STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105521	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVANTE AT BOCA RATON, INC.	**1130 NW 15TH STREET BOCA RATON, FL 33486**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide treatment and services in a manner that preserves dignity for 2 of 4 residents reviewed for dignity (Resident #34 and Resident #60). The findings included: 1. In an observation conducted on 03/02/20 at 9:00 AM, Resident #34 was observed lying in bed with his lower body exposed while wearing adult briefs. Further observation showed the door to his room was opened and located across the nurses' station. In this observation staff was observed walking up and down the hallway passing his room with the door open. In an observation conducted on 03/03/20 at 12:06 PM, Resident #34 was observed in his room with the lower part of his body exposed, and the door completely opened. Further observation showed staff passing the lunch trays on the floor, walking up and down the hallway. Recorded review of Resident #34 showed that he was admitted on [DATE]. Resident #34 is with impaired cognition related to dementia and his care plan dated 12/16/19 indicated that he has bowel incontinence. Further record review of the Minimum (MDS) data set [DATE] showed that Resident #34 is rarely/or never understood. 2. In an observation conducted on 03/02/20 at 1:01 PM, Staff B, a Certified Nurse Assistant, was observed helping Resident #60 with his lunch meal. Closer observation showed Staff B, standing over the bed while assisting Resident #60 with his lunch meal. In an observation conducted on 03/03/20 at 1:10 PM, Staff C, a Certified Nurse Assistant, was observed helping Resident #60 with his lunch tray. Closer observation showed her standing over Resident #60 while assisting him with the meal. In this observation Staff C reported that she does not take care of Resident #60 often, and that he does not want anyone sitting near him when he is eating. Record review of Resident #60 showed that he had cerebral infraction affecting the right dominate side with contracture of the right wrist. His care plan dated 01/20/20 revealed that he has communication problems and is rarely or never understood. Record review of Resident #60's Minimum (MDS) data set [DATE], showed that under section G for eating, he needs extensive assistant with one person assist. In an interview conducted on 03/05/20 at 3:30 PM, with the Administrator, the findings were reviewed with him.
F 0582 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** Based on record review and interview, the facilty failed to provide a resident with Advanced Beneficiary Notice upon discharge from Medicare Part A skilled services, for 1 of 3 residents reviewed (Resident #67). The findings included: A review of the SNF Beneficiary Protection Notification Review worksheet, completed by the Social Services Director was conducted. It documented that Resident #67 was not provided a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN). The worksheet documented resident's Medicare Part A skilled services start date 01/27/20 and Last covered day of Part A service 02/21/20. A Notice of Medicare Non-Coverage (NOMNC) letter signed by the resident on 02/18/20 documents, the effective date coverage of your current skilled services will end 02/20/20. During an interview, on 03/05/20 at 3:45 PM, with the Social Services Director, without being prompted by this survyeor, he stated, I have no reason for why he (Resident #67) was not given an ABN. He was discharged from therapy because he kept not participatiing and refusing therapy.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to accurately assess 1 of 22 sampled residents for vision, mobility and tube feeding (Resident #49). The findings included: Resident #49 was admitted on [DATE]. According to his most recent quarterly Minimum Data Set (MDS) completed on 01/04/20, the resident's Brief Interview for Mental Status (BIMS) score was 00, indicating 'severe impairment', with vision documented as 'adequate' (sees fine detail, such as regular print in newspapers/books). The assessment further documents that resident is total dependence of one person physical assist for locomotion on and off unit. The MDS also documented that the nutritional approach that was provided to Resident #49 during the 7-day look back period as being a feeding tube. Resident's Enteral Feed Order was discontinued on 11/24/19. On 03/03/20 at 9:10 AM, Resident #49 was observed up in wheelchair in corner of room, directly under a television mounted in same corner. Resident #49 did not respond to this surveyor greeting and calling him by name. When Staff W, a certified nursing assistant (CAN), was asked why he was positioned under the television where he could not watch the television, she replied, he was on the phone. He is blind, but he can hear. During an interview, on 03/04/20 at 11:34 AM, with Staff U, when asked about resident's vision, she replied, He came from the hospital and his wife told us on admission that he had lost vision in both eyes. He tells us that he can see shadows and some days he will tell us that he can't see at all. During an interview, on 03/05/20 12:39 PM, with Staff AA, a MDS coordinator, when asked about Resident #49's vision and mobility, she stated he has impaired vision, and could not ambulate when I did the assessment Staff AA confirmed that resident was blind upon admission. 03/04/20 12:42 PM, this surveyor approached the resident and asked him, 'How are you?' Resident #49 responded 'okay'. This surveyor asked, 'Are you hungry?' Resident responded, 'not really.' This surveyor asked, 'what would you like to do?' Resident 49 replied, 'I just want to go back to bed.' The entire conversation was conducted in English while the resident's lunch was on his over bed table. During an interview, on 03/04/20 at 12:55 PM, with Staff AA and the Director of Therapy, when asked about Resident #49's mobility, the Director of Therapy replied, He cannot ambulate himself he has not improved physically to be able to ambulate independently. If he has to go from one place to the next, somebody has to push him. He is also blind and would have to be guided to keep from hitting furniture and the walls. On 03/05/20 at 12:38 PM, the concerns were brought to the attention of the Corporate MDS Coordinator. She acknowledged the findings and stated that Resident #49's MDS was audited and that she found that the resident's nutrition approach was incorrect and that she submitted a correction.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide an ongoing activities program to meet the needs and preferences for 2 of 4 residents reviewed for activities (Residents #49 and #34). The findings included: 1). Resident #49 was admitted on [DATE]. His most recent quarterly Minimum Data Set (MDS) completed on 01/04/20, reveals the

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

