STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555902	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEIGHT STREET SKILLED CARE	**1611 HEIGHT STREET BAKERSFIELD, CA 93305**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0563 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.** Based on interview and record review, the facility failed to follow its visitation policy for one of seven sampled residents (Resident 71). This failure violated Resident 71's right to communicate with family members and friends. Findings: During an interview on 3/3/20, at 9:55 AM, with Resident 71, Resident 71 stated she was told visitors cannot come into the facility after 9 PM. During a concurrent interview and record review on 3/3/20, at 11:27 AM, with receptionist (REC) 2, he stated, visiting hours are eight to eight and visitors are informed of visiting hours. The facility's current Visitors Log, dated 2/26/20 through 3/3/20 indicated no visitors stayed past 8 PM. REC 2 verified the findings. During a review of the facility's policy and procedure (P & P) titled, Visitation, dated 5/17, the P&P indicated, The facility provides 24-hour access to all individuals visiting with the consent of the resident.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an Advance Directive (end of life health care decisions) was completed for three of three sampled residents (Resident 45, Resident 56, and Resident 28). This failure had the potential for staff to be unaware of treatments to be provided to the three residents in the event of a medical emergency. Findings: During a review of the clinical record for Resident 45 on 3/3/20, at 9:43 AM, the Physician order [REDACTED]. During a review of the clinical record for Resident 56 on 3/3/20, at 9:46 AM, the POLST, dated 10/30/19, indicated Resident 56's advance directive not available. During a review of the clinical record for Resident 28 on 3/3/20, at 9:47 AM, the POLST, dated 4/5/18, indicated Resident 28 did not have an advance directive or an acknowledgement form indicating an advance directive was offered. During a concurrent interview and record review on 3/3/20, at 11:18 AM, with the Administrator, Administrator reviewed the clinical records for Resident 45, Resident 56, and Resident 28. Administrator confirmed Resident 45, Resident 56, and Resident 28, did not have an advance directive or acknowledgement form in their clinical records. During a review of the facility's P&P titled, Advance Directives, dated 2015, the P&P indicated, The facility shall recognize the right of the resident, under California Statues and Court decisions to give or withhold informed consent to medical treatment. This includes the right to complete an advance directives indicating what forms of treatment are or are not provided in a medical emergency or near the end of life and who is authorized to make medical decisions on resident's behalf if resident loses the ability to make such decisions independently. 3. Forward the acknowledgement and include it in the resident's medical file (chart) and business file within 24 hours of admission.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accurately code Minimum Data Set (MDS- an assessment tool) for five of five residents (Resident 7, Resident 64, Resident 40, Resident 29, and Resident 16) when: 1. Resident 7, Resident 64, Resident 40, and Resident 29 were inaccurately coded as using restraints daily. 2. Resident 16's vision assessment was inaccurately coded. This failure resulted in inaccurate assessment data, which had the potential for incorrect care planning. Findings: 1. During a concurrent observation and interview on 3/3/20, at 9:22 AM, with Resident 64, in Resident 64's room, Resident 64 was sitting on the side of his bed. Resident 64 stated bedrails do not prevent him from getting out of bed, uses them for positioning while in bed. During a concurrent observation and interview on 3/2/20, at 9:48 AM, with Resident 7, in Resident 7's room, Resident 7 was sitting in a wheelchair. Resident 7 stated he gets in and out of bed by himself. Resident 7 stated the bedrails on his bed do not prevent him from getting out of bed. During a concurrent observation and interview on 3/3/20, at 8:37 AM, with Resident 29, in Resident 29's room, Resident 29 was sitting on the side of her bed. Resident 29 stated the bedrails on her bed help her to move but do not prevent her from getting out of bed. During a concurrent observation and interview on 3/4/20, at 2:35 PM, with Resident 40, in Resident 40's room, Resident 40 was sitting in wheelchair at bedside. Resident 40 stated she uses the