STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065345	A. Building B. Wing	02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Suites at Someren Glen Care Center, The	5000 E Arapahoe Rd Centennial, CO 80122

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 40465 Based on record review and staff interviews, the facility failed to ensure resident use of psychotropic medications was appropriate for two (#57 and #78) of five residents reviewed for unnecessary medication use out of 27 sample residents. Specifically, the facility failed to ensure: -Track non-pharmacological interventions for the use of the as-needed (PRN) psychotropic medication for Resident #57; and -Physician documentation and rationale for Resident #57 and #78 every 14 days to justify the continued use of a PRN psychotropic medication. Findings include: I. Facility policy and procedure The Psychotropic Medication Management policy, revised November 2018, was provided by the director of nursing (DON) on 2/5/19 at 5:30p.m. It read in pertinent part; -The nursing department will monitor those residents receiving psychotropic medications for unmet needs, side effects, and/or tolerance. An IDT (interdisciplinary) team in conjunction with the physician and pharmacist will evaluate the appropriateness and effectiveness of these medications. -Monthly psychotropic IDT committee will evaluate the effects of the medications on a resident ' s physical, mental, and psychosocial well-being and to consider whether the medication should be continued, reduced, discontinued or otherwise modified. -The physician reviews the plan of care, oders, resident ' s response to medication and determines whether to continue, modify or stop a medication. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-PRN orders for psychotropic medication are limited to 14 days and may only be extended if physician documents the rationale for the extended time period in the medical record and indicate a specific duration of time. PRN anxyolitics (anxiety medications) must be renewed every 14 days. PRN medications are to treat emergency or address acute or intermittent symptoms and must be used to treat a diagnosed specific condition. II. Resident #57 A. Resident status Resident #57, age 86, was admitted on [DATE]. According to the February 2019 computerized physician orders (CPO), diagnoses included dementia with behavioral disturbance, depression and chronic pain. The 12/19/18 minimum data set (MDS) assessment revealed the resident had short term memory impairment and long-term memory impairment and was severely impaired with daily decision making. The resident required extensive assistance from staff for most activities of daily living (ADLs), she was administered an antidepressant medication and received hospice care. B. Record review The February 2019 CPO documented, Lorazepam (anti-anxiety medication) give 0.25 ml (milliliters) sublinguilly every 8 (eight) hours as needed for anxiety. The medication was started on 1/2/19 with no end date documented. Review of the medication administration record (MAR) from 1/2/19 to 2/5/19 revealed the resident was administered the Lorazepam (brand name Ativan) PRN on 1/7/19, 1/8/19 and 1/30/18 and documented as effective. Behaviors of resident refusing care, crying and isolation were documented in the MAR from 1/2/19 to 2/5/19 with revealed the nurses indicated she had these behaviors 43 times out of 70 times. There were not any non-pharmacological interventions documented in the resident ' s MAR (see registered nurse (RN) #1 interview below). The behavior care plan, revised 12/4/18, documented the resident had the following behaviors: paranoia of her money missing, picking of her skin, and wandering. Pertinent interventions listed were document behavior and potential causes, program of activities of interest, let her see her money and support from family and caregivers. The 8/31/18 psychotropic medication regimen review care plan documented interventions of psychotropic IDT review on a quarterly basis, monitor for target behaviors and document in the MAR, monitor for potential side effects of psychotropic medications in the MAR and non-pharmacological interventions would be attempted and documented. -Review of the care plans revealed the resident had an antidepressant medication care plan but there was not a care plan addressing the resident taking an anti-anxiety medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The prescriber progress notes from 1/2/19 to 2/5/19 revealed: -The 1/17/19 nurse practitioner (NP) note failed to address Lorazepam PRN being ordered since 1/2/19. -The 2/5/19 NP note (during survey) documented in part that the resident representative reported had increased anxiety with behaviors of restlessness, not redirectable, inability of the residents to settle down with painful, distressed affect. It further documented, Ativan PRN made available during the time of transition used 3 (three) times in January and not yet used this month. The 1/8/19 quarterly psychotropic review documented non-pharmacological interventions of family visits. It was documented clarification order