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F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) resident's Brief Interview for Mental Status (BIMS) score was 00, indicating 'severe impairment', with hearing documented as 'adequate' (no difficulty in normal conversation, social interaction, listening to TV) and vision documented as 'adequate' (sees fine detail, such as regular print in newspapers/books). The assessment documents that the resident does not 'need or want an interpreter to communicate with a doctor or health care staff. The assessment further documents that resident is total dependence of one person physical assist for locomotion on and off unit. Resident's care plan for Activities, created on 10/10/19, documents, (Resident) has a potential for little or no activity involvement r/t Physical Limitations (dx [MEDICAL CONDITION] and [MEDICAL CONDITION] disorder). Resident also wishes not to participate. Prefers to remain in bed. Interventions include: Establish and record prior level of activity involvement and interests by talking with caregivers, and family on admission and as necessary * Explain the importance of social interaction, leisure activity time, encourage participation * Preferred activities are: TV and family visits * Room visits for Social stimulation and to offer supplies. On 03/02/20, the following observations were made: At 11:10 AM Resident #49 was observed sitting in his wheelchair at the nurse's station upon this surveyor arriving on unit, the resident did not respond to this surveyor's greeting the resident. At 12:16 PM Resident #49 was observed sitting in his wheelchair at the nurse's station. At 2:41 PM Resident #49 was observed sitting in his wheelchair at the nurse's station. On 03/03/20, the following observations were made: At 7:49 AM Resident #49 was observed in bed sleeping. At 9:10 AM Resident #49 was observed up in his wheelchair in corner of room, directly under a television mounted in same corner. Resident #49 did not respond to this surveyor greeting and calling him by name. When Staff W, CNA, was asked why he was positioned under the television where he could not watch the television, she replied, he was on the phone. He is blind, but he can hear. At 10:57 AM Resident #49 was observed in his wheelchair positioned between bed and air conditioning unit, facing in the direction where the television was mounted. At 12:18 PM Resident #49 was observed in his wheelchair positioned between bed and air conditioning unit, facing in the direction where the television was mounted. At 3:19 PM Resident #49 was observed in his wheelchair positioned between bed and air conditioning unit, facing in the direction where the television was mounted. On 03/04/20 at 9:32 AM Resident #49 was observed in his wheelchair positioned between bed and air conditioning unit, facing in the direction where the television was mounted. During an review of the 1:1 book, provided by activities, on 03/04/20 at 9:43 AM revealed no documentation for Resident #49 receiving 1:1 activities/visits. On 03/04/20 at 11:37 AM Resident #49 was observed in wheelchair positioned between bed and air conditioning unit, facing in the direction where the television was mounted. During an interview, on 03/04/20 at 12:14 PM, with Staff X, Activities Aide, when she was asked about activities provided to Resident #49 and his participation, she replied He comes out of the room on his own. He is Spanish and doesn't speak or understand English. I communicated with the nurses, 'what can I do with him?' I haven't talked to him about it because of the language barrier. During an interview, on 03/04/20 at 12:31 PM, with Staff U, RN, when asked how she communicates with Resident #49, she replied, he speaks English, he is not very talkative, but he talks. On 03/04/20 at 12:42 PM this surveyor approached the resident and asked him, 'How are you?' Resident #49 responded 'okay'. this surveyor asked 'Are you hungry?' Resident responded 'not really.' This surveyor asked, 'what would you like to do?' Resident #49 replied, 'I just want to go back to bed.' The entire conversation was conducted in English. During an interview, on 03/04/20 at 12:55 PM, with Staff AA, MDS Coordinator, and the Director of Therapy, when asked about Resident #49's mobility, the Director of Therapy replied, He cannot ambulate himself he has not improved physically to be able to ambulate independently. If he has to go from one place to the next, somebody has to push him. On 03/04/20 at 1:02 PM, the Activities Director informed this surveyor, (Staff X) just went up there and had a conversation with him in English. She further stated that the resident was asked to propel himself in his wheelchair and he rolled all the way to the door of his room. During an interview, on 03/05/20 at 8:55 AM, with Staff T, RN, When asked about Resident #49's mobility, she replied, from what I have seen of him in his bed, he can't propel himself in his wheelchair. He is blind. I have never seen him propel himself in his wheelchair. 2). In an observation conducted on 03/02/20 at 10:30 AM, Resident #34 was observed in bed, asleep, with no activities of any kind. In an observation conducted on 03/02/20 at 2:00 PM, Resident #34 was observed in bed, with no interaction or activity of any kind. In an observation conducted on 03/03/20 at 10:00 AM, Resident #34 was observed in bed, with no interaction or activity of any kind. In an observation conducted on 03/04/20 at 1:00 PM, resident #34 was observed in bed, with no interaction or activity of any kind. In an observation conducted on 03/05/20 at 12:30 PM, Resident #34 was observed sitting in his wheelchair with the television on, but the resident's wheelchair was facing the front door. Record review of Resident #34 showed that he was admitted on [DATE]. Resident #34 is with impaired cognition related to dementia. Further record review of the Minimum (MDS) data set [DATE] showed that Resident #34 is rarely/or never understood. Review of the care plan dated 12/16/19 for activities, showed that Resident #34 is depended on staff for all activities. It further revealed that he will maintain involvement by 1 to 1 group acts as well as activities that are compatible with physical and mental capabilities. Record review of the facility 1 to 1 activity log, showed that Resident #34 was attempted to be engaged by staff on 03/02/20 but he said no. Further review of the 1 to 1 activity log showed no other activities for the month of (NAME)for Resident #34. In an interview conducted on 03/04/20 at 8:55 AM, with Staff E, an Activity aide, she reported that all 1 to 1 activities are provided at least 3 times a week.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, facility failed to prevent decline in range of motion, by following physician's order for splints, for 1 of 3 sampled residents (Resident #60). The findings included: Record review of Resident #60's physicians' orders showed an order dated 11/08/17 for right hand cone splint for contracture management. Review of the care plan dated 01/20/20 showed that Resident #60 has right sided weakness and impaired cognition. He has a right hand cone splint for contracture management under the intervention section of the care plan. In an observation conducted on 03/02/20 at 10:20 AM, Resident #60 was observed in bed with no cone splint in place. Further observation showed no hygiene care performed at that time. In an observation conducted on 03/02/20 at 1:30 PM, Resident #60 was observed in bed with no cone splint in place. Further observation showed no hygiene care performed at that time. In an observation conducted on 03/02/20 at 3:00 PM, Resident #60 was observed in bed with no cone splint in place. Further observation showed no hygiene care performed at that time. In an observation conducted on 03/03/20 at 10:20 AM, Resident #60 was observed in bed with no cone splint in place. Further observation showed no hygiene care performed at that time. In an observation conducted on 03/03/20 at 3:30 PM, Resident #60 was observed in bed with no cone splint in place. Further observation showed no hygiene care performed at that time. In an interview conducted on 03/04/20 at 7:23 AM, with the Rehab Director she reported that any orders that are discontinued for hospice residents, staff will contact rehab for any changes. In this interview she reported that Resident #60's order for splint was never discontinued, and that staff have been using a towel in place of the cone splint. The Rehab Director further stated that she was able to locate the cone splint in the rehab room and she gave it to staff to use for Resident #60. In an interview conducted on 03/04/20 at 7:55 AM, with Staff A, a Certified Nurse Assistant, She was not sure if Resident #60 has an order for [REDACTED].
