STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255344	A. BUILDING _____ B. WING _____	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUITMAN COUNTY HEALTH & REHAB LLC	350 GETWELL DRIVE MARKS, MS 38646

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 07/ 11/23 through 07/13/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F658, F695, F761 , F812, and F880. The facility held a license for 60 beds, with a census of 49.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		8/25/23

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

Electronically Signed | 07/27/2023

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F 656	Continued From page 1 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to implement the care plan for impaired respiratory function for (1) one of 16 resident care plans reviewed. Resident #10 Findings include: A review of the facility policy titled, "Care plans, Comprehensive Person-Centered," revised December 2016 revealed, "Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident ... Policy Interpretation and Implementation... 8. The comprehensive,	F 656	"on 7/11/2023 Director of Nurses along with Minimum Set Data Nurse immediately reviewed care plan for resident #10 due to the deficient practice for compliance. " All residents have the potential to be affected by this deficient practice. "On 7/11/2023 Director of Nurses and MDS nurse In-Serviced all Nursing Staff on Comprehensive person centered care plan according to policy. 7/11/2023 & 7/12/2023 Director of Nurses and MDS nurse reviewed 100% of all resident care plans for compliance. on 7/26/2023 Comprehensive Care plan Policy	

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F 656	Continued From page 2 person-centered care plan will:.. b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being..." An observation of Resident #10 on 7/11/23 at 11:39 AM, revealed resident receiving oxygen (O2) via nasal canula and the O2 tubing and humidifier bottle with no date. A record review of the care plan for Resident #10 with a problem onset date of 3/22/22, revealed "(Proper name of Resident #10) is at risk for impaired respiratory function r/t (related to) Chronic Pulmonary Edema...Approaches...Change O2 tubing and Aquapack Q (every) Monday..." During an observation and interview with Licensed Practical Nurse (LPN)#1 on 7/12/23 at 8:30 AM, she confirmed there was not a date on the oxygen tubing or humidifier bottle and revealed it should be changed weekly. LPN #1 then confirmed she was uncertain of the last time the tubing and humidifier bottle was changed because there was no label or date of when it was last changed. An interview and record review of the comprehensive care plan with the Director of Nursing (DON) on 7/12/23 at 9:00 AM, confirmed staff were not following Resident #10's plan of care for oxygen therapy and revealed the purpose of the care plan is to direct the staff of the resident's specific care needed. Record review of the Face Sheet revealed that the facility admitted Resident #10 to the facility on 1/17/2018 with diagnoses of Persistent Vegetative	F 656	assigned per Skilled Nursing Facility Clinic to all nursing staff to be completed by 8/3/2023. On 7/11/2023 Quality Assurance Committee which included Director of Nurses, Administrator, Charge Nurse, Medical Director and MDS nurse reviewed policy Comprehensive Person centered care plan policy with no recommended changes at this time. "Director of Nurses and MDS nurse will review 3 care plans per week as well as scheduled care plans for the week for 4 weeks then monthly x 2 starting 7/27/2023. QA committee will review completed monitoring log(findings from care plan review meetings) from DON and MDS nurse on 8/18/2023 the review quarterly x 2	

