STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366176	A. Building B. Wing	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Elyria	1212 South Abbe Road Elyria, OH 44035

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37805 Based on medical record review, staff interview, and review of a facility policy, the facility failed to ensure residents were given an opportunity to formulate advanced directives on admission. The facility further failed to ensure resident's advanced directive wishes were consistent throughout the medical record. This affected two residents (#249 and #55) of 21 residents reviewed for advanced directives. The facility census was 95. Findings include: 1. Medical record review revealed Resident #249 admitted to the facility on [DATE]. Diagnoses included congestive heart failure and urine retention. Review of the resident's electronic health record (EHR) revealed the resident's advanced directive wish was to be a Do Not Resuscitate Comfort Care (DNR-CC), which meant no resuscitative actions to maintain life would be attempted. The EHR further revealed staff were directed to see the resident's living will for instructions. Further review of the resident's EHR revealed no documented evidence the resident requested to be a DNR-CC nor was a living will found for the resident. Interview on 09/18/19 at 8:53 A.M., with Registered Nurse (RN) #180 confirmed Resident #249's EHR revealed the resident's advanced directive whish was to be a DNR-CC and staff were directed to see the resident's living will for instructions. RN #180 searched the resident's EHR and paper chart, and was unable to find evidence the resident requested to be a DNR-CC nor could she find a living will for the resident. RN #180 confirmed there was no evidence the resident was given an opportunity to formulate an advanced directive. 16453 2. Review of Resident #55's medical record revealed the resident was admitted to the facility on [DATE]. On 11/15/18 a Do Not Resuscitate (DNR) form was signed, however the admission form continued to identify Resident #55 was a full code. Interview with Registered Nurse (RN)#177 on 09/18/19 at 8:18 A.M. confirmed Resident #55's admission record incorrectly identified Resident #55 was a full code and was not updated on 11/15/18 when Resident #55's code status changed.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37805 Based on medical record review, staff interview and review of a facility policy, the facility failed to notify a resident's physician, responsible party and Hospice provider of a change in a wound status and to timely notify a resident's family of a fall. This affected two residents (#13 and #94) of 21 residents reviewed for notification. The facility census was 95. Findings include: 1. Medical record review revealed Resident #13 admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, dementia and hypertension. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE], revealed the resident's cognition was severely impaired. Review of a nursing progress note dated 09/07/19 at 3:04 P.M., revealed the resident's dressing on her right leg was completed. A large amount of greenish, brown drainage was noted on the old dressing with a foul odor. There was no evidence in the medical record the physician, responsible party or the Hospice provider were notified. Interview on 09/18/19 at 2:49 P.M., with the Director of Nursing (DON) confirmed there was no evidence Resident #13's physician, responsible party or the Hospice provider were notified of the change in the status of the resident's wound. 2. Medical record review revealed Resident #94 admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), heart failure and Alzheimer's disease. Review of the resident's MDS assessment, dated 08/03/19, revealed the resident's cognition was impaired. The resident discharged from the facility on 08/17/19. Review of a nursing progress note, dated 08/01/19 at 11:00 P.M., revealed the resident slid out of his wheelchair onto his bottom. The resident suffered a small abrasion on his back. There was no evidence the resident's family was notified of the fall. Interview on 09/19/19 at 1:10 P.M., the DON revealed staff were supposed to notify the resident's physician and family/responsible party of any change in condition unless the resident was alert and oriented and did not wish them to do so. The DON confirmed the resident's family was not notified the resident's fall on 08/01/19. Review of facility policy titled, Family Involvement, most recent revision date 04/15/19, revealed the facility was to provide information to the family to keep them informed of the resident's status including their progress and changes. This deficiency substantiates Complaint Number OH00106695. 16453

