STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425149	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKE CITY SCRANTON HEALTHCARE CENTER	1940 BOYD ROAD SCRANTON, SC 29591

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility policy review, the facility failed to notify the physician of a change of condition of positive coronavirus (Covid)-19 test results for four (4) out of 35 sampled residents (Residents #13, #37, #40 and #47). The findings include: Review of the facility policy titled, Physician and Other Communication/Change in Condition dated 10/16/17 directed, Policy to improve communication between physicians and nursing staff to promote optimal patient/resident care, providing nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition .F. recent labs, x-ray results .3. Notify the physician of the change in medical condition . 1. Review of Resident #13's clinical record revealed an admission date of [DATE]. According to the Laboratory Report from Select Laboratories, Resident #13 was tested for Covid-19 on 7/20/2020, and the positive test result was reported to the facility on [DATE] at 4:33 p.m. Further review of the resident's clinical record revealed no notification was given to the resident's primary physician of the positive Covid-19 test result. During an interview on 8/19/20 at 11:14 a.m., the Director of Nursing (DON) reviewed the resident's record and agreed there was no documentation of notification to the resident's physician. The DON stated she expected the nurses to fill out a change of condition (SBAR) form and call to notify the physician. 2. Review of Resident #37's clinical record revealed an admitted d of 12/28/07. According to the Laboratory Report from Select Laboratories, Resident #37 was tested for Covid-19 virus on 7/20/2020, and the positive test result was reported to the facility on [DATE] at 4:48 p.m. Continued review revealed no notification was given to the physician of the positive test result. Further review revealed a physician progress notes [REDACTED]. [DIAGNOSES REDACTED]-CoV-2 (Covid-19) positive (U07.1, B97.29) - I only found out about positive test this morning. During interview on 8/19/2020 at 11:22 a.m., the DON stated she could not find notification of the positive test result given to the physician. The DON stated the physician should be notified in order to plan for a change of condition to aide in the plan of care. 3. Review of Resident #40's clinical record revealed an admission date of [DATE]. According to the Laboratory Report from Select Laboratories, Resident #40 was tested for Covid-19 virus on 7/20/2020, and the positive test result was reported to the facility on [DATE] at 1:41 p.m. Continued review of the resident's clinical record revealed no notification was given to the resident's physician of the positive test result. Further review revealed a physician progress notes [REDACTED]. [DIAGNOSES REDACTED]-CoV-2 (Covid-19) positive (U07.1, B97.29) - I only found out about positive test this morning. During an interview on 8/19/2020 at 11:01 a.m., the DON stated she did not find any notification of the positive test result to the physician in Resident #40's clinical record. 4. Review of Resident #47's clinical record revealed an admission date of [DATE]. According to the Laboratory Report from Select Laboratories, Resident #47 was tested for Covid-19 virus on 7/20/2020, and the positive test result was reported to the facility on [DATE] at 11:43 a.m. Continued review of the resident's clinical record revealed no notification of the positive test result was given to the resident's physician. Further review revealed a physician progress notes [REDACTED]. [DIAGNOSES REDACTED]-CoV-2 (Covid-19) positive (U07.1, B97.29) - I only found out about positive test this morning. During an interview on 8/19/2020 at 10:59 a.m., the DON stated the physician should have been informed about the positive test result, and there was no notification documented in the clinical record. During an interview on 8/18/2020 at 09:40 p.m., the physician for Residents #37, #40 and #47 revealed the facility staff were not reporting the Covid-19 positive results to him/her. The physician stated s/he did not find out about the results until s/he went to the facility. S/he stated that it was important for the results to be reported to him/her immediately because early treatment was vital in resolving [MEDICAL CONDITION].