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F 656	Continued From page 3 State and Chronic Pulmonary Edema.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to sign out controlled medications prior to administration to a resident for (1) one of (6) six residents reviewed during medication pass. Resident #29. Findings include: An observation, on 7/12/23 at 9:20 AM revealed Licensed Practical Nurse (LPN) #1 set up medications for Resident #29. The medications included Lacosamide, Xanax, and Norco. LPN #1 did not sign out the controlled medications prior to administering them. An interview on 7/12/23 at 9:25 AM, with LPN #1 revealed that she really did not know when she was supposed to sign them (controlled medications) out. She stated that she does it after she gives them in case the resident does not take it. An interview on 07/13/23 at 08:30 AM, with the Director of Nursing (DON) revealed that all controlled medications should be signed out when the nurse punches it out. If the nurse waits to sign out controlled medications, she could	F 658	"on 7/11/2023 Director of Nurses immediately In-serviced Licensed Practical Nurse #1 one on one on signing out Narcotics as soon as the medication is dispensed from container then administered to correct resident. " on 7/11/2023 All residents receiving narcotics by Licensed Practical Nurse #1 has the potential to be affected by this deficient practice. "On 7/11/2023 Director of Nurses and Administrator In-Serviced all Nursing Staff the correct way to sign out and administer narcotics according to policy. 7/24/2023 administering oral medications as well as documentation of medication administration video assigned per Skilled Nursing Facility Clinic to all nursing staff to be completed by 8/3/2023. On 7/11/2023 Quality Assurance Committee which included Director of Nurses, Administrator, Charge Nurse, Medical Director and Infection preventionist nurse reviewed policy and procedure Medication administration as well as controlled	8/25/23

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F 658	Continued From page 4 forget to do it and the count would be wrong or could lead to drug diversion. Record review of the July 2023 Physician Orders for Resident #29 dated revealed orders for Xanax 0.5 mg tablet 1 (one) PO (by mouth) BID (two (2) times a day) for anxiety, Lacosamide 150 mg tablet 1 PO BID for convulsions, and Norco 7.5-325 tablet 1 PO BID for pain. Record review of the facility Face Sheet for Resident #29 revealed an admission date of 6/15/23 with diagnosis that included Chronic Obstructive Pulmonary Disease, Heart Failure, generalized Anxiety Disorder, and Unspecified Convulsions.	F 658	substances with no recommended changes at this time. "Director of Nurses and Administrator will observe one of three scheduled medication passes to residents receiving narcotics to ensure narcotics are signed out correctly as soon as dispensed from container starting 7/24/2023 daily x2 weeks then twice a week x 3 weeks then monthly x 2. QA committee will review monitoring completed monitoring log(findings from medication observation and narcotic log observation) from DON and Administrator on 8/18/2023 and QA will review quarterly x2.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review the facility failed to label and date oxygen tubing and a humidifier bottle (Aquapack) for (1) one of (7) seven residents receiving oxygen therapy. Resident #10. Findings include:	F 695	" 7/11/2023 Licensed Practical Nurse #1 on duty removed oxygen tubing and humidifier bottle in use and put new oxygen tubing and humidifier bottle with correct date in use on 7/11/2023 for resident #10. Resident #10 was assessed by Director of Nurses and LPN #1 on 7/11/2023 for any negative outcomes from	8/25/23

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F 695	Continued From page 5 A review of the facility policy titled, "Oxygen Administration, "with a revised date of October 2022, revealed "Purpose The purpose of this procedure is to provide guidelines for safe oxygen administration...Equipment and Supplies: The following equipment and supplies will be necessary when performing this procedure ...6. Label oxygen supplies (tubing, mask. Etc.) with date and initial. Supplies should be changed at least weekly while in use ..." On 7/11/23 at 11:39 AM, an observation of Resident #10 revealed the resident was receiving oxygen (O2) per nasal canula and the oxygen tubing and humidifier bottle were not dated. An observation of Resident #10's O2 tubing and humidifier bottle with Licensed Practical Nurse (LPN) #1 on 7/12/23 at 8:30 AM, confirmed there was not a date on the oxygen tubing or humidifier bottle. State Agency asked how often should the O2 tubing, and humidifier bottle should be changed, and LPN #1 revealed weekly on Mondays. LPN #1 stated she was uncertain of the last time the tubing and humidifier bottle was changed because there was label or date of when it was last changed. LPN #1 confirmed when the tubing is changed it should be dated and revealed concerns from not changing the tubing and humidifier bottle as ordered is dust build up on tubing, increased risk for infection, and giving the resident non humidified oxygen causing sores or dry nostrils. An interview with the Director of Nursing (DON) on 7/12/23 at 9:00 AM, revealed that oxygen tubing and humidifier bottle should be changed weekly and initialed and dated. The DON	F 695	deficient practice. No negatives findings noted. " All 7 residents with oxygen orders were identifed of needing oxygen tubing and humifier bottle changed Mondays have the potential to be affected by this deficient practice. " On 7/11/2023 Director of Nurses and LPN #1 assessed 100% of residents in the facility with oxygen orders for correct labeled and dated oxygen tubing as well as humidifier bottles due to the potential negative outcomes of deficient practice. No negative outcomes noted. On 7/11/2023 Director of Nurses In-Serviced 11 LPNs and 2 Registered Nurse's on labeling and dating oxygen tubing as well as humidifier bottle. On 7/11/2023 QA Committee (Administrator, Director of Nurses, Infection Preventionist, charge nurse, Housekeeping Supervisor and Medical Director) reviewed the policy for "Oxygen Administration" with no recommended changes at this time. " The facility Director of Nurses will assess all residents with oxygen orders daily x 1 week then twice a week x 4 weeks then monthly x 2 starting 7/24/2023 to ensure labeling and dating is correct on all oxygen tubing and humidifier bottles. Quality Assurance Committee will evaluate Director Of Nurses monitoring log for observation findings on 8/18/2023 then review quarterly x 2	

