STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065144	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GUNNISON VALLEY HEALTH SENIOR CARE CENTER	1500 W TOMICHI AVE GUNNISON, CO 81230

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to prevent pressure injuries for one (#25) of two residents reviewed for pressure injuries out of 25 sample residents. The facility failed to assess and implement interventions for a newly placed medical device (knee brace). The facility further failed to regularly assess Resident #25's skin integrity underneath the knee brace after she was deemed to be high risk for pressure ulcer development. These failures led to the development of an unstageable pressure ulcer to the resident's right lower extremity caused by the leg brace. The pressure ulcer caused the resident to experience pain in the wound area as well as to endure painful dressing changes. Findings include: I. Facility policy and procedure The Pressure Injury Prevention-Long Term Care policy, reviewed 6/14/2019, provided by the director of nursing on 3/11/2020 at 4:23 p.m. read, review the residents medical record, including previous medical history, comorbid conditions, medications, and skin conditions, to identify [MEDICATION NAME] and extrinsic risk factors for pressure injuries. Regularly assess and inspect the residents skin, including skin color, temperature, texture or turgor, integrity, and moisture status. Focus on such high risk areas such as bony prominences, areas of [DIAGNOSES REDACTED], and areas under medical devices. II. Resident #25 status Resident #25, age over 70, was admitted on [DATE]. According to the March 2020 computerized physician orders, [DIAGNOSES REDACTED]. According to the most recent minimum data set (MDS) assessment completed 1/7/2020, the resident scored a seven out of 15 on the brief interview for mental status (BIMS) exam, indicating severe cognitive impairment. The resident required extensive physical assistance of two-plus staff for bed mobility, and was totally dependent on staff for transfers. Based on a formal and clinical assessment the resident was at risk for the development of pressure ulcers, but did not have any current or non healing pressure injuries of any stage. III. Record review Progress notes prior to wound development A nursing progress note, dated 1/1/2020 at 8:47 p.m., showed the resident was complaining of right knee pain all day shift per the nurse aide. The resident stated her knee felt better after a cold pack was placed on her knee for 10 minutes and Tylenol was administered. The nurse notified the resident's daughter of the pain. A nursing note on 1/2/2020 at 11:13 a.m. showed the resident was complaining of severe pain that morning. The physician was called and notified, and they increased the resident's Tylenol to 1000 mg three times a day. The daughter was called and requested that something more be done for the resident's pain. A physician progress notes [REDACTED].#25 was complaining of pain in the right ankle joint, and they were unsure of the etiology. There was no rash or evidence of infection or specific evidence of fracture. An orthopedic referral was made and the physician noted to send the resident to the emergency room if the signs or symptoms worsened, returned, changed, or any new symptoms developed. On 1/3/2020 at 11:09 a.m. a nursing progress note showed a licensed practical nurse (LPN) requested the registered nurse (RN) assess the resident as she was not doing well. Upon assessment it was noted the resident complained of pain when the RN moved the resident's right lower leg. The right lower leg was noted to be hot to touch with bruising behind the right knee and old bruising to the right shin. The right leg was slightly larger than the left leg. The RN notified the physician and the power of attorney and the decision was made to transport the resident to the emergency room for evaluation. A nursing progress noted on 1/3/2020 at 9:42 p.m. showed the resident returned to the facility from the ER. The report from the hospital documented the resident had a [MEDICAL CONDITION] tibia and fibula around the old hardware (past surgery) in the knee. A skin assessment was performed with no new areas except for bruising on the right knee. The resident exhibited increased pain and was given PRN [MEDICATION NAME]. A physician progress notes [REDACTED]. The physician had consulted with the orthopedic physician who recommended it was ok to weight bear if able, but not if causing pain; and ok to pivot transfer but not if causing pain; and a brace for comfort, otherwise not necessary. B. Braden scale The resident's quarterly Braden Scale for predicting pressure sore risk, completed 1/2/2020, scored the resident an 11, at high risk for the development of pressure injuries related to very limited sensory perception, occasionally moist, chairfast, completely immobile, probably inadequate nutrition, and a problem with friction and shearing. C. Wound documentation 1. Weekly wound observation assessments A weekly wound observation assessment, dated 1/31/2020, showed the first documentation of the wound acquired in the facility on the posterior right calf. The wound was specified as a device related pressure injury. The measurements were noted to be 34 mm x 15 mm x 0 mm with 25% slough and/or necrotic tissue present. There was no odor, but a moderate amount of serous drainage was noted. A comment on the observation assessment documented the resident was in a brace status [REDACTED]. However, upon removal, a small abrasion was noted. (The order from the physician was for comfort, otherside not needed. There was no order to not remove the brace.) The wound observation note read the wound was new and to request wound care orders and to cover until orders were received (wound care orders were not placed until 2/11/2020, 11 days later). The next weekly wound observation assessment, dated 2/14/2020 (no wound observation for the previous week), documented the wound was still with 25% slough and necrotic tissue with measurements of 32mm x 12 mm x 0 mm. There was moderate serosanguinous drainage and no odors. The weekly wound assessment, dated 2/21/2020, showed the wound was with slough and granulation tissue and no odor. Measurements were 32 mm x 12 mm with 25% necrosis or slough and moderate serosanguinous drainage. The weekly wound assessment, dated 2/28/2020, showed the wound measurements as 37 mm x 2 mm x 0 mm. The wound bed was 75% slough or necrosis with no odor and moderate serous drainage. The weekly wound assessment, dated 3/6/2020, showed the wound was 45mm x 20mm x 2 mm with 75% slough and moderate serous drainage and no odor (see dressing change observation below). 2. Skin observation tool noting areas of concern The skin observation tool to be completed by a licensed nurse showed the following: -12/30/2019: skin clean, dry, and intact, (old) left shin wounds freshly dressed. No other concerns at this time. -1/4/2020: skin in good condition, no bruising or skin tears noted. -1/27/2020: skin dry and intact, bruising noted to left shin and left lower extremity, red area to back of lower left leg. (There were no documented skin observations between 1/4/2020 and 1/27/2020 provided.) -2/3/2020: right heel breaking down with 1 cm in diameter; scab above right heel 2x4 cm. -2/10/2020: scab above back of right ankle, 1 cm x 2 cm -3/2/2020: right heel is dry and pink, purplish red area to side of right foot just below the 5th toe, wound to right calf, redness under left breast. -3/9/2020: skin clean, dry, and intact; redness beneath left breast, will apply as-needed [MEDICATION NAME]. D. Care plan Resident #25's care plan, initiated 6/13/2015 and most recently revised on 3/6/2020, documented the resident was at risk for impaired skin integrity, skin tears, and pressure ulcers related to fragile skin, limited mobility, incontinence, and the resident enjoyed lying in bed for long periods of time. Interventions on the care plan included: -2/11/2020: wound nurse to evaluate right leg injury as ordered; -3/6/2020: treatment as ordered to the right posterior calf. There were no interventions noted on the care plan related to the knee brace. The resident's actual skin breakdown and skin condition were not documented in the care plan. The care plan did not address pain management related to the resident's wound. E. physician's orders [REDACTED]. There were no orders not to remove the brace, or to remove the brace regularly to assess the resident's skin condition. Wound orders dated 2/11/2020 documented, Right posterior calf wound; cleanse with dermal wound cleanser or saline and apply therahoney to wound base. Cover with optimfoam and change on bath days or three times a week (there were no wound orders prior to 2/11/2020). Pain medication ordered for the resident was noted to be [MEDICATION NAME] 5 mg, give 0.5 tablet every 8 hours for pain as

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

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F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) needed. The resident was also receiving [MEDICATION NAME] 1000 mg three times a day for pain, regularly scheduled. F. Wound care nurse consult notes and physician note The wound nurse consult note, dated 2/11/2020, showed the resident had a 3.5 cm x 2 cm area of black, dry, adherent eschar to the posterior calf. There was slight periwound [DIAGNOSES REDACTED] and slight induration of about 0.1 cm around the wound. There was no branching [DIAGNOSES REDACTED], odor or drainage noted. From the history it could be determined that this was a medical device related unstageable pressure injury from the knee brace. This was the only documented visit from the consulted wound care nurse; no other visits were noted. A physician progress notes [REDACTED]. The physician noted the pressure ulcer was to the right calf. A physician progress notes [REDACTED]. No new orders were placed. The physician's note referenced the poor healing of the existing wound; it did not say the wound was caused due to poor vascular status. The wound nurse (on 2/11/20) and physician (on 3/4/20) both documented (see above) that the resident's wound was an unstageable pressure injury. IV. Wound observation/resident interview A dressing change was observed with RN #1 and the DON on 3/11/2020 at 11:15 a.m. RN #1 said she attempted to premedicate Resident #25 prior to the dressing change but she had refused (this was not documented in the Medication Administration Record [REDACTED]. RN #1 removed the old dressing from over her wound, and as she removed the dressing, green slough was pulled with the dressing. The resident was complaining of pain and jumping as RN #1 removed the dressing. The wound was over the resident's right Achilles tendon area and leading up to the lower aspect of the posterior calf. RN #1 went to cleanse the wound with a 4x4 gauze soaked in wound cleanser, and the resident was jumping in bed yelling no! repeatedly. RN #1 then applied [MEDICATION NAME] and the new dressing, and the resident was yelling please don't! and kicking and jumping in the bed. RN #1 did not offer pain medication in response to the resident's pain, during or after the dressing change. Resident #25 was interviewed on 3/9/2020 at 2:59 p.m., before the observed dressing change above. She said she had a wound on her right foot that caused her really bad pain, and they gave her Tylenol for the pain. She said the Tylenol helped thank god, cause I wouldn't know what to do without it. Resident #25 was interviewed again on 3/11/2020 at 5:23 p.m., several hours after the dressing change observation. She said the pain was in her right heel and the back of her leg, and the pain was terrible. She said it hurt at a level of 8 or 9 (out of 10) and the Tylenol they gave her helped bring it down to two or three. V. Staff interviews RN #1 was interviewed on 3/11/2020 at 11:25 a.m. She said Resident #25 would complain of pain in the mornings and she would usually take her pain medication. She said the resident would say her heel hurts her but she would touch her heel and the resident would not complain of pain. She said the resident's pain was in the wound area, not the heel. She said the resident complained of pain during dressing changes as well. She said the wound looks pretty yucky but she guessed it was getting better (although per documentation it was larger and deeper). She said the resident had a fracture and then a knee brace which was rubbing and then some necrotic tissue followed. She said the brace was for comfort but was always on when she worked. She said she thought they took it off at night and for her baths and skin assessments. She reiterated the brace was just for comfort. RN #2 was interviewed on 3/10/2020 at 2:48 p.m. She said she thought the wound was from the brace she was wearing after her injury as it was resting on the back of her leg. She said they were doing repositionoing and floating her leg and feet, but they should have been doing skin assessments under the brace. She said she had not been doing those when she worked because she had to cover both hallways when there were only two nurses working and it was not manageable to do all that. She said she did not have the time to do the skin assessments on the resident. She said the brace was always on when she worked and she was unsure if they took it off at night. She said the brace had been discontinued when the wound was discovered. Life enriching care aide/certified nurse aide (LEC) #3 was interviewed on 3/11/2020 at 2:19 p.m. She said they had put a huge brace on Resident #25 after her fracture and it was just rubbing on her leg. She said it had gotten to a point where there was ooze from the wound on the brace. She said the brace was on all the time, and they would only remove it when they got her dressed. She said they would put the brace over her clothes as well. She said the brace would even rub when the resident was in the wheelchair, and they should have been assessing the skin but she was not sure if they were. The physical therapist (PT) was interviewed on 3/12/2020 at 9:19 a.m. She said the resident was in a hinged knee brace that was monitored by nursing, which she believed they threw away after it was soiled. She said she was the staff member who first identified the wound when they were looking at her toes, and she saw the necrotic area. She said it started as friction from the device (knee brace). She said it was acquired in the facility and may have initially started as a deep tissue injury but was currently a decub (decubitus ulcer). She also said she thought it should be stageable at this point. The DON was interviewed on 3/12/2020 at 9:59 a.m. She said Resident #25 had a fracture and initially afterwards was wearing a leg brace at all times (there was no documentation to support the brace to be worn at all times), but the order was later changed for comfort. She said they performed a skin assessment after removing the brace and there was an abrasion; however, the wound care and physician notes reflect differently. She said they needed to keep the brace off at that point. She said the resident was at risk for developing pressure injuries due to her self limiting behaviors. She said Resident #25 suffered from chronic pain and hallucinations, and the resident had apparently eaten oxy ([MEDICATION NAME]) like it was candy prior to her coming to the facility. She said the resident's skin was assessed weekly routinely, with the brace on as well. She said there were no additional assessments for when the brace was put on. She said the wound was just a surface layer friction area that was reddened, similar to a rug burn. She said it was the device (the knee brace) that caused the resident's wound and the wound nurse had concurred. She said no new assessments or interventions were put in place for the knee brace other than the weekly skin checks and ensuring circulation. She said the charge nurse was responsible for assessing residents' skin and on a weekly basis. She said the resident had requested to keep the knee brace on at times. The DON said Resident #25 did complain of pain at the wound site during dressing changes, and that's when she was notified. She said they were treating the resident's pain with [MEDICATION NAME] and it typically was effective. She said the resident had spit out her meds the day of the wound observation.