F 0656 **Level of harm** - 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, record review and review of the facility's policy, it was determined the facility failed to develop and implement a comprehensive person-centered care plan for one (1) of five (5) residents with falls (Resident #170) out of a total sample of 16. Resident #170 had sustained two falls while attempting to go to the bathroom prior to a third fall on 7/11/2020. On 7/11/2020, Resident #170 fell when he/she transferred from his/her wheelchair to the toilet without assistance and sustained a left knee hairline patella fracture and laceration above his/her right eye. The resident had a history of [REDACTED]. The care plan failed to address the resident's high-risk behavior of independent toileting. The care plan included fall interventions such as encourage use of the call light and to ask for assistance which were known to be ineffective. (Refer to F-689) The findings include: Review of the facility's policy titled Person-Centered Care Plan Process, revised 7/1/16, revealed the facility will develop and implement a base line and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Review of the clinical record revealed the facility admitted Resident #170 on 10/5/17, with [DIAGNOSES REDACTED]. Resident #170 was discharged to the hospital on [DATE]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 6/19/2020, revealed the facility assessed Resident #170's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of three (3) out of 15. The facility further assessed the resident as extensive assistance with one (1) person assistance for bed mobility, transfers, dressing, toileting and personal hygiene. Continued review of the MDS revealed the resident required the assistance of one (1) person for transfers and one (1) person for toileting. Further review of the MDS revealed Resident #170 was assessed as frequently incontinent of bowel and bladder. The MDS revealed Resident #170 required one (1) person assistance to walk in his/her room and staff, used the wheelchair for mobility, and could stand and bear weight with one (1) person assistance. Continued review of the MDS revealed Resident #170 had not had any falls prior to admission or since admission or the prior assessment. Additionally, the MDS revealed that Resident #170 was frequently incontinent of bowel and bladder but was not on a toileting program. Review of the fall risk assessment, dated 12/19/19, revealed the facility assessed the resident with a score of four (4) indicating he/she was at low risk for a fall. Review of the fall risk assessment, dated 3/15/2020, revealed the facility assessed the resident with a score of 10 indicating he/she was at moderate risk for a fall. Review of the Patient/Resident Incident/Accident Investigation Worksheet, dated 7/11/2020, revealed Resident #170 was found sitting in the bathroom floor with a hematoma above his/her right eye with one-bedroom shoe on and one off at 3:50 a.m. Further review revealed Resident #170 stated he/she transferred self to bathroom and while trying to return to bed, he/she lost his/her balance and fell hitting his/her head on the wall and landed on his/her knee. Review of the Resident #170's

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 0656 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) Nursing Progress Note, dated 7/11/2020 at 4:56 a.m., revealed nurse responded to a sound that was heard in Resident #170's room at 3:50 a.m. The note stated the nurse found Resident #170 sitting in front of the toilet with hematoma and blood on his/her right forehead above his/her eye and bilateral knees light purple. The note further stated Resident #170 was transferred to the emergency room (ER) for evaluation and treatment related to the unwitnessed fall. Review of the Emergency Department (ED) Physician Note, dated 7/11/2020 at 6:36 a.m., revealed knee impression showed [MEDICATION NAME] hairline fracture seen involving the proximal third and midline third of the left patella on the lateral view. Review of the falls care plan, dated 10/19/17, revealed interventions started on 7/13/2020 (after the fall with injury on 7/11/2020) included call light within easy reach when in bed or in room, immobilizer to left knee as ordered, check skin routinely for breakdown, pressure pad alarm added to bed related to fall, check every shift for functioning and placement, and stress to resident the importance of calling for assistance with mobility and transfers. However, no additional interventions were added to the care plan for increased supervision of the resident while toileting. Interview with the MDS Coordinator on 8/19/2020 at 2:36 p.m., revealed the purpose of the care plan is for staff on the floor to follow to prevent falls or injuries and what assistance residents were assessed to need while they resided there. The MDS Coordinator stated he/she was taught that the care plan should be developed for the management of falls not for the prevention of falls. The MDS Coordinator stated that after a resident fell , the IDT determined the falls intervention which remained on the care plan until another fall occurred. Continued interview revealed that Resident #170 required assistance of one with toileting, but Resident #170 went to the bathroom without assistance at night. He/she stated that Resident #170 was noncompliant with using the call light while in bed to go to the bathroom and the care plan was updated to reflect this noncompliance; however, the staff had not updated the care plan to initiate specific interventions to prevent a fall. Interview, on 8/19/2020 at 4:20 p.m., with the Director of Nursing (DON), revealed that Resident #170's had not sustained a fall in a year so he/she felt that the falls interventions were appropriate for him/her prior to the last fall on 7/11/2020. The DON further stated that the falls care plan was initiated with the least restrictive interventions to allow Resident #170 to be as independent as possible. Continued interview revealed that he/she was not aware that Resident #170 was going to the toilet without assistance at night, so he/she didn't initiate additional interventions prior to the 7/11/2020 fall. Interview, on 8/19/2020 at 4:24 p.m., with the Administrator, revealed Resident #170 did what she wanted to do so developing a care plan to do something different would not honor her independence. The Administrator stated that if Resident #170 had a history of [REDACTED].