bedrails to help move in bed. Resident 40 stated she is unable to get out of bed without staff assistance. During a concurrent interview and record review on 3/2/20, at 3:09 PM, with MDS coordinator (MDSC), MDSC stated bedrails are being used for mobility and repositioning, not restraints. The MDS assessments indicated: a. Resident 64, MDS dated [DATE], indicated Section P- Restraints A. Bed rail. 2 = Used daily. The physician orders, dated 1/27/20, indicated Both half side rails up to promote bed mobility and assist in turning and repositioning in bed every shift. b. Resident 7, MDS dated [DATE], indicated Section P- Restraints A. Bed rail. 2 = Used daily. The physician orders, dated 2/25/20, indicated Both half side rails up to promote bed mobility and to assist resident with turning and repositioning in bed. every shift (sic). c. Resident 29, MDS dated [DATE], indicated Section P- Restraints A. Bed rail. 2 = Used daily. The physician orders, dated 1/28/20, indicated Both half side rails up to promote bed mobility and assist resident with turning and repositioning in bed every shift. d. Resident 40, MDS dated [DATE], indicated Section P- Restraints A. Bed rail. 2 = Used daily. The physician orders, dated 2/28/20, indicated Both half side rails up to promote bed mobility and assist resident with turning and re-positioning in bed. every shift (sic). During an interview with the Administrator and the Director of Nursing (DON) on 3/4/20, at 9:13 AM, Administrator and DON confirmed nearly all residents are MDS coded as having restraints because bedrails are being used. Administrator and DON stated bedrails are used as positioning and mobility devices and not restraints. During a review of the facility's policy and procedure (P&P) titled, Physical Restraints and Guidelines for Application, dated 10/15, the P&P indicated, It is the policy of this facility that each resident reach his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. According to the Resident Assessment Instrument Manual (RAI- a manual for coding the MDS) dated ,[DATE], the RAI indicated Definition of Physical Restraint: Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. 2. During an interview on 3/2/20, at 2:55 PM, with Resident 16, Resident 16 stated he wanted his [MEDICAL CONDITION]

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) removed for over a year. During a review of Resident 16's eye examination form, dated 3/29/19, the eye examination form indicated, Diagnosis: [REDACTED].) [MEDICAL CONDITION] (condition causing clouding of the eye lens), OU (both eyes). During a concurrent interview and record review, on 3/4/20, at 9:51 AM, with MDSC, Resident 16's MDS dated [DATE], was reviewed. MDSC verified there was no [DIAGNOSES REDACTED]. MDSC stated Resident 16's [DIAGNOSES REDACTED]. MDSC confirmed the MDS was inaccurate. MDSC stated he was responsible to ensure the information on the MDS is accurate.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive care plan for one of 41 sampled residents (Resident 16). This failure had the potential for Resident 16 to not receive individualized care and have his needs met. Findings: During an interview, on 3/2/20, at 2:55 PM, with Resident 16, Resident 16 stated he wanted his [MEDICAL CONDITION] removed for over a year. During a concurrent interview and record review on 3/3/20, at 3:24 PM, with Director of Social Services (DSS), Resident 16's eye examination form, dated 3/29/19 was reviewed. The eye examination form indicated, Diagnosis: [REDACTED].) [MEDICAL CONDITION] (condition causing clouding of the eye lens), OU (both eyes). 4.) discussed cat (cataract) sx (surgery) w (with)/pt (patient). pt wants surgery. Ophthalmology (study of eyes and vision) Referral IN-HOUSE, CAT. GOALS OF TREATMENT: Quality of life, Improvement of vision. During a concurrent interview and record review, on 3/4/20, at 10:37 AM, with DSS, Resident 16's medical record was reviewed. DDS was unable to provide a vision impairment care plan for Resident 16. During a review of the facility's policy and procedure (P&P) titled, Care Planning, undated, the P & P indicated, POLICY STATEMENTS: This facility will develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** Based on interview and record review, the facility failed to ensure comprehensive care plans were revised for three of four sampled residents (Resident 7, Resident 56, and Resident 72). This failure had the potential to result in inadequate and inappropriate care and treatment. Findings: During a concurrent interview and record review, on 3/5/20, at 1:21 PM, with Assistant Director of Nursing (ADON) and Director of Social Services (DSS), Resident 7's, Resident 56's, and Resident 72's care plans and Smoking Safety Evaluation (SSE) forms were reviewed: a. Resident 7's care plan dated 11/19/19 indicated, The resident requires a smoking apron while smoking. b. Resident 56's care plan dated 10/31/19 indicated, The resident's supplies are stored at nurse's station. c. Resident 72's care plan dated 12/1/19 indicated, The resident's supplies are stored with nursing. DSS stated that Resident 7 does not comply with wearing a smoking apron and DSS was unable to provide documentation of Resident 7's behavior and a revision of care plan to reflect non-compliance. ADON stated, The care plan was reviewed by the Interdisciplinary Team (IDT- professionals plan, coordinate, and deliver personalized care for residents) and should have been updated when they did the smoking evaluation. During a review of the facility's policy and procedure (P&P) titled, Care Planning-Comprehensive Person Centered, dated 3/28/17, the P&P indicated, The facility shall ensure development of a comprehensive care plan for each resident to meet his/her medical, nursing, and mental and psychosocial needs as identified in the comprehensive assessment. 8. Documentation in the resident's clinical record should include the following information: 8.1. Identification of reason or cause of treatment refusal. 16. Care Plans are to be reviewed, on a minimum, once every quarter (every 90 days) and whenever necessary, either as a result of significant change in resident's status and condition, or of discontinued plan of care based on new information derived from the resident's assessment to assure the continued accuracy of the assessment.
F 0685 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist a resident in gaining access to vision and hearing services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide medically related social services for one of 41 sampled residents (Resident 16) when: 1. Resident 16 did not receive a hearing evaluation and replacement of hearing aids/device. 2. Resident 16 did not receive follow up for vision care and recommended cataract surgery. This failure had the potential for Resident 16's hearing and vision to worsen. Findings: 1. During an interview, on 3/2/20, at 2:55 PM, with Resident 16, Resident 16 stated he was hard of hearing and wanted hearing aids. Resident 16 stated, he gave up on hearing aids. During a concurrent interview and record review on 3/3/20, at 3:17 PM, with Social Services Assistant (SSA), SSA reviewed the social services notes and stated, Resident 16 did not have hearing aids. SSA reviewed Resident 16's care plan, dated 4/30/19, which stated Resident 16 had hearing aids and a hearing deficit. During a concurrent interview and record review on 3/3/20, at 3:24 PM, with Director of Social Services (DSS), DSS stated Resident 16 had a hearing device. SSD reviewed Resident 16's Inventory List, dated 6/14/19, the Inventory List indicated under Prosthetic Devices 1 P (pair) hearing aids, verified by DSS. DSS was unable to provide documentation Resident 16 received a hearing assessment consultation. During a concurrent interview and record review on 3/4/20, at 9:51 AM, with MDS coordinator (MDSC), Resident 16's MDS, dated [DATE], was reviewed. Patient 16's MDS indicated minimal difficulty hearing. MDSC stated SSD performs hearing assessment for the MDS. During an observation and interview with Resident 16 on 3/5/19, at 9:32 AM, Resident 16 stated he wanted hearing aids because he cannot hear well enough without them. Resident 16 stated he had to have everyone repeat what they say and come closer to hear them. Resident 16 had difficulty hearing the interview questions at approximately three feet despite speaking loudly. Resident 16 appeared frustrated because he could not hear the conversation and he had to ask the surveyor to repeat the questions. 2. During an interview on 3/2/20, at 2:55 PM, with Resident 16 stated, Resident 16 stated he had wanted his [MEDICAL CONDITION] (condition causing clouding of the eye lens), removed for over a year. During a concurrent interview and record review, on 3/3/20, at 3:24 PM, with Director of Social Services (DSS), Resident 16's eye examination form, dated 3/29/19 was reviewed. The eye examination form indicated, Diagnosis: [REDACTED].) [MEDICAL CONDITION] OU (both eyes). 