) 22, 2019 at 11:37 a.m. with the Unit Manager (staff #37) and the resident's nurse (Licensed practical Nurse/LPN/staff #39). Staff #39 stated that she sent the stool sample to the lab for [MEDICAL CONDITION] on (MONTH) 21, because the resident had diarrhea for two days and the stool was loose, watery and malodorous. Staff #37 stated that they would only isolate a resident, if the results of the stool culture were positive for [MEDICAL CONDITION]. She also stated that the resident had not been receiving antibiotics. When asked how the facility was protecting other residents from potential exposure to [MEDICAL CONDITION] since resident #170 had not been placed on contact precautions, staff #37 repeated that they would place resident #170 on isolation, if the results of the stool culture for [MEDICAL CONDITION] were positive. Staff #37 said that the resident was not currently on isolation for [MEDICAL CONDITION], and that they are not isolating him at this time. Staff #39 said the lab had notified the facility today that they were unable to complete the processing of the stool specimen, which had been sent yesterday and that another specimen needed to be sent. Staff #39 said she was waiting for the resident to have another loose bowel movement, so she could send the specimen to the lab. Further review of the clinical record revealed there was documentation that another stool specimen needed to be sent. During an interview conducted on (MONTH) 22, 2019 at 11:40 a.m. with the Director of Nursing (staff #30), staff #30 stated he was not aware of any stool specimens that had been sent to the lab over the weekend and had not been notified that any stool specimens for [MEDICAL CONDITION] had been sent to the lab yesterday. An observation of resident #170 in the therapy gym was conducted on (MONTH) 22, 2019 at 12:15 p.m. Resident #170 was seated in the therapy gym receiving services from a therapist. In addition to resident #170, there was one other resident and two therapy staff who were also present in the therapy gym. During the observation, the resident stated that he had diarrhea earlier this morning. Resident #170 was seated in the therapy gym receiving services from a therapist. Neither resident #170, the other resident or therapy staff were wearing any PPE. During an interview conducted on (MONTH) 22, 2019 at 12:20 p.m. with a CNA (Certified Nursing Assistant/staff #1), the CNA stated that resident #170 had an episode of diarrhea at 11:30 a.m. today, which consisted of a large amount of watery loose stool with mucus, and a strong odor. During an interview conducted on (MONTH) 22, 2019 at 12:25 p.m. with the resident's nurse (LPN/staff #39), she stated that she was not aware the resident had diarrhea at 11:30 a.m. today. Another interview was conducted with staff #30 on (MONTH) 22, 2019 at 12:30 p.m. Staff #30 stated that resident #170 will need to be placed on isolation precautions, if the results of the stool culture are positive for [MEDICAL CONDITION] and until then, the resident was on standard precautions. He stated that standard precautions include maintaining the resident in his room, wearing gloves when assisting the resident, and hand washing after removing gloves. Staff #30 stated he was not aware that therapy staff had assisted the resident in his room without wearing gloves, or that the resident was in the therapy gym with no protective equipment on. When asked how residents were being protected from possible exposure to [MEDICAL CONDITION] he stated, I will have to check. During an interview conducted on (MONTH) 22, 2019 at 1:20 p.m. with staff #30 and a Nurse Consultant (staff #87), staff #87 stated that although a stool specimen for [MEDICAL CONDITION] culture had been sent to the lab for resident #170, he did not fit the profile of having suspected [MEDICAL CONDITION], according to the facility's infection control protocols and did not require isolation precautions for [MEDICAL CONDITION]. Staff #87 also stated that because the CNA's had not documented more than one loose stool, the resident did not have diarrhea. When asked about the nurse and CNA who reported that the resident was having episodes of diarrhea, and how staff were protecting other residents from possible exposure to [MEDICAL CONDITION], staff #87 stated I see what you mean. An interview was conducted on (MONTH) 22, 2019 at 1:30 p.m. with a CNA (staff #44). The CNA stated that resident #170 had a loose stool earlier in the day and when she assisted with cleaning the resident, she had not taken any specific infection prevention precautions. She stated that if a resident has a loose stool, she documents the loose stool and notifies the nurse. An interview was conducted on (MONTH) 22, 2019 at 2:32 p.m. with the physician for resident #170 (staff #86). The physician stated that the nurse caring for resident #170 had called him yesterday (April 21) and described the resident's diarrhea symptoms to him. He stated that he gave the nurse an order to send a stool specimen for [MEDICAL CONDITION] culture. The physician further stated that the resident should have been placed on isolation precautions yesterday, when it was suspected that he may have [MEDICAL CONDITION]. A nurses note dated (MONTH) 23, 2019 at 8:54 a.m., included that a change in condition had been noted and symptoms included diarrhea on (MONTH) 20, 2019. The note included that the physician had been notified on (MONTH) 21, 2019 at 2:00 p.m., orders had been obtained and a stool sample had been sent for [MEDICAL CONDITION] culture. An interview was conducted on (MONTH) 23, 2019 at 1:31 p.m. with the therapy staff (staff #70) who had been observed assisting resident #170 in his room on (MONTH) 22 at 11:35 a.m. Staff #70 stated that she had not been notified that a stool sample for [MEDICAL CONDITION] for resident #170 had been sent, or that resident #170 was suspected to possibly have [MEDICAL CONDITION]. Staff #70 said that if she had been notified of the suspected [MEDICAL CONDITION], the resident would have received therapy services in his room, and he would not have been brought to the therapy gym. Review of a policy and procedure titled, Infection Prevention and Control Program Description revealed that the infection

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) prevention and control program is a comprehensive process that addresses preventing, identifying, reporting, investigating and controlling infections and communicable diseases. The policies and procedures are based on national standards including recommendations from the Centers for Disease Control (CDC). Activities of the program include implementation of standard and transmission based precautions, and infection prevention and control practices followed by staff. Goals of the program include decreasing the risk of infection for patients and staff and implementing appropriate control procedures. The policy also included that the (facility) infection control Preventionist is responsible for initiating specific precautions to prevent the transmission of infection. Review of a policy titled, [MEDICAL CONDITION] revealed to place patients with more than three diarrheal stools in presumptive contact precautions, while waiting for test results to come back. A policy and procedure titled, Contact Precautions included that in addition to standard precautions, contact precautions will be used for diseases transmitted by direct or indirect contact with the patient or the patient's environment. The purpose of the policy is to reduce the risk of microorganisms by direct or indirect contact. The process included placing a sign on the patient's door which reads, STOP. Please see the nurse before entering the room and that staff must wear gown and gloves when entering the room, and that before exiting the room, remove and bag gown and gloves and wash hands upon exiting the room. Review of the CDC guidelines revealed that [MEDICAL CONDITION] is a spore forming bacterium that causes inflammation of the colon known as [MEDICAL CONDITION]. Risk factors include antibiotic use, serious underlying illness and age over 65. [MEDICAL CONDITION] spores are shed in feces and transferred to patients mainly via the hands of people who have touched a contaminated surface or item. [MEDICAL CONDITION] spores can live for months or sometimes years on surfaces. For prevention of transmission of [MEDICAL CONDITION] in healthcare settings, use contact precautions for patients with known or suspected [MEDICAL CONDITION]. The guidelines included to use gloves and gowns when entering patient rooms and during care, and for all interactions that may involve contact with patient or potentially contaminated areas in the patients environment. The policy also stated that before exiting the patient room, discard gowns and gloves, and wash hands to contain the [MEDICAL CONDITION] pathogens.