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to administer the tube feeding regimen for 3 of 3 sampled residents (Residents #34, #65, and #101). The facility failed to assess and evaluate the tube feeding regimen to prevent significant weight loss for Resident #34. Additionally, the facility failed to provide the tube feeding regimen as per physician's orders [REDACTED].#101. The findings included: 1. Record review of the facility's policy titled Weight Management, revised on 07/02/19, showed that all residents admitted to the facility will be weighted according to the following: day one on admission, day two, day five, and then 2nd week. It further showed that any weight change of 3 pounds from the previous weight needs to be retaken. Recorded review of Resident #34 showed that he was admitted on [DATE] and was discharged to the hospital for one day on 11/03/19. Resident #34 is with impaired cognition related to dementia and is dependent on tube feeding as sole means of nutrition because of dysphasia. Order noted for Enteral feeding 3 times a day

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F 0693 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) of Diabetic Source (tube feeding formula), 250 ml 2 cans for a total of 6 cans daily. Record review of Resident #34's weights showed that when he was admitted on [DATE] no weight was taken upon admission. His weight on 09/18/19 was 142 pounds, on 09/23/19 it was 148 pounds, on 01/08/20 it was 146 pounds, and on 02/06/20 it dropped to 139 pounds. Further review showed that the weights were not taken upon admission, or day 2 as per facility's policy. Record review of the initial nutrition screen dated 09/16/19, showed that the clinical dietitian used the hospital record weight of 176 pounds to calculate Resident #34's nutritional needs. Reviewed of the dietitian's progress notes did not show any follow up notes to reflect the weight decline that was noted on 02/06/20 with 4.66% weight loss in one month. The last note that was completed by the dietitian was on 01/31/20. In an interview conducted on 03/04/20 at 9:11 AM, with the clinical dietitian, she reported that the Restorative Certified Nursing Assistants will take the weights on the residents and give them to the Unit Manager who puts them into the computer system. In this interview the clinical dietitian reported that she will not follow up on any residents with weight loss of less than 5%. The surveyor pointed out that any weight loss that is not addressed in a timely manner can later be greater than 5%, and that the facility's policy is to re-take the weights on any residents with any weight changes of 3 pounds. In an interview conducted on 03/04/20 at 10:56 AM, with Staff F, a Restorative Certified Nursing Assistant, she reported that any weight loss that is 3 pounds or more she will re-take the weight and let the clinical dietitian know. Surveyor voiced concern that weights are not taken accordingly to facility's policy as well as the diffident method of weighting is not consistent. In this interview Staff F acknowledged all findings. Record review of Resident #34's care plan dated 12/16/19, showed that under the nutrition focus the facility will take the weights as per protocol. It further showed that Resident #34 will maintain nutritional status. Review of progress note dated 02/03/20 by the physician showed that the clinical dietitian reported a non-significant weight gain and recommended to continue with current tube feeding regimen. In an interview conducted on 03/05/20 at 12:30 PM, with Resident #34, he agreed to have his weight taken when asked by the surveyor. In an observation conducted on 03/05/20 at 12:55 PM, Staff F was in Resident #34's room to take his weight as per surveyor's request. In that observation Resident #34's weight was taken using a Hoyer lift which was calibrated first. Resident #34's weight was recorded at 131.8 pounds, which is a Significant weight loss of 5.32% in one month. 2). Resident #65 was admitted on [DATE]. On her Admission/Medicare 5 day Minimum Data Set (MDS) Resident #65 was not assessed for cognition due to resident is rarely/never understood. The MDS documented that the resident was dependent upon staff for all Activities of Daily Living. Resident's [DIAGNOSES REDACTED].* hypertension *[MEDICAL CONDITION]* Diabetes Mellitus * [MEDICAL CONDITION] * [MEDICAL CONDITION] * [MEDICAL CONDITION] * Malnutrition * Dysphagia * Muscle weakness. Resident's orders for tube feeding are: Enteral Feed - Every shift [MEDICATION NAME] 1.5 at 50 ml/h, start time 1400 hours, total volume 1000 mL infused/24H, via PEG AND every shift TF . 02/26/20 and Enteral Feed as needed May stop enteral feed to provide ADL care to the resident. Resume enteral feeding after providing care The facility's policy for Weight Management documents, All residents admitted to the facility will be weighed according to the following schedule: Day one on admission day two, day five, and then 2nd week. Resident's care plan for nutrition, created on 01/27/20, documents, (Resident) has nutritional problem r/t traumatic subdural hemorrhage, weakness, dysphagia-dependent on TF regimen for nutrition/hydration needs. Interventions of the care plan include, Administer medications as ordered * Monitor/document/report to MD PRN for s/sx of dysphagia * Obtain and review lab/diagnostic work as ordered. Report results to MD and follow up as indicated * Provide and administer TF regime +nutrition supplements as ordered * RD to evaluate and make diet change recommendations PRN * Weights per protocol. Resident did not have a documented weight until 14 days after admission, with the exception of a weight that was struck out by a Unit Manager. On 03/02/20 at 11:27 AM it was noted that there was approximately 300 ml left in the pre-portioned 1000 milliliter bag with the tube feeding pump not dispensing contents to the resident as it was not on. At a rate of 50 ml/hr it was determined that Resident #65 would not receive the full 1000 ml as ordered. On 03/03/20 at 7:45 AM, approximately 500 ml was dispensed to the resident with 500 ml left in the pre-portioned 1000 ml bag that was dated 03/02/20 at 2115. There was no documentation provided to justify not following dietary orders of start time 1400 hours at 50 ml/hr and no documentation provided to ensure that resident would receive the full benefit of the 1000 ml as ordered. Skilled note, dated 03/01/20 at 4:07 PM, in assessment form, documents, In bed HOB elevated, no s/s of acute distress noted or reported. No facial grimaces or pain voiced. PEG patent and in place. Medications