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#20) of five residents reviewed for unnecessary medications out of 25 sample residents was free from unnecessary drugs. Specifically, the facility failed to ensure [MEDICAL CONDITION] medications included evidence that informed consent was provided for and by the resident; which included evidence of education, targeted behaviors, potential side effects and correct dosage. Findings include: I. Facility policy and procedures The Initiation of a [MEDICAL CONDITION] Drug policy, reviewed January 2020, provided by the nursing home administrator (NHA) on 3/12/2020 at 11:00 a.m., documented that the resident's family was to be notified and a consent from the resident's power of attorney (POA) or responsible party must be completed. The consent should be obtained prior to the initiation of the new medication. II. Facility census and conditions The facility's resident census and conditions form, dated 3/10/20 and provided by the NHA, documented 19 residents in the facility were being prescribed antidepressant medications. III. Resident status Resident #20, age 89, was admitted on [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 1/2/2020 minimum data set (MDS) assessment revealed no brief interview for mental status (BIMS) score, but documented the resident had both short-term and long-term memory deficits. Per staff assessment, the MDS documented the resident showed little interest or pleasure in doing things, felt depressed and hopeless, displayed both appetite and sleep disturbances, had little energy, said she felt bad about herself, had trouble concentrating and was restless nearly every day during the 14-day lookback period. It documented the resident felt life was not worth living on most days of the lookback period. The resident scored 26/30 on the total severity mood scale. The MDS documented the resident was not having hallucinations or delusions. It revealed the resident was having daily behavioral symptoms not directed towards others, such as itching and picking at her skin. The resident wandered on four to six days during the seven day lookback period. The resident received an anti-depressant medication on three days during the seven day lookback period. IV. Record review A. Care plans The care plan dated 1/3/2020 documented due to Resident #20's poor short term memory, the resident could become anxious, nervous, tearful and tended to wander throughout the Blue Mesa memory care community. An intervention was to administer medications as ordered. Although the facility developed a specific care

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) plan in relation to the use of anti-anxiety medications, the facility failed to create a specific care plan in relation to the use of antidepressant medications. B. March 2020 CPO The CPO included the following pertinent medication orders [REDACTED]. This medication was ordered on [DATE]. -[MEDICATION NAME] ([MEDICATION NAME], an antianxiety medication), 0.5 mg every 10 hours for anxiety. This medication was ordered on [DATE]. (However, see below, an incomplete consent form was documented several months earlier on 10/29/19.) C. Consents for [MEDICAL CONDITION] medications The consent for [MEDICATION NAME] was signed by the resident's responsible party on 3/11/2020. The possible side effects listed on the form included drowsiness, dry mouth and fatigue. No specific target behaviors related to anxiety (per physician order) were included on the form. The incorrect dosage of 50 mg one time day was documented on the form, although the resident was currently prescribed 12.5 mg per day (see CPO above). The consent for [MEDICATION NAME], 0.5 mg Q 12 (every) hours PRN (as needed) for agitation and [MEDICAL CONDITION] was signed by the resident's responsible party on 10/29/19. No potential side effects were listed on this form. No specific target behaviors related to anxiety (per physician order) were included on the form. D. Interdisciplinary progress notes The pharmacy note documented by the director of nursing (DON) on 1/24/2020 documented Resident #20 was receiving [MEDICATION NAME], 25 mg for [MEDICAL CONDITION]. E. Staff interviews The NHA was interviewed on 3/11/2020 at 10:04 a.m. and said she did not think the facility has been requiring consents for the use of antidepressants. She said the facility had been monitoring behaviors for the use of those drugs, but she did not think they were asking for the consents. The traveling minimum data set (MDS) coordinator was interviewed on 3/11/2020 at 10:59 a.m. and said it was usually the responsibility of the social services director (SSD) or the MDS coordinator to obtain consents for [MEDICAL CONDITION] medications. She was asked if the facility had a consent for the use of [MEDICATION NAME] for Resident #20 before the resident began receiving the medication. She said the facility only requested the consent earlier that morning. She said the facility should have been requesting a consent for any [MEDICAL CONDITION] medication in use, regardless of the class of medications. She said antidepressant medications should have informed consents completed for every drug prescribed. The social services director (SSD) was interviewed on 3/11/2020 at 11:14 a.m. She said the nursing staff completed the informed consent forms for [MEDICAL CONDITION] medications. She said there should have been a consent completed for this resident for the use of [MEDICATION NAME]. The NHA was interviewed on 3/11/2020 at 11:17 a.m. She said the facility completed a consent from Resident #20's son that morning. She