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, it was determined the facility failed to provide effective supervision to prevent accidents for one (1) of five (5) residents with falls (Resident #170) out of a total sample of 16. Resident #170 had experienced two falls since her/his admission and the third fall was on 7/11/2020. On 7/11/2020, Resident #170 fell when he/she transferred from his/her wheelchair to the toilet without assistance and sustained a left knee hairline patella fracture and laceration above his/her right eye. There was no documented evidence that Resident #170 was assessed as a high fall risk after he/she fell and appropriate interventions were not developed and implemented to prevent further falls. (Refer to F-656) The findings include: Review of the facility's policy, Falls Management, revised 3/29/19, revealed the facility would identify each resident who is at risk for falls and would plan care and implement interventions to manage falls. The policy revealed a fall risk evaluation would be completed to determine if a resident is a fall risk upon admission, quarterly, with a significant change and post fall. The policy stated the fall risk evaluation assisted in identifying the appropriate preventative interventions that would be recorded on the resident's care plan. The policy further revealed assistive devices would be provided based on the individual needs of the resident. Review of the clinical record revealed the facility admitted Resident #170 on 10/5/17, with [DIAGNOSES REDACTED]. Resident #170 was discharged to the hospital on [DATE]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 6/19/2020, revealed the facility assessed Resident #170's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of three (3) out of 15. Continued review of the MDS revealed the resident required the assistance of one (1) person for transfers and one (1) person for toileting. Further review of the MDS revealed Resident #170 was assessed as frequently incontinent of bowel and bladder. The MDS revealed Resident #170 required one (1) person assistance to walk in his/her room, used the wheelchair for mobility, and could stand and bear weight with one (1) person assistance. Continued review of the MDS revealed Resident #170 had no falls prior to admission or since admission or the prior assessment. Additionally, the MDS revealed that Resident #170 was frequently incontinent of bowel and bladder but was not on a toileting program. Review of the Care Plan, initiated 10/19/17, revealed the resident had a potential for falls related to weakness, debility, noncompliance with safety measures, and he/she would not call for assistance with transfers. Interventions started on 4/17/18 included encourage/assist resident to change positions slowly, especially from lying or sitting to standing, encourage use of call light for assistance, discourage resident from picking up things that have fallen and remind the resident to ask for assistance, therapy referral as indicated, use assistive devices for transfers (Hoyer, sit/stand lift, side rails, etc.) as indicated and assess for need to assign assistive devices that would alert staff to unsafe movement. Interventions started 2/22/19 included non-skid socks when out of bed. Intervention started on 2/27/2020 included two (2) leg rests and two (2) siderails to assist with mobility. Interventions started on 7/13/2020 included call light within easy reach when in bed or in room, immobilizer to left knee as ordered, check skin routinely for breakdown, pressure pad alarm added to bed related to fall, check every shift for functioning and placement, and stress to resident the importance of calling for assistance with mobility and transfers. Further review of the care plan revealed Resident #170 experienced frequent bladder and bowel incontinence, has the potential for urinary tract infection [MEDICAL CONDITION] and the resident refused staff assistance to the bathroom. Interventions started on 4/17/18 revealed offer bedpan or toileting frequently and when resident asks, pads and briefs, report any signs of skin breakdown and report signs and symptoms of UTI. Review of the fall risk assessment, dated 12/19/19, revealed the facility assessed the resident with a score of four (4) indicating he/she was at low risk for a fall. Review of the fall risk assessment, dated 3/15/2020, revealed the facility assessed the resident with a score of 10 indicating he/she was at moderate risk for a fall. Review of the Nurse's Progress Note, dated 6/22/2020, revealed Resident #170 was continent of bowel and bladder and used the toilet in his/her room with assistance at times. Review of the Physician's Progress Note dated 7/2/2020, revealed Resident #170 was assessed as a high fall risk due to weakness and complications. Review of the Patient/Resident Incident/Accident Investigation Worksheet, dated 7/11/2020, revealed Resident #170 was found