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F 695	Continued From page 6 confirmed if the tubing and humidifier bottle was not dated there was no way to be certain of when it was last changed and confirmed concerns of not changing the tubing as ordered is increased risk of infections. A record review of Resident #10's Physician Orders for July 2023, revealed an order dated 1/24/19 for "O2 at 3 L/MIN (liters per minute) continuously Chronic Pulmonary Edema" and an order dated 4/24/23, "Change O2 tubing and AquaPack Q (every) Monday." Record review of the Face Sheet revealed the facility admitted Resident #10 to the facility on 1/17/2018 with diagnoses including Persistent Vegetative State and Chronic Pulmonary Edema.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		8/25/23

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F 761	Continued From page 7 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to discard out of date Influenza vaccines and failed to secure injectable Lorazepam in a locked secured box in the refrigerator for (1) one of (1) one medication storage room. Findings include: Review of the facility policy titled, "Storage of Medications" with a revised date of April 2007, revealed, "Policy Statement The facility shall store all drugs and biologicals in a safe, secure, and orderly manner ...Policy Interpretation and Implementation ...The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed ...Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurse's station or other secured location ..." An observation on 07/12/23 at 03:50 PM, with Licensed Practical Nurse (LPN) #2 revealed 10 Fluzone single dose vaccines with an expiration date of 5/20/23, 11 single dose flu vaccines with an expiration date of 5/11/22, one (1) multidose five (5) milliliter (ml) vial out of date on 1/27/22, and four (4) five (5) ml vials of Flu vaccine out of date on 6/30/23. The observation also revealed	F 761	"on 7/12/2023 Licensed Practical Nurse who is also the Administrator immediately removed all expired vaccines and discarded all vials of ativan from emergency narcotic kit due to not being refrigerated. New refrigerator and Secure box was purchased and put in place on 7/13/2023. " All 49 residents had the potential to be affected by this deficient practice if the medication had been administered. "on 7/12/2023 Director of Nurses checked all 49 residents physician orders for ativan and vaccine orders. No residents had Intramuscular ativan ordered and Flu Vaccine administration according to policy ended on 3/31/2023. no negative findings noted. All nursing staff in-serviced on expired medications and proper storage of ativan on 7/12/2023 per Director of Nursing and Administrator. Quality Committee which included Administrator, Medical Director, Charge Nurse, Director of Nurses reviewed policy Storage of Medications on 7/12/2023 with no recommended changes at this time "Director of Nurses and Administrator to	