needed because there were previously two PRN Ativan orders. The 2/5/19 social service progress note documented in part, Resident currently taking Zoloft (anti-depressant) 50mg (milligrams) for mood disorder and taking Ativan as needed for Anxiety. -There were no other social service progress notes from 1/2/19 to 2/5/19. Review of nurse progress notes from 1/2/19 to 2/5/19 revealed a 1/7/19 note documented the resident had increased anxiety after dental visit. -There were no other nurse progress notes addressing Resident #57 ' s anxiety. The Behavior Symptoms Report was reviewed from 1/2/19 to 2/519 and it revealed Resident #57 had the behavior of rejection of care documented by the certified nurse aides (CNA) on 1/7/19, 1/8/19, 1/12/19 and 1/27/19. C. Staff interviews The hospice registered nurse (HRN) and director of nursing (DON) were interviewed on 2/5/19 at 4:00 p.m. The HRN said she was the nurse for Resident #57 and #78. She said the prescriber often ordered PRN Lorazepam for resident receiving hospice care for comfort. She said the PRN Lorazepam should be available if a resident becomes more anxious. She said it was ordered six months at a time for each hospice resident in order to have it available if needed. The DON said they reviewed the PRN psychotropics in their quarterly meetings where the medical director, nurse unit managers, social service director, pharmacist and nurse practitioner attended. She said they did not evaluate the PRN Lorazepam ordered by hospice for their residents in case they needed it for their comfort. She said that the HRN and herself were reviewing their mutual residents MARs and discontinuing the PRN Lorazepam for residents that were not administered it. She said moving forward she would meet with the HRN to review any residents receiving PRN psychotropics and providing the physician rationale if needed. RN #1 was interviewed on 2/6/19 at 10:12 a.m. He said the nurses monitored resident behaviors, non-pharmacological interventions and side effects of psychotropic medications in the resident ' s MAR. He said the nurses attempted non-pharmacological interventions for resident behaviors before administering PRN psychotropics and documented it in the MAR. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He said for Resident #57 she had behaviors they were monitoring in the MAR of crying and isolation. He said she rarely had behaviors and that she liked to stay in her room. He said she was on Lorazepam PRN for anxiety but rarely took it. He said he did not locate in her MAR where the nurses were charting her non-pharmacological interventions. He said he notified the nurse unit manager to ensure they were charting her non-pharmacological interventions since she had an order for Lorazepam PRN. The social service director (SSD) was interviewed on 2/6/19 at 10:35 a.m. She said residents were reviewed at a minimum quarterly if a resident received PRN psychotropics. She said she reviewed the nursing progress notes and behavior tracking in each resident ' s MAR to discuss in the meeting. She said the team reviewed the psychotropic medications ordered and behaviors to formulate recommendations on whether it was effective or not. She said the recommendations were forwarded to prescribers and nursing management followed up. She said was responsible for updating the resident ' s psychotropic and behavior care plan with their medications ordered, target behaviors and non-pharmacological interventions. She said when hospice residents were ordered PRN psychotropics she did not always update their care plans with the most current information. She said for Resident #57, she was ordered Lorazepam PRN that was initiated by the hospice nurse. She said they reviewed it in their psychotorpic meeting on 1/8/19 and the recommendation was to clarify her two Ativan PRN orders. She said she did not care plan her Lorazepam use or her target behaviors for it. She said she also did not review her non-pharmacological interventions since the nurses were not documenting them in Resident #57 ' s MAR. The pharmacy service consultant (PSC) and DON were interviewed on 2/7/19 at 1:36 p.m. The PSC said she reviewed the residents medication regimen monthly and more often if the facility requested. She said she documented her recommendations and sent them via email to the DON. She said she checked the following month to see if her recommendations were followed up on by the provider and received some of them scanned via email from the DON. The PSC said for PRN psychotropics the regulations were to be reviewed within 14 days by the prescriber and a stop date if not administered. She said if the prescriber saw fit for the resident to be continued longer than 14 days they needed to provide documented rationale for continued use and indicate the duration. She said with residents that receive hospice care, PRN Ativan was often ordered in case the resident needed it for comfort care and ordered six months at a time. She said it was to ensure the nurses had it on hand with the prescriber's order if a resident needed it. She acknowledged it was more for the nurses convenience than