4.) discussed cat (cataract) sx (surgery) w (with)/pt (patient). pt wants surgery. Ophthalmology (study of eyes and vision) Referral IN-HOUSE, CAT. GOALS OF TREATMENT: Quality of life, Improvement of vision. DSS was unable to provide documentation of follow up with the Ophthalmologist (doctor specializing in eyes and vision) or a referral regarding Resident 16's request for cataract surgery. DDS was unable to provide documentation the physician was notified of the eye examination findings. During a concurrent interview and record review, on 3/3/20, at 3:57 PM, with Director of Nursing (DON,, Resident 16's Eye examination form, dated 3/29/19, was reviewed. DON was unable to provide documentation of follow up regarding the cataract referral and cataract surgery recommendation. DON stated, It was definitely missed. DON stated, they should have met with the patient and discussed the cataract surgery. During an interview on 3/5/20, at 9:32 AM, with Resident 16, Resident 16 stated he wanted his [MEDICAL CONDITION] removed. Resident 16 stated he liked to read because it was the only thing he could do here. Resident 16 stated he cannot read now because his vision is blurry and he really wants to read again. During a review of CMS' (Center for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, dated 10/19, indicated, Hearing . minimal difficulty: . The resident hears speech at a conversational levels. moderate difficulty: Speaker has to increase volume and speak distinctly. Although hearing-deficient, the resident compensates when the speaker adjusts tonal quality and speaks distinctly. Hearing aid . Health Related Quality of Life. Problems with hearing can contribute to social isolation. Many residents with impaired hearing could benefit from hearing aids or other hearing appliances. Vision. Health Related Quality of Life. Decreased ability to see can limit the enjoyment of everyday activities and contribute to social isolation. Residents who do not have adequate vision, despite using a visual appliance, might benefit from a re-evaluation of the appliance or assessment for new causes of vision impairment. During a review of the facilities' policy and procedure (P & P) titled, Social Services Department, undated, the P & P indicated, Social Services staff will coordinate Dental, Optometry (vision) and Audiology (hearing) evaluations for Residents. PROCEDURE: 1. Social Services will maintain a system to monitor the Dental, Optometry, and Audiology evacuations. 2. Dental, Optometry, and Audiology evaluations will be scheduled on an annual basis and/or as needed.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate**

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) **supervision to prevent accidents.** Based on observation, interview and record review, the facility failed to ensure adequate smoking assessment, monitoring, and supervision for four of four sampled Residents (Resident 2, Resident 7, Resident 56, and Resident 72) when: 1. Facility staff supervising residents (Resident 2, Resident 7, Resident 56 and Resident 72) during smoke break did not know how to operate a fire extinguisher. 2. A Smoking Safety Evaluation (SSE) for one resident (Resident 7) was not complete. 3. Facility did not follow smoking care plan for one resident (Resident 2). These failures had the potential to compromise the safety of the residents. Findings: 1. During a concurrent observation and interview on 3/4/20, at 10:35 AM, with Receptionist (REC) 1, in designated smoking area, REC 1 was supervising the smoking residents and stated he did not know how to operate a fire extinguisher. During a concurrent interview and record review on 3/4/20, at 11:12 AM, with Director of Staff Development (DSD), employee's personnel file for REC 1 was reviewed. DSD stated he was hired as a full time employee on 11/4/19 but has not attended any fire safety classes since hired. During an interview on 3/4/20, at 11:20 AM, with Administrator, Administrator stated everyone who supervises the residents should know how to use a fire extinguisher and confirmed REC 1 should not be supervising smoking residents. 2. During a concurrent observation and interview on 3/3/20, at 10:30 AM, in designated smoking area, Resident 7 ignited his cigarette with a lighter that he had in his possession and refused to wear the smoking apron (protects resident's clothing from burning ash). Resident 7 stated, I keep my own cigarette and lighter with me all the time. During a concurrent interview and record review on 3/5/20, at 2:41 PM, with Assistant Director of Nursing (ADON), Resident 7's Smoking Safety Evaluation, dated 11/19/19 was reviewed. The SSE did not indicate whether the resident has the ability to light, hold, and extinguish cigarette safely. ADON stated, The Interdisciplinary Team (IDT-professionals plan, coordinate and deliver personalized care for residents) should have assessed resident (to determine) if he has the ability to complete these tasks. 