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F 761	Continued From page 8 nine (9) vials of Lorazepam 2mg(milligram)/ml (millimeter) in a locked drawer in the medication room in plastic box sealed with a zip tie. The Lorazepam vial label revealed to refrigerate. The vials were not refrigerated. The refrigerator did not have a secured lock box inside for the storage of control medications requiring refrigeration. LPN #2 confirmed these findings. An interview, concerning the out-of-date flu vaccines, on 7/12/23 at 3:53 PM with LPN #2 revealed if out of date medications are used, they may not be giving the most effective dose to the resident. LPN #2 confirmed the Lorazepam vials indicated to refrigerate. She stated they have always kept them in this locked drawer. An interview on 7/12/23 at 4:10 PM, with the Administrator (ADM) revealed Ativan (Lorazepam)should be in the refrigerator to maintain its potency. She confirmed the vials are labeled to refrigerate. The ADM confirmed the vials were in a plastic container with other medications sealed with a zip tie and in a locked drawer in the medication room that could easily be taken. She stated the Lorazepam should be in a locked box secured inside the refrigerator. She confirmed the refrigerator did not have a secured box, but they would get one. An interview on 07/13/23 at 10:20 AM, with the Director of Nursing (DON) confirmed the flu vaccines were out of date and should have been removed from the refrigerator. She stated that the Lorazepam should be in the refrigerator in a secured locked box. An interview on 07/13/23 at 10:29 AM, with Licensed Practical Nurse (LPN) #3 concerning flu	F 761	check 2 Medication Carts and 1 Medication supply room for expired medication and improperly stored medication twice a week x 2 weeks then weekly x 2 weeks then monthly x 2 months starting 7/24/2023. Quality Assurance committee will reviewing monitoring log (observation of completed findings) on 8/18/2023 the review quarterly x 2	

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F 761	Continued From page 9 vaccines revealed that she was responsible for them and should have discarded them. She stated that none of the out-of-date vaccines had been given to a resident. A telephone interview on 7/13/23 at 12:58 PM, with the facility Consultant Pharmacist revealed he was in the facility during the survey. He confirmed they probably should have caught the out-of-date flu vaccine in the refrigerator. He stated the resident could be at risk for not receiving an effective dose if an out-of-date vaccine was given. The Consultant Pharmacist stated that ideally Lorazepam should be stored in the refrigerator and the facility should have a secured lock box in the refrigerator. Review of the inpatient influenza vaccination record revealed the last influenza vaccine given was on 2/3/23 from a vial with an expiration date of 6/30/23.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		8/25/23

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F 812	Continued From page 10 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review the facility failed to ensure kitchen sanitation was maintained in a manner that meets professional standards for 44 of 49 residents whose meals are prepared in the kitchen. Findings include: Review of the facility policy titled "Machine Warewashing", with a revision date of 6/14, revealed, " ...Procedure...3. The dishmachine operator documents the machine temperature and concentration of the sanitizing solution for warewashing after each meal on the Dishmachine Temperature/Chemical Log..." Review of the facility policy titled, "Manual Warewashing", with a revision date of 10/17, revealed, "...Procedure... 6. The concentration of the sanitizing solution is checked with an appropriate test kit when the sink is filled...9. The employee using the three compartment sink documents temperature and concentration." A record review of the July Dish Machine and Pot/Pan Sink form revealed that there was no documentation of temperatures or chemical sanitation levels for the low temperature dish machine or the pot/pan sink from 7/1/23 through 7/10/23.	F 812	" On 7/11/2023, The Dietary manager immediately checked sanitation level and temperature for the Dish Machine, pot/pan sink. Temperature reading for dish machine was 126 (normal is above 120). Water Temperature for Pot/pan sink was 130 (above 110 is normal) Sanitation level was 310 (betweeen 200-400 is normal) " 44 of 49 residents have potential for illness related to this deficient practice. " All 44 of the 49 residents were assessed for sign and or symptoms of any food-borne illness on 7/12/2023 by Infection Preventionist and Director of Nurses with no negative findings. on 7/11/2023 Dietary manager immediately in-serviced all dietary staff on proper Dish Machine/ pot pan sink sanitation levels and temperatures according to manufacturer recommendations. In-serviced on documentation of logs of both dishwasher temp and sanitation log per Dietary manager. Quality Assurance Committee which included Administrator, Dietary Manager, Infection Preventionist, Director of Nurses, Charge Nurse, Medical Director and Social Worker reviewing Manual Warewashing and Dishwashing Machine Use on 7/13/2023 with no recommended changes to the	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUITMAN COUNTY HEALTH & REHAB LLC	350 GETWELL DRIVE MARKS, MS 38646