contacting the prescriber when a resident needed it for comfort and obtaining orders when behaviors arose. She said for Resident #57, she sent a review the previous week to the DON about the resident PRN Lorazepam and there had not been followed up yet. She said the staff were monitoring behaviors of isolation and crying. She said she was administered it three times since the order started on 1/2/19 with no stop date, rationale or duration indicated by the prescriber. III. Resident #78 A. Resident status Resident #78, age 98, was admitted on [DATE]. According to the February 2019 computerized CPO, diagnoses included depression, dementia with behavioral disturbance, hallucinations and anxiety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/4/19 MDS assessment revealed the resident had severe cognitive impairments according to the brief interview for mental status (BIMS) score of three out of 15. The resident required extensive assistance from staff for ADLs, she was administered an antipsychotic, antianxiety and antidepressant medication, and received hospice care. B. Record review The February 2019 CPO documented, Lorazepam give 0.5 ml by mouth every 2 (two) hours as needed for anxiety. The medication was started on 12/27/18 with no end date documented. The resident had a routine order, Lorazepam give 0.5 ml by mouth two times a day for anxiety for six months. The medication was started on 10/9/18 with a stop date of 4/9/19. The January 2019 MAR revealed the resident was administered Lorazepam PRN on 1/6/19 and it was administered effective. It was not administered from 2/1/19 to 2/5/19. Behaviors of resident restlessness, agitation, increase in complaints, delusions, hallucinations, psychosis and refusing care were documented in the MAR for 1/1/19 to 2/5/19 and the resident did not have these behaviors. Non-pharmacological interventions were documented in the MAR from 1/1/19 to 2/5/19. On 1/6/19 the resident was not offered a non-pharmacological intervention documented for the PRN Lorazpam administered. The resident was redirected on 1/28/19 and offered one-to-one on 1/30/19 which were effective. No intervention required was documented in the MAR. The behavior care plan, revised 12/4/18, documented the resident had the following behaviors: paranoia, crying, isolation and hallucinations. Pertinent interventions listed were document behavior and potential causes, program of activities of interest and support from family and caregivers. The 10/6/17 anti-anxiety medication care plan documented pertinent interventions to monitor for side effects and effectiveness of the medication. The 1/8/19 quarterly psychotropic medication form documented the resident was ordered Seroquel (antipsychotic), Lorazepam routine and PRN and Effexor (antidepressant). The recommendations were to attempt a dose reduction on the Effexor dose. The prescriber progress notes from 12/27/18 to 2/5/19 revealed: -The 1/23/19 NP note failed to address Lorazepam PRN being ordered since 12/27/18. -The 1/31/19 physician note documented in part, Dementia with depression, anxiety, delusions-nursing staff reports that Seroquel significantly is helping with her symptoms. Behavior symptoms report was reviewed from 1/2/19 to 2/519 and it revealed Resident #78 had the behavior of frequent crying on 1/4/19, with no other behaviors documented by the CNA staff. Review of nurse progress notes from 12/27/18 to 2/5/19 revealed the resident was anxious on 12/27/18 wanting to go home and the Lorazepam PRN was ordered by the hospice nurse. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No other behaviors regarding the resident ' s anxiety were documented in the nurses notes. The 1/27/19 social service progress note documented in part, Taking an antidepressant for MDD (major depressive disorder), Ativan for anxiety and Seroquel for dementia with behaviors. Per nsg (nursing), mood/behaviors overall stable. C. Staff interviews The licensed practical nurse (LPN) #2 was interviewed on 2/6/19 at 9:17 a.m. She said she tracked resident behaviors and non-pharmacological interventions in their MAR. She wrote progress notes if a resident displayed behaviors and PRN psychotropic was administered. She said for Resident #78 her behavior were crying. She said rarely cried but when she did she was calmed by sitting with her and engaging conversation and answering questions she had or holding her hand. She said she had any crying or anxiousness on her shift so she had not administered the PRN Lorazepam. The PSC and DON were interviewed on 2/7/19 at 1:36 p.m. The PSC said the resident was ordered PRN Ativan since 12/27/18. She said she sent a recommendation about the PRN psychotropic to consider duration and rationale since it had been ordered for more than 14 days. She said she sent it last week and it had not been followed up on yet by the prescriber. She said the target behaviors the staff were monitoring were restlessness, refusing care and increased complaints. She said the resident was on routine Ativan twice a day as well and only been administered the PRN Ativan one time in January 2019 and had not been administered it this month.