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 16453 Based on medical record review and staff interviews, the facility failed to ensure written notification of the facilities bed hold policy was provided to the resident and representative, at the time of transfer. This affected two residents (#75 and #94) of two reviewed for hospitalization s. The facility census was 95. Findings include: 1. Review of Resident #75's medical record identified admission to the facility occurred on 04/19/19 and he was paying privately for services at the facility. The record identified on 07/21/19 and 08/05/19 Resident #75 required hospitalization s. Further review of the medical record identified a lack of written notification of the bed hold policy to Resident #75 and his representative, at the time of transfer/discharge. Interview with Business office Manager (BOM) #128 on 09/18/19 at 10:50 A.M. confirmed she had no written notification of the bed hold policy being provided to Resident #75 or his representative. 2. Review of Resident #94's medical record identified admission to the facility occurred on 07/28/19, with medical diagnosis including; Chronic obstructive pulmonary disease (COPD), oxygen dependence, high blood pressure, Alzheimer disease and depression. The record identified on 08/10/19 Resident #94 was transferred from the facility to the hospital and stayed there until 08/16/19, then returned to the facility. The record identified Resident #94 was utilizing and insurance benefit and would need to pay privately to hold his bed in the event of a transfer or discharge. The record lacked evidence the facility provided the bed hold policy and procedure to Resident #94's representative at the time of transfer on 08/10/19. Interview with the facility Administrator on 09/19/19 at 2:49 P.M. confirmed the facility did not provide a bed hold notification for Resident #94.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16453 Based on medical record review, observations, staff interview, resident interview, and facility policy review, the facility failed to ensure two residents (#13 and #75) of three reviewed for pressure ulcers had treatments and services to promote healing and prevent new ulcers from development. The facility identified nine residents with pressure ulcers. The facility census was 95. Findings include: 1. Review of Resident #75's medical record identified admission to the facility occurred on 04/19/19 with medical diagnosis including; B cell lymphoma, feeding tube, pressure ulcer stage 4 (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) to sacrum with sepsis, anemia and multiple strokes. The readmission assessment dated [DATE] revealed Resident #75 was cognitively intact. Review of the wound clinic notes dated 09/13/19 revealed Resident #75 returned from the appointment with new physician orders to hold the wound vacuum for one week, complete skin preparation with calmoseptine/mycolog cream mix to peri-wound (skin surrounding open area), a wet to dry dressing with Dakins' solution, cover with ABD (thick dressing) and paper tape, change BID (twice a day). Review of the Treatment Administration Record (TAR) for September 2019 revealed on 09/13/19 when Resident #75's dressing was ordered to be completed twice a day, the staff inadvertently transcribed the order for once a day. The TAR identified on 9/14/19 and 09/15/19 the dressing was documented as being completed once a day. The TAR confirmed the dressing was not completed at all on 09/16/19, and was only scheduled for once a day on 09/17/19. Observation of Resident #75's wound dressing change on 09/17/19 at 11:21 A.M., with Registered Nurse (RN) #19 and State tested Nursing Assistant (STNA) #116 revealed RN #19 removed Resident #75's old dressing which was dated 09/15/19, confirmed by RN #19 and STNA #116. Resident #75 revealed the dressing was not changed on 09/16/19, because two nurses called off and no one had time to do it. RN #19 then cleaned the wound with normal saline and applied Calmoseptine cream (over the counter-moisture barrier cream) to the peri wound. RN #19 then applied the wet to dry Dakins solution dressing, applied paper tape. Interview with RN #19 on 09/17/19 at 11:45 A.M. confirmed he did not use the cream that was ordered by the wound clinic on 09/13/19, which was a mixture of mycolog (a prescription anti-fungal cream). Interview with RN/Unit manager #77 on 09/17/19 at 2:11 P.M. confirmed prescription wound cream (calmoseptine/mycolog cream) was located in the treatment cart. RN #77 removed the cream from the box and confirmed the cream was sealed and had never been used since arriving at the facility from the pharmacy on 09/14/19. RN #77 confirmed nursing staff were documenting applying it. The RN further confirmed Resident #75's wound orders were not transcribed correctly from the wound clinic visit of 09/13/19, resulting in Resident #75's dressing only being completed once on 09/14/19, 09/15/19, and not completed at all on 09/16/19. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	37805 2. Medical record review revealed Resident #13 admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia and hypertension. Review of the resident's physician orders revealed an order dated 08/10/19 for staff to off load the resident's heels while in bed. Staff were able to use soft boots as needed. Observations on 09/17/19 at 1:18 P.M. and on 09/18/19 at 8:44 A.M. and 2:32 P.M., revealed Resident #13 laying in bed with her heels on the mattress. No soft boots were observed. Interview on 09/18/19 at 8:45 A.M., with State tested Nursing Assistant (STNA) #70 confirmed Resident #13 was lying in her bed with her heels on the mattress. Further interview at 2:36 P.M., Registered Nurse (RN) #180 confirmed the resident was lying in her bed with her heels on the mattress. Review of a facility policy titled, Wound Care (pressure injury), most recent revision date 04/05/19, revealed treating and/or preventing pressure injury involved relieving pressure, restoring circulation, promoting adequate nutrition and resolving and/or managing related disorders. Staff were to provide care measures such as risk factor management, use of topical treatments, wound cleaning, debridement and use of dressings to support wound healing.