3. During a concurrent observation and interview on 3/3/20, at 10:10 AM, in designated smoking area, Resident 2 ignited his cigarette with a lighter he had in his possession. Resident stated, I keep my cigarette and lighter. They don't put it at the nurse's station. During a concurrent observation and interview on 3/3/20, at 10:42 AM, with ADON, at nurse's station one, the smoking box (a locked metal box where cigarettes and lighters are kept) was opened and did not have Resident 2's cigarette and lighter. ADON stated, The staff who's scheduled to go out there gets the cigarettes from the box and then gives it to them and lights it for them. During an interview on 3/3/20, at 11 AM, with REC 1, REC 1 stated, I just come out here to watch them. I don't pick up anything from the smoking box. During a concurrent interview and record review on 3/5/20, at 1:21 PM with ADON, Resident 2's SSE, dated 2/19/20 and care plan dated 6/28/19 were reviewed. The SSE indicated the resident requires assistance to light and extinguish cigarette safely. The Resident 2's care plan indicated, The resident's smoking supplies are stored with nursing. ADON verified the findings. During a review of the facility's policy and procedure (P&P) titled, Physical Environment-Smoking, dated 2017, the P&P indicated, 7. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include . d. Ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation).
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** Based on interview and record review, the facility failed to ensure its drug regimen review policy and procedure (P&P) was followed for one of 41 residents (Resident 29). This failure had the potential to negatively impact Resident 29's health and safety. Findings: During a concurrent interview and record review, on 3/3/20, at 3:40 PM, with the Director of Nursing (DON), Resident 29's medical record was reviewed. A note from the facility's consultant pharmacist (CP), dated 2/27/20, indicated a pharmacist recommended lab draws be done monthly for blood clotting time and thinness of blood, because of a blood thinning medication taken by Resident 29. A box was checked indicating I disagree with the pharmacist's recommendation. Please see physician's comments below for brief explanation of reason for disagreeing with recommendations. The Physician's Justification comment area was blank. DON stated the physician should have completed a justification for disagreeing with the pharmacy recommendation. During an interview with the CP on 3/5/20, at 10:36 AM, CP stated he does not call the Medical Director of the facility if the ordering physician does not write a justification for disagreeing with the pharmacist's recommendation. During a review of the facility P&P titled, Medication Regimen Review, undated, the P&P indicated, The Consultant Pharmacist shall review the medication regimen of each resident at least monthly. 8. The Consultant Pharmacist will provide a written report to physicians for each resident with an identified irregularity. If the situation is serious enough to represent a risk to a person's life, health, or safety, the Consultant Pharmacist will contact the Physician directly to report the information to the Physician, and will document such contacts. If the Physician does not provide a pertinent response, or the Consultant Pharmacist identifies that no action has been taken, he/she will then contact the Medical Director, or if the Medical Director is the Physician of Record--- the Administrator.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 observation, interview, and record review, the facility failed to ensure one multi-dose vial of influenza (flu) vaccine was labeled with date it was opened. This failure had the potential for nursing staff to administer medication with reduced potency and to adversely affect residents' health. Findings: During a concurrent observation and interview, on [DATE], at 9:06 AM, with Registered Nurse (RN) 9, in Medication Room at Station One, an opened multi-dose vial of influenza vaccine was noted in the medication refrigerator. The opened vial did not have an open date written on the vial. RN 9 stated there was no open date on the vial and was not able to determine if the vaccine had expired. During a review of the Centers for Disease Control and Prevention website at www.cdc.gov, regarding Injection Safety, it indicated, If a multi-dose (vial) has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days.