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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. 40465 Based on observations, record review and staff interviews, the facility failed to ensure food items were stored and served under sanitary conditions in the main kitchen and one of three serving units. Specifically, the facility failed to ensure: -Appropriate use of gloves when handling ready-to-eat foods; -Food temperatures were obtained before serving food and hot food items were held at the proper temperature to reduce the risk of food borne illness; and -Food items were stored properly in the main kitchen. Findings include: I. Appropriate use of gloves when handling ready-to-eat foods. A. Professional reference The Colorado Department of Public Health and Environment (2013) The Colorado Retail Food Establishment Rules and Regulations, retrieved from: https://www.colorado.gov/pacific/sites/default/files/Reg_BOH_RetailFoodRegulations.pdf. It read in pertinent part; -Ready-to-eat is considered a food without further washing, cooking, or additional preparation and that is reasonably expected to be consumed in that form. -Employees prevent bare hand contact with ready-to-eat food by properly using suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. -Single-use gloves shall be used for only one task, such as working with ready-to-eat food, or with raw animal food. Single-use gloves shall be used for no other purpose, and discarded when damaged, when interruptions occur in the operation, or when the task is completed. B.Facility policy and procedure The Food Handling Guidelines policy, revised January 2019, was provided by the director of dining services (DDS) on 2/5/19 at 1:43 p.m. It documented in pertinent part, Single use disposable gloves are worn when preparing food that will not be cooked again (ready-to-eat foods) and while serving food. Gloves are placed over clean hands. Gloves are changed between tasks or if punctured or ripped. Hands are washed after gloves are removed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1.Observations -On 2/04/19 at 1:03 p.m. dietary aide (DA) #1 was serving the lunch meal. She wore gloves and touched many surfaces including the serving utensils, silverware, diet cards, plates and the outside of various food containers. She did not wash her hands and don new gloves when handling bread, a ready-to-eat food. She grabbed the bread from the bag, buttered it, cut the crust off and cut it in half and then served it. -At 1:08 p.m., the registered dietitian (RD) was observed donning gloves and touched the serving utensils and the microwave door. Without washing her hands and donning new gloves, she took bread out of the bag, buttered it and served it. She then took another piece of bread out of the bag placed it on a plate and served it. -On 2/5/19 at 9:05 a.m. DA #1 was serving the breakfast meal. She wore gloves as she touched utensils, diet cards and she peeled a banana by touching the outside peel then grabbed the inside of the banana (ready-to-eat food) with her gloved hand that touched other various surfaces. She served these items. -On 2/5/19 the lunch meal was continuously observed from 12:24 p.m. to 1:02 p.m. DA #1 and DA #2 were serving tacos that consisted of corn and flour tortillas. They were observed touching diet cards, serving utensils, refrigerator doors, cabinet where clean dishes were held without donning new gloves to touch the tortillas served at the meal. DA #2 had a rip in her glove towards the end of service and she did not wash her hands and don new gloves when the rip occurred. 2. Staff interviews The registered dietitian consultant (RDC) and the DDS were interviewed together on 2/5/19 at 1:58 p.m. The RDC said she would expect the staff to change their gloves when changing tasks. She said if one staff was serving the ready-to-eat foods with gloved hands and another staff member serving food items off of the tray line then that was acceptable. She acknowledged the staff did not change their gloves when handling ready-to-eat food items and touching soiled surfaces. She said she provided inservicing to the dietary staff on when to change their gloves such as when touching dirty surfaces or when their gloves are ripped or torn and performing hand hygiene before donning a new pair of gloves. She said she inserviced on using utensils when handling ready-to-eat foods. II. Food temperatures were obtained before serving food and hot food items were held at the proper temperature to reduce the risk of food borne illness. A. Professional reference The Colorado Department of Public Health and Environment (2013) The Colorado Retail Food Establishment Rules and Regulations, https://www.colorado.gov/pacific/sites/default/files/Reg_BOH_RetailFoodRegulations.pdf. It read in pertinent part; - The temperature of potentially hazardous foods shall be 41 F (fahrenheit) or below or 135 F or above, at all times.Potentially hazardous food is a food that requires time/temperature control for safety to limit pathogenic microorganism growth or toxin formation. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Temperature measuring devices shall be available, used, capable of reading both hot and cold temperatures. Temperature measuring devices shall be used to determine required food temperature(s). B. Facility policy and procedure The Food Handling Guidelines policy, revised January 2019, was provided by the director of dining services (DDS) on 2/5/19 at 1:43 p.m. It documented in pertinent part; - Foods should be held for hot for service at a temperature of 140 F or higher. - Temperatures of hot food in service will be documented at the beginning of service and either middle and end of service on the temperature log. The Meal Temperature Record policy, revised January 2019, was provided by the DDS on 2/5/19 at 1:58 p. m. It documented in pertinent part; -Allow adequate time prior to meal service to complete the meal temperature report. -Utilize Taste and Temperature sheets to assure that appropropriate utensil sizes are available. Include all therapeutic and texture modified diets when printing these sheets. -An accurate temperature of all menu items is to be taken and recorded, utilizing a calibrated thermometer. If hot food temperatures are not greater than or equal to the standards, or cold temperatures are not less than or equal to the standards, respond accordingly to correct. Do not serve food at unacceptable temperatures. -When food is transported to remote serving location temperatures are taken and recorded in the kitchen before transport as well as at the final serving location. -Record ending temperatures or at one hour interals during service. Temperatures below or above standards may indicate procedural and/or equipment problems. Address any concerns noted. -If a supervisor is not the person to take and record temperatures they must review the recorded temperatures prior to meal service to ensure temperatures meet standards. 1. Observation and interview On 2/5/19 the lunch meal service was continuously observed from 12:24 p.m. to 1:02 p.m. The meal consisted of southwestern tomato soup, pork and steak tacos, rice, beans, sauteed zucchini and rice pudding. DA #2 obtained the temperatures of the soup, steak, pork, rice and beans. DA #2 did not obtain the temperatures of the mechanical soft and pureed menu selections for the meal and the rice pudding offered for dessert and served the items without ensuring they were the proper temperature. DA #2 said she did not obtain the temperature of the mechanical soft and puree menu items and the rice pudding because they were not listed on her temperature log to record. She said the temperature logs were printed by the managers and placed in the binder in order to obtain temperatures at meal service. She said that on some of the temperature sheets the mechanical or puree menu items were not printed on the temperature log so she did not think it was required. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	DA#2 obtained post meal food temperatures at 1:02 p.m. and the rice pudding was 127.5 F and the pureed rice pudding was 127.4 F. All other temperatures obtained were the appropriate temperature. 2. Record review The Arroz Con Leche (rice pudding) recipe was provided by the DDS on 2/5/19 at 1:43 p.m. It documented in pertinent part, Serve immediately or maintain at 140 F or above. Review of the meal temperature sheet for 2/5/19 lunch revealed there was not a place designated for the rice pudding and the mechanical and puree food items as DA #2 indicated. 3. Staff interviews The RDC and the DDS were on 2/5/19 at 1:58 p.m. The DDS said the dietary staff maintained a temperature log in the main kitchen of food items before being transported to the serving units. He said the dietary staff were to obtain food temperatures before service and at the end of service. He said the dietary managers printed the taste and temperature logs for the staff from their menu system based on what food items were being served at that meal. He said he did not review the logs to ensure all food items offered at the meal were populated. The RDC said the expectation of the dietary staff was to record all temperatures of food items on the serving line and if not prepopulated on their log to write in the information on the bottom. She said she updated the temperature logs to indicate if a food item was missing on the log, the temperature must be obtained and written on the log. She said she would be