sitting on the bathroom floor with a hematoma above his/her right eye with one-bedroom shoe on and one off at 3:50 a.m. Further review revealed Resident #170 stated he/she transferred him/herself to the bathroom and while trying to return to bed, he/she lost his/her balance and fell hitting his/her head on the wall and landed on his/her knee. Review of the Nurse's Progress Note, dated 7/11/2020 at 4:56 a.m., revealed Licensed Practical Nurse (LPN) #8 responded to a sound that was heard in Resident #170's room at 3:50 a.m. The note indicated LPN #8 found Resident #170 sitting in front of the toilet with a hematoma and blood on his/her right forehead above his/her eye and bilateral knees light purple. The note indicated Resident #170 was transferred to the emergency room (ER) for evaluation and treatment related to the unwitnessed fall. Review of the Emergency Department (ED) Physician Note, dated 7/11/2020 at 6:36 a.m., revealed knee impression showed [MEDICATION NAME] hairline fracture seen involving the proximal third and midline third of the left patella (knee cap) on the lateral view. Interview with Certified Nursing Assistant (CNA) #5, on 8/18/2020 at 2:11 p.m., revealed Resident #170 didn't want to use the bedpan or brief so he/she would propel him/herself down the hall in his/her wheelchair to the bathroom. CNA #5 often found Resident #170 trying to get out of bed at night to go to the bathroom. CNA #5 stated Resident #170 required one-person assistance with toileting and he/she made rounds frequently, every two (2) hours, on him/her. Interview with CNA #3 on 8/18/2020 at 2:33 p.m., revealed Resident #170 was assessed as requiring the assistance of one (1) person to use the bathroom and the resident wore a pullup (incontinence brief). The CNA stated Resident #170 went to the bathroom often at night without assistance and his/her roommate would sometimes notify the staff when he/she got out of bed to go to the bathroom. CNA #3 stated Resident #170 would not use the call light because he/she was confused at times and could not remember to do so. CNA #3 stated he/she rounded on Resident #170 every two (2) hours at night because he/she would get up and go to the bathroom unassisted. Interview with CNA #4 on 8/18/2020 at 9:32 p.m., revealed he/she helped Resident #170 get off the floor in the

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F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) bathroom the last time he/she fell in the facility. CNA #4 stated he/she was not assigned to Resident #170 that evening, but he/she helped the staff because the CNA assigned to the resident was in another resident's room at the time of the fall. Interview with LPN #8 on 8/18/2020 at 10:56 p.m., revealed he/she found Resident #170 in the bathroom sitting on the floor with hematoma above her eye on 7/11/2020. Continued interview revealed Resident #170 fell trying to get up off the toilet while the CNA working the hall was in another resident's room. LPN #8 stated Resident #170's fall resulted in a patella fracture. He/she stated that Resident #170 would often go to the bathroom unassisted and would not use the call light due to having dementia. However, no specific falls interventions were initiated to prevent a fall in the bathroom. Interview with Resident #170's family member on 8/18/2020 at 8:52 p.m., revealed Resident #170 was admitted to the facility with an unsteady gait, weakness, dementia, which increased his/her risk for falls. Resident #170's family member stated the resident needed assistance to go to the bathroom but went without requesting assistance from staff. The family member stated that he/she informed staff when he/she visited that Resident #170 wouldn't use the call light for assistance to the toilet; however, no additional interventions were put in place to ensure his/her safety. Interview, on 8/18/2020 at 9:40 p.m., with Resident #170's Physician revealed Resident #170 was assessed as a high falls risk while at the facility due to his/her advanced age, weakness, decreased vision, lack of coordination and confusion, as stated in his progress notes. The physician stated it wasn't safe for Resident #170 to transfer or use the toilet independently. Interview, on 8/19/2020 at 4:20 p.m., with the Director of Nursing (DON) revealed Resident #170 wasn't assessed as a high falls risk because he/she hadn't fallen at home prior to admission and hadn't fallen in a year. The DON stated that Resident #170's care planned interventions were appropriate for him/her and no other interventions were developed for him/her until after his/her fall on 7/11/2020. Interview with the Administrator on 8/19/2020 at 4:24 p.m., revealed Resident #170's sustained a fall on 7/11/2020 because he/she went to the bathroom at will and he/she wouldn't let staff assist him/her. The Administrator stated that he/she felt they were doing the best they could to maintain Resident #170's independence without restraining him/her.