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 observation, interview, and record review, the facility failed to follow its food labeling policy and procedure (P&P). This failure had the potential to place residents at risk for developing foodborne illnesses'. Findings: During a concurrent observation and interview, on 3/2/20, at 8:29 AM, with Dietary Supervisor (DS), in the dry food storage room, an open bottle of apple cider vinegar, without an open date or use by date, was on the shelf. DS confirmed the findings. During a review of the facility's P&P titled, General receiving of delivery of food and supplies, dated 2018, the P&P indicated, .Label all items with the delivery date or a use-by-date.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to implement infection control practices for three of 41 sampled Residents (Resident 76, Resident 6, and Resident 77) when: 1. Hand hygiene was not properly performed during wound care for Resident 76. . 2. Hand hygiene was not properly performed while assisting Resident 6 and Resident 77 with feeding. This failure had the potential to transmit infection and disease to residents, staff, and visitors. Findings: 1. During a concurrent observation and interview, on 3/3/20, at 2:55 PM, in Resident 76's room, Licensed Vocational Nurse (LVN) 1 did not perform hand hygiene before and after changing gloves. LVN 1 stated he was supposed to wash his hands

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) before putting on new gloves but forgot to do it. During an interview on 3/3/20, at 3:15 PM, with Assistant Director of Nursing (ADON), ADON stated, All staff should do hand hygiene before putting on new gloves. During an interview on 3/4/20, at 2:50 PM, with Director of Staff Development (DSD), DSD stated, Every time we put on a new pair of gloves, we should wash our hands. During a review of the facility's policy and procedure (P&P) titled, Wound Care, Routine, undated, the P&P indicated, .K. Remove gloves and wash hands. During a review of the facility's P&P titled, Hand Washing/Hand Hygiene, dated 2017, the P&P indicated, .2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections . n. Before handling clean or soiled dressings, gauze pads, etc.t. After removing gloves. 2. During an observation, on 3/2/20, at 12:03 PM, in the Bistro dining room, Rehabilitative Nurse Assistant (RNA) touched chairs and tables as she moved though the dining room, then passed trays to residents. RNA adjusted the placement of Resident 65's and Resident 77's wheelchairs to be closer to the table where they were seated. RNA then sat down on a chair at the same table, adjusted her chair to be closer to the table and then began assisting Resident 77 with feeding. No hand hygiene was observed after she touched the various surfaces and before she began feeding Resident 77. During an observation on 3/2/20, at 12:13 PM, in the Bistro dining room, Certified Nurse Assistant (CNA) 1 sat at a table with Resident 6, who was on a Geri chair (padded, reclining chair on wheels). CNA 1 adjusted her own chair to be closer to the table, adjusted the recliner portion of Resident 6's chair, and then began feeding Resident 6. No hand hygiene was observed after she touched the various surface sand before she began feeding Resident 6. During an interview on 3/2/20, at 12:27 PM, with CNA 1, CNA 1 verified she did not wash her hands before feeding Resident 6. During an interview on 3/2/20, at 12:30 PM, with RNA, RNA verified she did not perform hand hygiene after touching the wheelchairs and chairs and before feeding Resident 77. During an interview on 3/2/20, at 12:39 PM, with Dietary Supervisor (DS), DS stated staff should wash their hands if surfaces are touched before passing trays to residents or assisting residents with feeding. During an interview on 3/4/20, at 2:53 PM, with Director of Staff Development/Infection Control and Preventionist (DSD/ICP), DSD/ICP stated the facility's expectation is for staff to wash hands or perform hand hygiene when surfaces are touched prior to passing resident meal trays or assisting with feeding residents. During a review of the facility's P&P titled, Handwashing/Hand Hygiene, dated 11/17, the P&P indicated the facility, considers hand washing/hand hygiene the primary means to prevent the spread of infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 4. A. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations. s. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; . v. Before and after assisting a resident with meals.