providing inserving to the staff once the temperature log form was updated. The RDC said she expected the rice pudding temperature should have been obtained before the start of service. She said if it was not within temperature range of 140 F then corrective action should of took place before serving it to the residents. She said the post meal temperatures obtained of the rice pudding and the pureed rice pudding (see above) were not acceptable. III. Failure to ensure food items were stored properly in the main kitchen. A. Professional reference The Colorado Department of Public Health and Environment (2013) The Colorado Retail Food Establishment Rules and Regulations, https://www.colorado.gov/pacific/sites/default/files/Reg_BOH_RetailFoodRegulations.pdf. It read in pertinent part, Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded. B. Manufacturer recommendation for thickened liquids (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Suites at Someren Glen Care Center, The	5000 E Arapahoe Rd Centennial, CO 80122

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The label for the thickened liquids was provided by the DDS on 2/5/19 at 1:45 p.m. and it documented in part, Once opened, store at ambient temperatures for up to 8 (eight) hours or refrigerate for up to 7 (seven) days. 1.Observation The initial tour of the main kitchen was conducted on 2/4/19 at 8:45 a.m. The refrigerator by the serving line that kept items used for meal service had three 46 fluid ounce thickened liquid cartons with labels that documented opened on 1/14/19 and to use by 2/14/19. 2. Staff interview The RDC and the DDS were on 2/5/19 at 1:58 p.m. The RDC said that the thickened liquids should be stored once opened based on the manufacturer recommendations indicated on the label. She said the dietary staff labeled food items once opened and since thickened liquids were not included on their quick reference guide for refrigerated foods they put a use by date of 2/14/19. She said based on when the thickened liquids were opened on 1/14/19, the use by date should be 1/21/19. She said she discarded the three containers of thickened liquids. She said she updated the quick storage guide for the dietary staff to use within seven days after opening and provided inservicing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40221 Based on observations and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infection for current facility residents. Specifically, the facility failed to follow and maintain proper hand hygiene practices between the cleaning of residents ' rooms, between resident contact, and failed to properly sanitize shared equipment between resident use. Findings include: I. Hand hygiene failures A. Facility policy The Hand Hygiene policy/Hand Hygiene Table revised 11/18 and 1/19, provided by the nursing home administrator (NHA) on 2/6/19 at 11:56 a.m., read in pertinent part: -The community considers hand hygiene the primary means to prevent the spread of infections. Hand hygiene includes both hand washing and the use of alcohol based sanitizer. -All associates shall follow the hand hygiene procedures to help prevent the spread of infection to other associates, residents, and visitors. -Between resident contacts. -Before performing resident care procedures. -After handling items potentially contaminated with blood, body fluids, secretions, or excretions. B. Professional reference The Center for Disease Control Guideline and Recommendations for Disinfection in Healthcare Facilities (updated 2/15/17) Retrieved from: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/Cleaning of Patient-Care Devices It read in pertinent part: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Disinfect noncritical medical devices (e.g., blood pressure cuff) with an EPA-registered disinfectant using the label ' s safety precautions and use directions. Most EPA-registered disinfectants have a label contact time of 10 minutes. However, multiple scientific studies have demonstrated the efficacy of disinfectants against pathogens with a contact time of at least 1 minute. By law, all applicable label instructions on EPA-registered products must be followed. If the user selects exposure conditions that differ from those on the EPA-registered product label, the user assumes liability from any injuries resulting from off-label use and is potentially subject to enforcement action under FIFRA. Ensure that, at a minimum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis (such as after use on each patient). If dedicated, disposable devices are not available, disinfect noncritical patient-care equipment after using it on a patient (who is in isolation) before using this equipment on another patient. Perform low-level disinfection for