as per order and tolerated well. All safety precautions maintained. On 03/03/20 at 12:19 PM Resident #65 was observed in a lounge chair in her room with the tube feeding pump off and not dispensing, approximately 425 ml dispensed. Again, there was no documentation to justify any interruption in the Enteral feeding or to justify why the Enteral feeding order was not followed. During an interview, on 03/03/20 at 3:36 PM with Staff Y, RN, when asked about the resident's order for Enteral feeding, she replied, we keep it (the pump) running until the 1000 is infused and then we turn it off and reset it with a new bag. The bag is good for 24 hours. If there is residual, we still hang a new bag after 24 hours. When Staff Y was asked why there would be an interruption in the enteral feeding, she replied, When the patient is being changed or transferred. Once it is more than 24 hours, we change the bag regardless of what is in it. Sometimes we have trouble with the pump and sometimes it's the bag. When she was asked about staff removing her from the enteral feeding, she stated that she would have been the one to remove the bag and 'stick' the new bag. During an interview, on 03/03/20 at 4:41 PM, with the Registered Dietician, when asked about Resident #65's enteral feeding order, she replied, They used to order it by time, but now they are written by milliliter and we know how many milliliters are being consumed by the resident. She (Resident #65) is supposed to be on for 20 hours continuous, with four hours off, allowing for staff to provide care (cleaning, changing, repositioning). The RD confirmed that the staff were not following the orders for 50 ml/hr with a start time of 1400 in order for the resident to receive the full benefit of the 1000 ml within 24 hours, 20 continuous. When asked about the facility's policy for monitoring residents' weight, she replied, The Unit Manager does the intake. All of the residents, unless they refuse, are weighed monthly. At the conclusion of the interview, the Registered Dietician confirmed and acknowledged that the resident's weight was not measured per facility's policy/protocol. A progress note dated 03/03/20 at 6:29 PM, documents, Resident is currently on [MEDICATION NAME] 1.5 @50cc/h 1000 ml to be infused in 24 hours, but according to the feeding bag measurement, resident only received approximately 700 ml of feeding within the 24 hrs. Resident remains in stable condition and maintaining ideal weight. MD and family member notified. 3). On 03/04/20 at 9:29 AM, observation of medication administration via a Gastrostomy (G) tube feeding for Resident #101, performed by Staff I, a Licensed Practical Nurse was conducted. Observation revealed Staff I pours the following medication, individually, into a medication cup as follow: Vitamin C 250 mg, one tablet; chewable Aspirin 81 mg, one tablet; [MEDICATION NAME] 10 mg, one tablet; [MEDICATION NAME] 10 mg, one tablet; and [MEDICATION NAME] 25 mg, one tablet. Continue observation revealed Staff I proceeded to the resident's room with five medication cups and two six-ounces cups filled with water. Observation revealed Staff performed hand washing and proceeded to administer the resident's medication. During the medication administration, Staff I connected the syringe to the resident's [DEVICE], pulled gastric content (residual) of about 5 millimeters (ml), disconnected the syringe, removed the syringe plunger and reconnected the syringe. Staff I proceeded to administer the resident's medication. Observation revealed the medication going down very slow and the resident's right forearm over the G-tubing. Further observation revealed Staff I connected the syringe plunger and pushed the medication down with the plunger twice. During the observation, Staff I was asked to move the resident's forearm away from the G- tube to check if that was causing an obstruction. Observations revealed Resident #101's [DEVICE] by the port/connection area with dark spots and tube feeding like dark particles. Staff I stated that the resident had the tube for a long time and that the dark spots and particles are from the feeding. Staff I stated that the tube feeding runs continuously. On 03/05/20 at 2:01 PM, an interview was conducted with Staff I and stated that Residents #101 has small and large medications and sometimes it goes down slowly. Staff I was asked if he thought that the tubing was clogging and stated that some medications go down good and other don't. Staff I was asked if it was appropriate to use the tube feeding syringe plunger to push the medication down and states that is was not okay to use the plunger.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure that controlled substance medication

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) was reconciled for 3 of 3 record reviewed (Resident #11, #97 and #23). The findings included: 1) On 03/04/20 at 2:01 PM, a side by side review of the facility's controlled substance records for the first floor East side medication cart was conducted with Staff O, a Registered Nurse. The review revealed Resident #11 controlled medication utilization record for [MEDICATION NAME]-[MEDICATION NAME] 5-325 mg every 6 hours as needed for pain and documented that one tablet of [MEDICATION NAME]-[MEDICATION NAME] 5-325 mg was pulled on 03/01/20 at 9:15 AM. Continue side by side review of the resident's Medication Administration Record (MAR) for (NAME)2020 revealed a lack of documentation of the [MEDICATION NAME]-[MEDICATION NAME] 5-325 mg given on 03/01/20 at 9:15 AM. During an interview, Staff O stated that she pulled one tablet of [MEDICATION NAME]-[MEDICATION NAME] 5-325 mg on 03/01/20 at 9:15 AM from the controlled substance box and did not document it on the MAR. Staff O stated that is to be documented on both, the controlled medication utilization record and the MAR. 2) On 03/04/20 at 2:33 PM, a side by side review of the facility's controlled substance records for the first floor South side medication cart was conducted with Staff P, a Registered Nurse. The review revealed Resident #97 controlled medication utilization record for [MEDICATION NAME] 50 mg 1 tablet every 6 hours as needed for pain and documented that one tablet of [MEDICATION NAME] 50 mg was pulled on 02/23/20 at 1500 hours (3:00 PM) and on 02/21/20 at 1815 hours (6:15 PM). Continued side by side review of the resident's Medication Administration Record (MAR) for February 2020 revealed a lack of documentation of the [MEDICATION NAME] given on 02/23/20 at 1500 hours and on 02/21/20 at 1815 hours. During an interview, Staff P stated that [MEDICATION NAME] is to be documented on both, the controlled medication utilization record and the MAR. Staff P confirmed that [MEDICATION NAME] 50 mg pulled from the controlled substance box was not documented on the MAR. On 03/04/20 at 2:40 PM, a joint interview was conducted with Staff P and Staff Q, Unit Manager. Staff Q stated that the nurses are to document controlled substance medications on the MAR and the controlled medication utilization record. 