said she had spoken with various nurses earlier that morning and learned that the facility nurses were aware that they should be completing the informed consent form for the use of antidepressant medications. The NHA was interviewed a final time on 3/12/2020 at 10:06 a.m. She said the facility did have an action plan in place related to informed consents for [MEDICAL CONDITION] medications, but the plan was possibly lost in the background with the addition of the new DON a few months prior. She said the ongoing plan to ensure the completion of consents for medications would be a triple check on the electronic computer dashboard. She said she or the DON needed to begin monitoring the charts for new prescriptions on a daily basis. She said the second checks would be for the MDS coordinator to check when completing the admission MDS and the SSD to check when completing the PASRR (pre-admission screen/resident review) information. She said the third check would be when the facility met with their pharmacist on a monthly basis to review residents' medications.
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 observations, interviews and record review, the facility failed to maintain an infection control program designed to prevent the spread of infection in one of three neighborhoods. Specifically, the facility failed to: -Implement appropriate hand hygiene practices and glove use while providing activities of daily (ADL) care to Resident #26; and -Implement appropriate hand hygiene practices during housekeeping cleaning tasks on the(NAME)Park neighborhood. Findings include: I. Professional standard According to the Centers for Disease Control and Prevention's Hand Hygiene in Healthcare Settings, retrieved from https://www.cdc.gov/handhygiene/providers/guideline.html, on 3/16/2020 and dated 1/30/2020, the guidance included the following recommendations: Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices Before moving from work on a soiled body site to a clean body site on the same patient After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal When using alcohol-based hand sanitizer (ABHS): -Put product on hands and rub hands together -Cover all surfaces until hands feel dry -This should take around 20 seconds When cleaning with soap and water: -When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. -Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet. -Avoid using hot water, to prevent drying of skin. -Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. -Either time is acceptable. The focus should be on cleaning your hands at the right times. II. Hand hygiene during ADL care A. Observations On 3/9/2020 at 3:52 p.m., ADL care was observed for Resident #26. Life enriching care/certified nurse aides (LECs) #8 and #7 entered the room, sanitized their hands and donned disposable gloves. They turned the resident onto his left side and he had been incontinent of stool. LEC #8 removed his adult incontinence brief, provided peri care, and then doffed her soiled gloves and placed them in the trash. At 3:55 p.m., LEC #8 reached into her scrub top pocket, retrieved a clean pair of gloves, and without washing or sanitizing her hands, donned the clean pair. She applied barrier cream to the resident's bottom and then placed a clean incontinence brief underneath him. They turned the resident onto his back and provided peri care again, from the front. LEC #8 touched the bed control with her gloved left hand and lowered the head of the bed. The LECs pulled the resident up in bed and then LEC #8 touched the bed control again and raised the head of the bed. LEC #8 placed a pillow under the resident's knees and they positioned him onto his left side, placing a pillow behind his back. Without washing or sanitizing her hands, LEC #8 touched the bed control again with her soiled gloves and raised the resident's head of the bed further. At 3:58 p.m., LEC #8 doffed her gloves and threw them in the trash. The phone in her pocket rang and she silenced it without washing or sanitizing her hands first. She removed the trash liner from the trashcan and carried it into the bathroom. She opened a cupboard to check the supplies and then she left the room without washing her hands. B. Staff interviews LEC #2 was interviewed on 3/12/2020 at 10:26 a.m., and he confirmed he routinely worked with Resident #26. He said when ADL care was provided for residents, staff should remove their gloves after they were dirty, wash or sanitize their hands, and then don clean gloves. He said cross contamination could occur if hands were not washed after soiled gloves were removed and before donning a clean pair. He said he had not received any additional hand hygiene training related to the COVID-19 pandemic other than the basic reminders for handwashing. The director of nurses (DON), who was also the infection control preventionist, was interviewed on 3/12/2020 at 10:32 a.m. She clarified the facility had implemented a new screening process related to the COVID-19 pandemic for all vendors and families who entered the building, and had handwashing stations set up at the front and back doors. She explained staff who simply entered the community had to wash their hands upon entrance now and she had started a tracking log for ill staff's absences. The DON said education on hand washing was typically provided to LECs upon hire, annually, and more frequently if she saw a need. She said a family member had shared a concern recently that a staff member had not washed