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**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 review of facility policy, the facility failed to ensure 52 of 55 residents, who received food prepared in the kitchen, received food prepared, distributed, and served under sanitary conditions as evidenced by: improper levels of sanitizer fluid in the dish machine. The findings include: An initial tour of the kitchen was conducted with the Dietary Manager (DM) on 8/17/2020 at 10:55 a.m. Upon inspection of the dish machine, the DM conducted a test of the rinse solution using a chlorine test strip provided by Eco-Lab. The test strip turned a light purple color which indicated the level of chlorine was at 10 parts per million (PPM). A second test was performed by the DM with a second rinse cycle. The test strip remained a light purple color. An inspection of the bucket of the sanitizer solution had approximately six (6) inches of product available and the dispensing line fully immersed in the fluid. The DM stated she wanted to switch out the bucket to a new bucket and would re-test the levels again. Upon the completion of the switch, the DM tested the dish machine rinse solution. The first test strip turned a very dark purple almost black in color indicating levels over 200 PPM. A second test strip was observed to be a very dark purple indicating the levels were 200 PPM or more PPM. During an interview with the DM on 8/17/2020 at 11:25 a.m., he/she stated the chemical company they used was Ecolab and they had just been out within the last month to service the machine. He/She stated that no one had reported any low levels of sanitizer and the machine was tested three (3) times a day at breakfast, lunch, and dinner. A review of the sanitation logs dated 8/1/2020 to 8/17/2020 documented sanitation test results ranging from 50 PPM to 200 PPM. Copies of the inspection report, sanitizer log, and policy and procedure for dish machine sanitizing were requested. On 8/18/2020 at 2:00 p.m. the DM provided the policy and procedure for kitchen sanitation, the product specification for ECO-SAN the dish machine sanitizer, and the sanitizer log maintained by the kitchen staff. A review of the facility policy and procedure titled, Retail Food Establishments Regulations 61-25, dated 6/23/95 documented in Section 4, paragraph I (pg. 39), Utensils and equipment shall be exposed to the final chemical sanitizing rinse in accordance with manufacturers' specifications for time and concentration. A review of the Product Specification Document for ECO-SAN, documented this product degrades with age. Use a chlorine test kit and increase dosage, as necessary, to obtain the required level of available chlorine. It also documented that the sanitizer in the final rinse should be 100 PPM, should not exceed 200 PPM and should not fall below 50 PPM to ensure sanitation of tableware. A review of the FDA 2017 Food Code Section 4-302.14(pg.502) Sanitation Solutions, Testing Devices The use of chemical sanitizers requires minimum concentrations of the sanitizer during the final rinse step to ensure sanitation and too much sanitization in the final rinse could be toxic. section 4-501.18 (pg.506)(NAME)Washing Equipment, Clean Solutions Failure to maintain clean wash, rinse, and sanitation solutions adversely affects the ware washing operations. Equipment and utensils may not be sanitized, resulting in subsequent contamination of food. As a result, pathogenic organisms may be transferred from utensils to food.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to prevent the possible spread of communicable diseases and infections. Staff failed to don required personal protective equipment when entering residents' rooms who were on quarantine. Staff failed to sanitize equipment after each use and failed to perform hand hygiene when indicated, on two (2) of four (4) units. Findings include: 1. On 8/17/2020 at 3:25 p.m. during observation of medication pass, Licensed Practical Nurse (LPN) #5 entered resident #54's room wearing Personal Protective Equipment (PPE) consisting of a face mask covering his/her mouth and nose. LPN #5 placed the medication cup with medication on the resident's bedside table and washed his/her hands in the sink. LPN #5 then realized he/she had entered a quarantine room without donning the proper PPE and turned and left the resident's room and donned a plastic gown and gloves. Observation on the door entering resident #54's room was a sign taped on the outside that stated Quarantine Proper Personal Protection Equipment (PPE) is to be worn when entering this room. Gloves, Gown, Mask, Face Shield or Goggles. Start date 08/07/2020 and End Date 08/21/2020. Interview on 8/17/2020 at 3:30 PM with LPN #5, she was asked why she entered resident #54's room and immediately came out, she state, I realized after I went in the room administer his