3) On 03/05/20 at 7:20 AM, a side by side review of the facility's controlled substance records for the second floor- South side medication cart was conducted with Staff R, a Licensed Practical Nurse. The review revealed Resident #23 controlled medication utilization record for [MEDICATION NAME] 50 mg 1 tablet four times a day as needed and documented that one tablet of [MEDICATION NAME] 50 mg was pulled on 03/03/20 at 9:00 AM. Continued side by side review of the resident's Medication Administration Record (MAR) for (NAME)2020 revealed a lack of documentation of the [MEDICATION NAME] given on 03/03/20 at 9:00 AM. During an interview, Staff R stated that he pulled a tablet of [MEDICATION NAME] 50 mg on 03/03/20 at 9:00 AM and did not document it on the MAR. Staff R stated that [MEDICATION NAME] is to be documented on both, the controlled medication utilization record and the MAR.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and observation the facility's medication error rate was greater than 5 percent, for 2 of 5 residents observed during medication administration (Residents #69 and #101). There were 2 medication errors for 28 opportunities which is a rate of 7.14%. The staff failed to follow manufacturer's guidelines for proper use of an [MED] [MEDICATION NAME] KwickPen for Resident #69, and the facility failed to administer a medication as ordered by the physician for Resident #101. Findings included: 1) A letter from ELI Lilly and Company in response to an inquiry about proper usage of the company's [MED] [MEDICATION NAME] KwickPen stated the following: Lilly does not recommend the use of a syringe to withdraw [MED] from cartridges or KwikPens . This is an unsafe practice that may lead to an accidental needle stick. Additionally, transfer of concentrated [MED]s (e.g., [MED] U-200) is particularly dangerous because the unit markings on a U-100 [MED] syringe do not accurately reflect the true [MED] dose and may lead to an overdose. In addition to being unsafe, this practice is not the FDA approved method of administration per the product's Instructions For Use provided in the packaging literature. (Eli Lilly and Company, Received by surveyor on 05 (NAME)2020). On 03/04/20 at 8:46 AM, an observation of an [MED] injection was made with Staff G, a Licensed Practical Nurse (LPN). Just prior to the administration of the [MED], the nurse tested the resident's blood glucose level, and it was 162. This blood glucose level required 2 units of [MEDICATION NAME] [MED] based upon a sliding scale. Resident #69 is supplied with a [MED] [MEDICATION NAME] KwickPen manufactured by Eli Lilly and Company. Staff G prepared the injection for Resident #69 by removing a 100 unit/ml [MED] syringe from the upper left drawer of her medication cart and the KwickPen located in the same drawer. The KwickPen was correctly labeled for Resident #69. Staff G then proceeded to clean the top of the KwickPen cartridge with an alcohol wipe. Staff G then used the 100 unit/ml [MED] syringe to draw the 2 units of [MED] required. Staff G then administered the [MED] to Resident #69 in the resident's left upper arm at the outer lateral aspect of the arm. At the end of the observation Staff G was questioned as to why she drew the [MED] from the KwickPen device instead of using the device as intended? Staff G replied that she had the appropriate needles in the bottom drawer of her cart, which she opened to show this writer, but it was easier to use the [MED] syringe which is stored in the top drawer as stated above. On 03/04/20 at 4:20 PM, a meeting was conducted with the Director of Nursing (DON) and Staff G. Staff G admitted that she had told her DON about the improper [MED] administration. The DON confirmed this to be true. The DON explained that she had begun to administer an in-service for proper administration using the pen device. (Photographic Evidence obtained). 2) On 03/04/20 at 9:29 AM, observation of medication administration via a Gastrostomy (G) tube feeding for Resident #101, performed by Staff I, a Licensed Practical Nurse was conducted. Observation revealed Staff I pours the following medication, individually, into a medication cup as follow: Vitamin C 250 mg, one tablet, chewable Aspirin 81 mg, one tablet, [MEDICATION NAME] 10 mg, one tablet, [MEDICATION NAME] 10 mg, one tablet and [MEDICATION NAME] 25 mg, one tablet. Staff I stated that he was looking for a bottle of [MEDICATION NAME] medication ordered for the resident and stated that he did not have it. Staff I was asked how many pills he was going to administer to Resident #101 and stated five and that he will look for the [MEDICATION NAME] to be given later. Continue observation revealed Staff I proceeded to the resident's room with five medication cups and two six-ounces cup filled of water. Observation revealed Staff performed hand washing and proceeded to administer the resident's medication. During the medication administration, Staff I stated that the resident was ordered only five (5) millimeters (ml) of water before and after each medication. Observation revealed Staff I administered the five (5) ml of water flushes before and after each medication. At 9:45 AM, Staff I stated he is done with Resident #101's medication administration and that he will get a new bottle of [MEDICATION NAME] for the resident later. Review of Resident #101's physician orders [REDACTED]. [MEDICATION NAME] tablet 1000 mg via [DEVICE] two times a day for Diabetes (01/08/20). Observation revealed Staff I did not administer 50 ml of water flush before and after medication administration. Review of Resident #101 Medication Administration Record [REDACTED]. The resident's MAR indicated [REDACTED]. On 03/04/20 at 1:30 PM, during an interview, Staff I was asked when he administered the [MEDICATION NAME] 1000 mg to Resident #101 and he stated that he did it during surveyor medication administration observation. Staff I confirmed that he poured five pills. Staff I was apprised that [MEDICATION NAME] was not part of the five pills poured and administered during observation. On 03/04/20, during an interview, the Director of Nursing was informed of the findings.