their hands during peri care or in between changing gloves. She said she provided additional handwashing training on 3/6/2020 that required a return demonstration from staff. She said when staff washed their hands with soap and water they should scrub their hands for a minimum of 20 seconds. The DON said she had worked with LECs in the past regarding Resident #26's peri care, and explained the staff might be kept in the resident's room for long periods of time because he had frequent bowel movements. She explained they would provide peri care and then he might immediately have another bowel movement that would require care. She said LECs should wash or sanitize their hands before donning clean gloves. III. Hand hygiene during housekeeping cleaning procedures A. Observations On 3/11/2020 at 10:03 a.m., environmental services technician (EVST) #1 was observed cleaning the dining room, kitchenette and nurses' station of the(NAME)Park neighborhood. She was wearing gloves and wiped off a dining table. She opened a compartment on top of her housekeeping cart with a dirty gloved hand and touched the clean glove box. Before removing a new glove, she removed her soiled gloves and threw them away, then donned a clean pair of gloves without washing or sanitizing her hands. She began talking to a resident and withdrew a new cleaning wipe from a dispenser. She wiped down the bar eating surfaces, picked up placemats and wiped underneath them, then returned to her cart and threw the cleaning wipe away. At 10:08 a.m., she withdrew a new cleaning wipe and wiped down the surface of a four-top table, as well as the arms and seats of chairs. At 10:09 a.m., she doffed the soiled gloves, pushed her hair away from her face, then donned a new pair of gloves without washing or sanitizing her hands. She pushed the housekeeping

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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.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) cart towards the nurses' station, retrieved another cleaning cloth, and wiped down the counter surfaces. At 10:11 a.m., she returned to the cart and placed the soiled wipe in the trash, and walked to the kitchen sink and washed her hands briefly, for 10 seconds. She returned to the cart and donned clean gloves. At 10:13 a.m., she removed a broom and swept up the floor of the dining area. At 10:16 a.m., she returned to the housekeeping cart and doffed her gloves. She donned a clean pair of gloves without washing or sanitizing her hands, and then wiped down the kitchen counter and nurses' station surfaces. At 10:19 a.m., she returned to her cart, doffed the dirty gloves, and donned clean gloves without washing or sanitizing her hands. She withdrew a clean cleansing wipe and continued wiping off the kitchen counter surfaces. At 10:24 a.m., she returned to her cart, doffed the dirty gloves and donned clean gloves without washing or sanitizing her hands. She withdrew a clean cleansing wipe and wiped down the bar eating surface. At 10:26 a.m., she doffed the dirty gloves, then went back to the kitchen and opened all of the drawers and cupboards underneath and around the sink without washing or sanitizing her hands. She walked to the clean utility room, retrieved a new package of clean paper towels and restocked the towel dispenser with them without washing or sanitizing her hands. At 10:27 a.m., she returned to her housekeeping cart, donned a clean glove on her right hand and kept her left hand bare. She withdrew a clean wipe and wiped down the surface of the kitchen bar, again using her right hand. She threw the dirty glove in the trash and then pushed her housekeeping cart down to the end of the hallway without washing or sanitizing her hands. B. Staff interviews EVST #1 was interviewed on 3/11/2020 at 10:30 a.m. She said she was the floor tech (technician) for the facility that day and she was responsible for cleaning the common areas, hallways, and public restrooms. She said the facility did not always have a floor tech who worked, but there was one at least two or three times each week. She said the environmental services manager (EVSM) required them to wash their hands frequently and change their gloves often. She said each time she removed her gloves she was supposed to wash her hands. She said she did not carry ABHS on her housekeeping cart or on her person because there were so many dispensers located throughout the building. The EVSM was interviewed on the morning of 3/12/2020. She said she had seven years of hotel and hospitality experience in environmental services and had been the facility's director for approximately one year. She said the EVSTs should use hand sanitizer or wash their hands every time they removed a pair of gloves. She clarified if they had touched anything with body fluids or stool, that might require a physical handwashing with soap. Otherwise, they could just use the ABHS and put on a clean pair of gloves. She said she did most of the hand hygiene training with the EVSTs, which included telling them to use the ABHS for 30 seconds or wash their hands with soap and water for 30 seconds. She said she had received an email from CMS (Centers for Medicare and Medicaid Services) the day before that addressed measures they should take related to COVID-19, which she shared with the environmental services staff. It focused on ensuring the high touch surfaces were cleaned and she said she was happy to know it was the same things that they were already doing.