(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 812	Continued From page 11 During an interview with the Dietary Manager on 7/11/23 at 9:15 AM, she confirmed there were no documented temperatures or chemical sanitation levels for the low temperature dish machine or pot/pan sink from 7/1/23 through 7/10/23. She stated that she was off during that time and did not realize it was not done. The Dietary Manager stated that the tray aids and cooks were responsible for checking and documenting the temperatures and chemical sanitation levels; and that the cooks were responsible for making sure that it was completed when she was out. She verified that the temperatures and chemical sanitation levels should have been checked and documented. During an interview with Tray Aide #1 and Tray Aide #2 on 7/11/23 at 1:20 PM, they both confirmed that they did not check temperature or chemical sanitation levels for the dish machine or pot/pan sink while the Dietary Manager was out. During an interview with the cook on 7/11/23 at 1:22 PM, revealed he had checked some of the temperatures and chemical sanitation levels for the dish machine and pot/pan sink, but he did not document them. He stated that he should have documented the temperatures and chemical sanitation levels. The cook stated that if the temperatures and chemical sanitation levels for the dish machine and pot/pan sink are not checked then you cannot be sure the dishes are clean, and this can lead to foodborne illness for the residents. During an interview with the Administrator on 7/11/23 at 3:30 PM, she confirmed that the kitchen staff should have documented temperature and chemical sanitation levels for	F 812	policy at this time. All dietary staff will be assigned Dishwashing machine Use policy and procedure on Skilled Nursing Facility Clinic to be acknowledged and completed by 8/3/2023. "on 7/24/2023 The Dietary Manager will check daily x 2 weeks then twice a week for 2 weeks then weekly x 1 for correct sanitation levels/temperature level and Administrator will check for correct levels twice a week x 5 weeks then monthly x 2 The Quality Assurance committee will review completed monitoring log of observations on 8/18/2023 then quarterly x 2	

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F 812	Continued From page 12 the dish machine and pot/pan sink. The Administrator stated that failure to ensure temperatures and chemical sanitation levels are adequately maintained could lead to resident illness.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		8/25/23

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F 880	Continued From page 13 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility policy review the facility failed to perform hand hygiene upon removing gloves, failed to dispose of a pill after it fell on the medication cart,	F 880	" Licensed Practical Nurse #1 was counseled and educated on proper hand hygiene, infection control practices and reusable equipment cleaning during	