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 observations and interviews, the facility failed to label an opened bottle of a sterile saline solution; failed to secure a controlled substance medication kit; failed to store medications at proper temperatures to preserve their integrity, and failed to remove an expired indwelling catheter from the storage room. The findings included: 1) On [DATE] at 2:06 PM, a side by side review with Staff O, a Registered Nurse, of the facility's medication cart for the east unit on the first floor was conducted. The review revealed an opened, undated sterile saline bottle in the bottom drawer of the cart. During an interview, Staff O stated that she did not know what the bottle was doing there and added that she did not place it in the cart. 2) On [DATE] at 4:14 PM, a side by side review of the facility first floor medication room was conducted with Staff S, a Registered Nurse. Staff S was asked to open the cabinet where controlled substance medications are stored, and it revealed that the cabinet lock was opened. Staff S stated that she opened for the pharmacy and she thought he locked it. Staff S stated that the cabinet is to be locked at all times. 3) On [DATE] at 4:24 PM, a side by side review of the facility Seaside's medication room was conducted with Staff T, a Registered Nurse. The review revealed

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	105521	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVANTE AT BOCA RATON, INC.	1130 NW 15TH STREET BOCA RATON, FL 33486

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) three of five bags of Frozen intravenous antibiotic ([MEDICATION NAME]) placed inside the refrigerator top shell. Staff T stated that the bags should be placed at the bottom of the refrigerator. During an interview, Staff T stated that they have an active order to administer [MEDICATION NAME] intravenously. Staff T stated that she will discard the antibiotic. During the review, Staff U, a Registered Nurse came into the room and she was apprised of the frozen antibiotic bags and stated that she thinks it did not need to be thrown out. Staff T and Staff U were asked to contact the pharmacist. On [DATE] at 11:45 AM, during an interview, Staff U stated that the pharmacist instructed them to discard the frozen IV antibiotic bags. 4) On [DATE] at 4:30 PM, a side by side review of the facility Seaside's medication room was conducted with Staff T, a Registered Nurse. The review revealed a Foley (indwelling) catheter with an expiration date of ,[DATE]. Staff T confirmed that the Foley catheter was expired and asked what she should do with it. Staff T was informed to check with her supervisor.
F 0801 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.** Based on observation, interviews, and record review, the facility failed to have a Certified Dietary Manager in the absence of a full time clinical dietitian. The findings included: Record review of the facility's staff key personnel, showed that they do not have anyone listed under the Certified Dietary Manager section. In an observation conducted on 03/02/20 at 12:30 PM ,in the main kitchen, they did not have a current Food Service Director or a Certified Dietary Mansger. In an interview conducted on 03/02/20 at 12:45 PM, with the corporate dietitian, she reported that she comes into this facility 3 times a week. She reported that she is only here part time but is available by phone as needed. In an interview conducted on 03/02/20 at 12:20 PM, with the Corporate Food Service Director, he reported that he is only covering this facility for the day. He further stated that this facility does not have a current Food Service Director or a Certified Dietary manager. In an interview conducted on 03/02/20 at 12:50 PM, with Staff D, Registered Nurse Unit Manager, she reported that the corporate dietitian comes into the facility two days a week on Mondays and Wednesdays. In an interview conducted on 03/02/20 at 2:00 PM with the Administrator, he reported that the facility does not have a current Food Service Director or a Certified Dietary Manager.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to store, serve and prepare foods in a manner to prevent the growth and spread of foodborne pathogens. The findings included: 1). During the initial kitchen tour on 03/02/20 at 9:08 AM, accompanied by Staff V, Cook, the following observations were made: a. The internal temperature cooked chicken in a 1/3 size 4 inch deep hotel pan, in the walk in cooler, was 51 degrees F. According to staff, the chicken was in the process of cooling from the previous day. It was noted that the pan of chicken was tightly wrapped with plastic wrap. Staff V discarded the chicken. b. The internal temperature of a container of spaghetti sauce in a 1/3 sized 4 inch deep hotel pan that was stored in the reach in cooler, dated 03/03/20, was 51 degrees Fahrenheit (F). According to staff, it had been in the process of cooling since the previous day. It was noted that the container of spaghetti sauce was tightly wrapped in plastic wrap. Staff V discarded the spaghetti sauce. c. Full sized 4 inch deep drip pans that were stored on a shelf with cleaned and sanitized equipment was noted to have food debris on them. d. There was an accumulation of debris under shelving and equipment in all areas of the kitchen. e. A drain tube from the walk in cooler was draining into a floor drain with the tube below the water line creating a possible back-flow of contaminated water. f. The hood vents over the cooking equipment were not running during the entire tour. Staff V, Cook stated that the hood vents did not work and could not find the switch to turn on the hood vents. g. A pipe from the walk in cooler had a leak that was forming ice directly over a shelf containing sliced bread in plastic bags that the bread came in. It was noted that there was also ice resting on top of the packages of bread. None of the packages appeared to have been penetratred by the ice. h. The handle on the walk in cooler door was encrusted with food residues. i. The facility was using plastic milk crates that are not designed to be easily cleanable for shelving in the dry storage room and in the walk in freezer. j. The heating elements from the pellet warmer, according to staff, were stored in the dry storage room, encrusted with food residues. k. A staff member's purse, according to staff, was stored on a shelf in the beverage area, with assorted drink mixes. l. A soft-sided cooler used for [MEDICAL TREATMENT] lunches/snacks was noted to be encrusted with food residues. m. The faucet at the mop sink in a janitorial closet was leaking into the basin. Staff acknowledged the findings and verbally acknowledged understanding of the concerns. All temperatures were taken using the facility's calirated metal-stemmed probe thermometer. 