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to implement policies and procedures related to pneumococcal immunizations for two (#26 and #19) of five residents reviewed for immunizations out of 25 sample residents. Specifically, the facility failed to offer and provide the pneumococcal 23-valent [MEDICATION NAME] vaccine (PPSV23) to the residents. Findings include: I. Professional standard According to the Centers for Disease Control and Prevention (CDC) Recommended Immunization Schedule for Adults Aged [AGE] years or Older, United States, 2020, retrieved from https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf (3/2020), the routine pneumococcal vaccination for adults aged [AGE] years or older and were immunocompetent, one dose of PPSV23 should be administered. II. Record review A. Resident #26 Resident #26, age 82, was admitted [DATE] and readmitted [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The medical record for Resident #26 showed he received the pneumococcal conjugate vaccine (PCV13) on 10/11/18, but had not been offered or given the PPSV23. The 1/1/2020 minimum data set (MDS) assessment documented the resident's pneumococcal vaccine was up to date. B. Resident #19 Resident #19, age 67, was admitted on ,[DATE]. According to the March 2020 CPO, [DIAGNOSES REDACTED]. The medical record for Resident #19 showed he refused the PCV13 on 3/13/18. There was no documentation to show the resident was offered, given, or refused the PPSV23. The 12/30/19 MDS assessment documented the resident's pneumococcal vaccination was not up to date because the pneumococcal vaccination was offered and he declined. However, he was not offered the PPSV23. III. Staff interviews The minimum data set coordinator (MDSC) was interviewed on 3/12/2020 at 11:11 a.m. She said the 1/1/20 MDS assessment for Resident #26 showed his pneumococcal vaccinations were up to date and confirmed he had received the PCV13 in the past. However, she was unable to find documentation he had been offered or given the PPSV23. She said she would have to refer to the MDS requirements for the documentation and could modify and fix it if needed. The MDSC confirmed the 12/30/19 MDS for Resident #19 documented his pneumococcal vaccinations were not up to date, and had no documentation that he had been offered, given, or refused the PPSV23. The director of nurses (DON) was interviewed on 3/12/2020 at 10:32 a.m. She said residents or their representatives were asked about their immunization histories upon admission, and if they were unsure about them, the facility would ask local physicians to provide the records. She said they provided the residents with the latest vaccine information, had them sign a consent to receive them, and then provided them with the vaccine unless it was contraindicated. She said the facility had a computerized tracking sheet for the residents for the pneumococcal vaccinations and confirmed they followed the CDC's Recommended Immunization Schedule for Adults Aged [AGE] years or Older, United States, 2020. The DON said she did not have acceptance or declination information for Resident #26's PPSV23, and confirmed he would have been eligible to receive it in November 2019. She said she became the facility's DON in mid-October 2019 and the responsibility for the pneumococcal vaccines became her responsibility when the previous MDSC left. She said it was her understanding that the PPSV23 and PCV13 needed to be administered five years apart. The DON said she did not have any documentation that Resident #19 was offered, administered, or refused the PPSV23.