noncritical patient-care surfaces (e.g., bed rails, over-the-bed table) and equipment (e.g., blood pressure cuff) that touch intact skin. C. Observations of breaks in infection control practices on the secure unit On 2/5/19 at 9:45 a.m., certified nurse aides (CNAs) #2, #3, and #4 were observed on the secure unit assisting multiple residents in wheelchairs from the dining area to the living room area, then returning to a dining table to assist a resident with her rolling walker, touching her on the arms and the walker. No hand sanitization was done between residents. CNA #3 was observed touching multiple wheelchairs and residents on their arms and hands, then assisted a resident with breakfast with no hand sanitization done between residents. CNA #2 observed obtaining multiple residents' blood pressure readings without sanitizing her hands or the blood pressure cuff between residents. -At 11:26 a.m., multiple residents returned from an activity off the secure unit and several unknown CNAs were observed assisting them to the living room area, touching wheelchairs and residents on the arms with no hand sanitization done between residents. -At 11:51 a.m., several unknown CNAs, on the secure unit, were observed assisting residents that were walking or in wheelchairs, to the dining tables for lunch, touching the residents ' arms, hands, and a resident ' s oxygen tubing, with no hand sanitization done between residents. On 2/6/19 at 10:50 a.m., licensed practical nurse (LPN) #1 was observed obtaining a resident ' s pulse oximetry reading, (a non-invasive method for monitoring a person ' s oxygen saturation on the fingertip). When she obtained the pulse oximeter from the basket of the vitals sign machine, a blood pressure cuff fell to the floor, she picked it up by the tubing, shook it, and placed it back in the basket, she did not sanitize it. She did not sanitize the pulse oximeter prior to obtaining the reading, nor afterwards, before she placed it back in the basket of the vital signs machine. D. Staff interviews The director of nursing (DON) was interviewed on 2/6/19 at 12:58 p.m. She said staff should use hand sanitizer between any resident contact, especially on the secure unit since those residents respond well to human contact. When a nurse or a CNA used a pulse oximeter or a blood pressure cuff on a resident, it should be cleaned with (brand name) wipes after use and before it is used on another resident. She said the facility did not have a policy on cleaning/sanitizing of shared equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #1 was interviewed on 2/6/19 at 1:45 p.m. She said when a resident ' s blood pressure or pulse oximeter reading was obtained or the equipment comes in contact with the floor, it should be sanitized with the wipes that were kept in the medication cart. CNA #1 was interviewed on 2/6/19 at 1:55 p.m. She said staff should sanitize their hands and shared equipment between contact with residents and wash their hands with soap and water if soil can be seen. 40465 III. Failed to ensure proper handwashing when cleaning resident rooms A. Facility policy and procedure The Patient Room: Daily & Isolation Cleaning Procedures policy, last revised 2011, was provided by the NHA on 2/6/19 at 1:38 p.m. It documented in pertinent part; -When getting started, conduct hand hygiene, don gloves and any other required protective equipment (PPE). -After cleaning the restroom area, remove gloves and PPE. Perform hand hygiene and don fresh gloves. The procedure on cleaning resident rooms was provided by NHA on 2/6/18 at 1:38 p.m. It documented detailed instructions on how to clean a resident room but failed to indicate when to don and doff gloves or when staff were to perform hand hygiene. B. Observation and interview The housekeeper (HK) was observed on 2/6/19 at 9:24 a.m. He donned gloves before cleaning resident room [ROOM NUMBER]. He cleaned #304 and when exiting the room, he doffed his gloves and threw them away. He donned new gloves and started to clean room [ROOM NUMBER]. After cleaning room [ROOM NUMBER], he exited the room and doffed his gloves and threw them away. He moved to room [ROOM NUMBER], donned new gloves, cleaned the room and doffed his gloves upon exiting. The HK did not wash perform hand hygiene before donning a new pair of gloves when cleaning resident rooms #304, #305 and #306. -No hand hygiene or sanitation was observed in between the HK cleaning three different rooms. The HK said he wore gloves before entering a resident ' s room to clean it and discarded his gloves after cleaning each room. He said he did not perform hand hygiene before donning a new pair of gloves. C. Staff interviews (continued on next page)

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