2). In an observation conducted on 03/02/20 at 12:15 PM, in the 2 South unit, the speed rack arrived on the floor with the lunch trays. Closer observation showed staff passing trays to residents, and not covering the trays with the plastic covers while going into residents rooms. In an observation conducted on 03/02/20 at 12:45 PM, in the 2 East unit, the speed rack arrived on the floor with the lunch trays. Closer observation showed staff passing the lunch trays to residents and not covering the rack with the plastic cover. In an observation conducted on 03/02/20 at 12:32 PM, The Corporate Food Service Director, went into the main kitchen/ food production area not wearing a hairnet protection. He left the kitchen for a few minutes and then walked back into the kitchen/production area without wearing a hairnet. In that observation he was seen again walking into the kitchen at 12:42 PM not wearing a hairnet protection. In an interview with the Administrator conducted on 03/02/20 at 2:00 PM, he acknowledged all findings. In an observation conducted on 03/03/20 at 12:03 PM, in the first floor South, the speed rack arrived on the floor with the lunch trays. Closer observation showed staff passing the lunch trays to residents and not covering the rack with the plastic cover. In an interview conducted with Staff AA, a Certified Nurse Assistant, on 03/03/20 at 12:10 PM, she reported that the speed cart needs to be completely covered while delivering meals to resident's rooms.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and observation the facility failed to: 1) properly perform hand hygiene; 2) properly clean multi-use point-of-care equipment, as per facility policy, prior to and after use for Resident #69; 3) prevent cross contamination of clean laundry from personal items and food waste; 4) prevent cross contamination of soiled linens for Resident # 17. Findings included: 1) In the facility policy titled Infection Control - Point of Care Devices and Inject Safety, the first step of the procedure states: 1.Shared point-of-care devices are to be cleaned and disinfected before and after each use with a disinfectant wipe included on the Environmental Protection Agency (EPA) List D. According to the CDC web site hand washing guidelines include: To ensure hand hygiene and proper use of gloves, health care workers should: 1.Wash their hands with soap and water or use an alcohol-based hand rub before preparing and administering an injection; before and after donning gloves for obtaining blood samples; after inadvertent blood contamination; and between treating patients. 2.Wear gloves for procedures that might involve contact with blood, and change gloves and wash hands between patients. Hand Washing: 1.Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. 2.Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails. 3.Scrub your hands for at least 20 seconds. Need a timer? Hum the Happy Birthday song from beginning to end twice. 4.Rinse your hands well under clean, running water. 5.Dry your hands using a clean towel or air dry them. 2) On 03/04/20 at 8:46 AM , an observation of blood glucose test was made with Staff G, a Licensed Practical Nurse (LPN). A blood glucose test requires a glucometer, which is a machine that measures blood sugar levels; a lancet, which is a device used to stick the finger to retrieve a blood sample; and test strips for the machine to analyze the blood sample. Staff G prepared a disposable tray on her medication cart and placed the above items on the tray. The glucometer was removed from an unlabeled bag. This writer had Staff G confirm that this glucometer was in use for multiple residents (shared). Staff G did not clean and disinfect the glucometer prior to entering Resident #69's room to perform the blood glucose test. After the glucometer was used it was brought back to the medication cart where Staff G briefly wiped the glucometer with an alcohol wipe, allowed it to air dry, placed it back in the plastic bag and put it back in the medication cart. Alcohol

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	105521	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVANTE AT BOCA RATON, INC.	**1130 NW 15TH STREET BOCA RATON, FL 33486**

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) wipes are not considered to provide sufficient cleaning or disinfection of point-of care equipment because it evaporates too quickly and requires too large a volume to be effective. Alcohol wipes are not part of the EPA List D as a disinfectant wipe. An observation of the medication cart revealed that the disinfectant wipes required were available for use at the time the alcohol wipe was used instead. 3) On 03/04/20 at 8:46 AM, an observation of blood glucose test was made with Staff G a Licensed Practical Nurse (LPN). A blood glucose test requires a glucometer, which is a machine that measures blood sugar levels, a lancet, which is a device used to stick the finger to retrieve a blood sample, and test strips for the machine to analyze the blood sample. In addition, an observation of [MED] administration was made as well. Prior to performing the glucometer blood test, Staff G prepared a disposable tray on her medication cart and placed the above items on the tray. Staff G then proceeded to Resident #69's room where she entered the room (maintaining dignity and privacy), put on her gloves and proceeded to perform the test. Staff G did not wash her hands prior to the test or after removing her gloves. Staff G determined that Resident #69 needed [MED] based upon the result of a blood glucose level of 162. Staff G then proceeded to gather the needed supplies for [MED] administration using a disposable tray. Staff G placed her [MED] syringe with the [MED] drawn-up and alcohol wipes on the tray. Staff G proceeded to Resident #69's room, where she set down the tray in site of the bathroom, and washed her hands. This writer then timed Staff G, with a watch with a second hand, as she washed her hands. Staff G was timed to have spent 10 seconds washing her hands before putting on gloves. This is 10 seconds short of the CDC guidelines. After the [MED] administration, Staff G removed her gloves and washed her hands. Again, Staff G was timed using the same method described above. Staff G washed her hands for 10 seconds after removing her gloves. When Staff G was asked about hand hygiene she was able to provide the correct time for hand washing to be 20 seconds. When informed that she had only washed her hands for 10 seconds Staff G stated that she did not realize that she was not washing for the recommended time. On 03/04/20 at 4:20 PM, an interview was conducted with the Director of Nursing (DON) and Staff G. Staff G acknowledged she had told her DON about the improper cleaning of a point-of- care device and improper hand washing technique. 