medication that I had not donned the proper PPE's. 2. On 8/17/2020 at 4:00 p.m. an Activity Aide entered Resident #54's room only wearing a face mask covering his/her mouth and nose. In an interview on 8/17/2020 at 4:05 p.m. PM with the Activity Aide stated, I forgot to place on a PPEs of a gown, gloves and a shield when I went in to (his/her) room to assess (his/her) needs for activities. In an interview on 8/19/2020 at 10:30 a.m. Registered Nurse (RN) #1, the Infection Control Preventionist, stated, Staff should not enter resident rooms that are on quarantine unless they have donned the Personal Protection Equipment (PPE) of gloves, gown, mask, face shield or goggles. RN #1 further stated, I am aware that LPN #5 and the Activity Aide failed to don the required PPE to enter a quarantine room where resident #54 resides. Review of PPE Competency Validation: Donning and Doffing. Standard Precautions and Transmission Based Precautions revealed that LPN #5 and the Activity Aide completed this competency on 8/12/2020. 3. The facility provided the policy titled, Cleaning, Disinfecting and Sterilizing Patient/Resident Care Equipment, dated 9/2011 directed, The rationale for cleaning, sterilizing or disinfecting patient/resident care equipment is determined by the risk of infection involved in the equipment's use. 3. Non-critical items are those that either do not ordinarily touch the patient/resident or touch only intact skin. Such items include crutches, bedboards, blood pressure cuffs and other medical accessories .it is imperative that these items are clean. Observation of Medication Administration on 8/18/2020 at 8:47 a.m. revealed Licensed Practical Nurse (LPN) #1 took the following equipment into Resident #29's room: wrist blood pressure cuff, pulse oximeter, thermometer and glucometer. LPN #1 applied the blood pressure cuff to the resident's left wrist, the pulse oximeter to the resident's left forefinger and used the glucometer on the left fifth finger. LPN #1 exited the room and placed all the equipment on top of the medication cart. LPN #1 cleaned the glucometer and thermometer with bleach wipes thoroughly and put them away but failed to clean the oximeter, blood pressure cuff or the top of the medication cart. LPN #1 used hand sanitizer and then handled the contaminated blood pressure cuff again with bare hands. At 9:16 a.m., LPN #1 prepared Resident #8's medications without cleaning his/her hands. LPN #1 then went to Resident #8's room to get the blood pressure on the resident's right wrist, with the same contaminated cuff, and handled the top lip surface of the medication cup with his/her bare uncleaned hands. Both Resident #29 and Resident #8 had physician orders [REDACTED]. During an interview on 8/18/2020 at 9:24 a.m., LPN #1 stated s/he was never taught to clean the blood pressure cuff or the

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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) pulse oximeter, only the thermometer and the glucometer. LPN #1 stated s/he should have cleaned the blood pressure cuff and pulse oximeter and the top of the cart; now s/he realizes it. Review of the Nursing Competency: Non-Critical Equipment Use, Cleaning, and Disinfecting revealed LPN #1 completed the competency correctly on 8/12/2020. During an interview on 8/18/20 at 9:31 a.m., Registered Nurse (RN) #1 stated they were also the Infection Control Nurse. RN #1 stated LPN #1 should have cleaned all the equipment between residents and cleaned the top of the medication cart to prevent cross contamination. RN #1 further stated LPN #1 should always handle medication cups by the bottom and not where the resident places their mouth. RN #1 stated all nursing staff has been trained on infection control and cross contamination. 4. Observation on 8/18/20 at 1:20 p.m. during wound care for Resident #37 it was observed LPN #1 did not wash the resident's tray table before s/he placed a towel barrier on the table. LPN #1 cleaned the open wound with gauze on the periwound in one direction, then cleaned with another gauze in the other direction. LPN #1 then used another gauze across the entire area, from periwound down across the open wound, and on to the other side periwound. LPN #1 did not clean the wound bed separate from the surrounding skin. LPN #1 threw away or bagged wound care items and did not clean the resident's tray table after use. During an interview on 8/18/20 at 1:48 p.m., the Director of Nursing (DON) stated LPN #1 should have cleaned the tray table first, and at the end of the treatment, and should have cleaned the wound from the inside of the wound outward to prevent possible contamination of the wound. During a follow-up interview on 8/18/2020 at 2:10 p.m., the DON stated the facility did not have a policy describing how to clean a wound from the wound bed outward in a circular motion, but that method is a standard of practice of infection control for nurses.