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F 880	Continued From page 14 and failed to use a barrier when administering eye drops for (2) two of (6) six residents reviewed during medication pass. Resident #15 and #29. Findings include: Review of the facility policy titled, "Handwashing/Hand Hygiene", revised 2015, revealed, "Policy Statement This facility considers hand hygiene the primary means to prevent the spread of infection. Policy Interpretation and Implementation ...2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors ...6. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: ...m. After removing gloves ..." Review of the facility policy titled, " Installation of Eye Drops", undated, revealed, "Purpose The purpose of this procedure is to provide guidelines for installation of eye drops to treat medical conditions, eye infections and dry eyes." After the eye drops are administered, the steps in the procedure include remove gloves and discard into designated container. Wash and dry your hands thoroughly. Clean your equipment and return it to its designated area. An observation during medication pass on 7/12/23 at 8:30 AM, with Licensed Practical Nurse (LPN) #1, revealed during the administration of the Artificial Tears eye drops LPN #1 placed the eye drop box and the eye drop bottle top on the overbed table without a barrier and without disinfecting the table. LPN #1 donned gloves to administer the eye drops. She removed her gloves after administering the eye	F 880	medication administration by the Director Of Nursing (DON) on 7/12/2023. Resident #29 was assessed by DON on 7/12/2023 for signs and symptoms of infection with no negative findings related to this deficient practice. All residents that received medications by LPN #1 on 7/12/2023 were assessed by Director of Nurses for signs and symptoms of infection on 7/12/2023 with no negative findings related to the deficient practice. " All residents receiving medications have the potential to be affected by this deficient practice. All residents that were administered medications by LPN#1 have the potential to be affected by this deficient practice. " On 7/12/2023, the facility Quality Assurance Committee including Administrator, Medical Director, Infection Control Preventionist, Director of Nursing, Charge Nurse, and Housekeeping Supervisor reviewed infection control and hand hygiene practice policies and there are no recommended changes at this time. On 7/24/2023, the DON and Infection Control Preventionist began a mandatory training of all staff on Hand Hygiene and Standard practices of Infection Control by assigning Hand Hygiene video in Skilled Nursing Facility Clinic and assigning Hand wash hygiene policy and procedure for all staff to acknowledge and complete by 8/4/2023 Infection Prevention and Director of Nurses assigned videos on Skilled Nursing Facility Clinic Administering eye	

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F 880	Continued From page 15 drops and did not wash her hands before administering the remainder of the residents' medications. LPN #1 exited the resident room and placed the contaminated eye drops in the medication cart drawer. An observation on 7/12/23 at 8:40 AM, with LPN #1 revealed LPN #1 dropped a Folic Acid 1 milligram tablet on the top of the medication cart and picked it up and administered it to Resident #29. An interview on 7/12/23 at 1:30 PM, with LPN #1 confirmed that she did drop a pill on the top of the medication cart during medication pass. She stated that she should have discarded it and got another one because of contamination. She stated that she thought about it but went ahead and put it in the cup. LPN #1 confirmed she should have used a barrier for the eye drops to prevent contamination and placing them in the medication cart drawer contaminated the drawer. She stated that she realized she should have washed her hands after taking her gloves off and before giving the resident the rest of her medication. She stated that she should wash her hands anytime she removes her gloves. An interview on 07/13/23 at 08:30 AM, with the Director of Nursing (DON) revealed staff should wash their hands anytime gloves are removed to prevent contamination and spread of infection. Barriers should be used to prevent the spread of infection or wipe the table with a purple top (disinfectant) wipe because you don't know what is on the tables in resident's rooms. The DON stated that if a medication is dropped on the top of the cart, it should be disposed of and if it was picked up without the nurse having on gloves and	F 880	medication, Administering Oral medication and preventing med errors as well as assigning policy and procedures Instillation of eye drops and examples of donning personal protective equipment to be completed by 8/4/2023. These competencies will be completed by 8/4/2023. After completion of assignments staff will complete a competency check off on 8/7/2023 & 8/8/2023 to accommodate all shifts by the Director of Nurses and Infection Preventionist during medication administration for proper hand hygiene, use of barrier and standard infection control practices. Nursing staff is in-serviced on date of hire, quarterly and as needed for infection control & prevention to ensure proper policy and procedures are followed to ensure no residents will be negatively affected. " The DON and Infection Control Preventionist will monitor hand hygiene, use of disposable tray(barrier) and medication pass to ensure medication is not contaminated twice week for two weeks and weekly for two weeks then weekly x 1 then monthly x 2 for compliance and document. Monitoring began on 07/28/2023. Any issues of noncompliance with infection control practices will be addressed immediately and reviewed in Quality Assurance Committee meeting to review completion of monitoring log findings on 8/18/2023 then quarterly x 2	

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F 880	Continued From page 16 put into the medication cup, the whole cup of medications was contaminated.	F 880		