4) On 03/05/20 at 10:29 AM while touring the laundry room with the Director of Housekeeping and Laundry Services, this writer was shown the room where clean clothing is prepared to return to the residents. In this room there was a covered shelf unit that had a food wrapper and trash on top of the shelf cover. Further into the room, on a shelf near and holding clean clothes, the following was found near and commingled with the clean clothes: a personal non-disposable lunch bag, an opened bottle of water, two beverage cups and a paperback book. The Director of Housekeeping and Laundry services was unaware that these items posed a contamination risk to the clean clothing stored in the same place. When asked if there was a better place for the items, the Director was unsure if there was one but stated he would have the items removed. (Photographic evidence was obtained). 5) On 03/02/20 at 2:41 PM, observation revealed Resident #17, was on transmission-based precautions for positive [MEDICAL CONDITION] (MRSA) in the urine. On 03/03/20 at 9:04 AM, an interview was conducted with Staff I, who states the resident is on contact precaution for urine infection. On 03/03/20 at 9:45 AM, observation revealed a used yellow gown and gloves (Personal Protective Equipment) in the regular trash can bag in the resident's bathroom, no biohazard bag noted for the deposit of used personal protective equipment (PPE) inside the resident room. On 03/03/20 at 10:08 AM, observation revealed the facility's Housekeeping and Laundry Director placing a biohazard/red bag bin inside Resident #17 room. An interview was conducted with Housekeeping and Laundry Director and he stated that he was just told by one of the nurses that they need the biohazard bin. Observation revealed the Director leaves the room and did not empty or discard PPE trash in the resident's bathroom and leaves the door open. On 03/03/20 at 10:54 AM, observation revealed the Laundry Aide delivering clean clothes to the residents in the same hallway of Resident #17. Observation revealed Staff J, a laundry aide entered the resident room without donning PPE, leave the door open. Further observation revealed Staff J turned around touches the bathroom doorknob and closes the bathroom door. An interview was conducted with Staff J and stated that she entered the resident's room to check if he has dirty clothes. Staff J was asked what the transmission-based box on the door means and stated that she will put a gown, and gloves when picking up dirty linens, but that she does not see any dirty linens in the room. Furthermore, observation revealed Staff J left the room without hand sanitation and continues to deliver clean clothes to the residents. On 03/03/20 at 11:07 AM, observation revealed Staff K, and Staff L, Certified Nursing Assistants, donning a yellow gown and gloves outside the resident's room. During an interview Staff K was asked where she would place her used PPE and stated that on 03/02/20, she placed her used PPE into a regular trash bag and took it to the soiled utility room located down the hallway. Staff K stated that she did not see the red bag bin in the resident room on 03/02/20 and added that it was brought in today (03/03/20). Staff L stated that they should have two bins with a red bag, one for trash, one for the linens. During the interview, Staff K and Staff L were shown the bathroom regular trash can with used PPE in the bag and they both stated that it should not be there. On 03/03/20 at 11:18 AM, an interview was conducted Staff M, a housekeeper. Staff M states that Resident #17's room should have a red bag for the trash. She was apprised that the bathroom trash can has a regular bag with used PPE inside. Staff K stated that the resident is incontinent and wears a brief. On 03/04/20 at 8:54 AM, observation revealed Resident #17 continues to be on contact precautions and one biohazard bin is in his room with a red bag containing used PPE. Review of the resident's care plan initiated on 02/28/20 and revised on 03/03/20 documents .Resident [MEDICAL CONDITION] (urine) and is on contact isolation with interventions to include, contact isolation: wear gowns and mask when changing contaminated linens. Place soiled linens in bag marked biohazard. On 03/04/20 at 5:02 PM, an interview was conducted with the Director of Nursing and the Corporate Regional Nurse. The both states that Personal Protective equipment goes into the regular trash if is not soiled, and if soiled into the red/biohazard bag. They were apprised that a biohazard bag was not placed in the resident's room until 03/03/20 and that every staff member interviewed has a different answer related to what to do with the residents on transmission-based precautions used PPE and linens. The Director of Nursing was asked where the aides are supposed to place the dirty linens and stated that she will ask the aides. On 03/05/20 at 11:30 AM, an interview was conducted with Staff H, a laundry aide, who stated that the linens for residents on transmission based precautions are sent out for cleaning. Review of the facility's policy titled Infection Control-Standard and Transmission-based Precautions revised on 03/2/19 documents .all staff including environmental services staff are to comply with transmission-based precautions . The facility policy does not address how to handle used PPE and soiled linens for residents on transmission-based precautions.