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37805 Based on medical record review, observation, staff interview, and review of a facility policy, the facility failed to ensure interventions to prevent injury from falls were in place. The facility further failed to ensure resident's call light system was in resident's reach while in their room. This affected one resident (#13) of three reviewed for falls. The facility census was 95. Findings include: Medical record review revealed Resident #13 admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia and hypertension. Review of a nursing progress note dated 09/06/19 at 8:05 P.M. revealed Resident #13 fell from her wheelchair and was found sitting on the floor. Interventions included to use a matt on the floor, next to the resident's bed, due to the resident's impulsiveness and confusion. Observations on 09/16/19 at 4:25 P.M. revealed Resident #13 was in her bed. The resident's fall matt was observed to be propped up against a cupboard on the opposite side of the room. Observations on 09/17/19 at 1:18 P.M. revealed Resident #13 was lying in her bed. Her call light system was observed to be not in her reach and lying on a chair. The resident's fall matt was observed to be propped up against a cupboard on the opposite side of the room. Interview on 09/17/19 at 1:23 P.M., with State tested Nursing Assistant (STNA) #116 verified Resident #13's call light was not within the resident's reach and her fall matt was not in place. Observation on 09/18/19 at 8:44 A.M. revealed Resident #13 was again lying in bed her bed. Her call light system was noted to be lying on the floor under her bed. Interview on 09/18/19 at 8:45 A.M., with STNA #70 confirmed Resident #13's call light was lying on the floor, under the bed, and not within the resident's reach. Review of a facility policy titled, Fall Management, most recent revision date 04/15/19, revealed staff were to promote patient safety and reduce patient falls by proactively identifying patient's fall indicators. Staff were to ensure resident's environment remained as free of accident hazards as possible and received adequate supervision and assistive devices to prevent accidents. This deficiency substantiates Complaint Number OH00106695.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37805 Based on medical record review, observation, staff interview, and review of a facility policy, the facility failed to ensure an catheter securement device was used to prevent possible injury from the use of an indwelling urinary catheter. This affected one resident (#249) of two reviewed for urinary catheters. The facility census was 95. Findings include: Medical record review revealed Resident #249 admitted to the facility on [DATE] with diagnoses including congestive heart failure (CHF) and urine retention. Review of the resident's physician orders revealed an order dated 09/14/19 to insert an indwelling Foley urinary catheter. Observation of catheter care on 09/18/19 at 11:30 A.M. for Resident #249, with State tested Nursing Assistant (STNA) #9, revealed there was no catheter securement device (a device designed to securely hold the catheter in place to prevent urine back-flow and urethral trauma caused due to catheter movement or dislodgement) in use for the resident's catheter. The STNA revealed staff were supposed to use a strap style anchoring device for safety to keep the catheter tubing from getting caught on resident's pants or briefs and to prevent the tubing from being pulled out. STNA #9 confirmed there was not a catheter securement device in use for Resident #249's catheter. Review of a facility policy titled, How to Care for Your Foley Catheter, dated 2019, revealed catheter care included to keep the catheter tube secure.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 16453 Based on medical record review, observation, and staff interviews, the facility failed to provide a resident with nutritional interventions as ordered for a significant weight loss. This affected one resident (#75) of two reviewed for nutrition. The facility identified three residents with significant weight loss in the census of 95. Findings include: Review of Resident #75's medical record identified admission to the facility occurred on 04/19/19 with medical diagnosis including; B cell lymphoma, feeding tube, pressure ulcer stage 4 (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) to sacrum with sepsis, anemia and multiple strokes. The record identified Resident #75's admission weight was 161 pounds (lb) on 04/26/19. Resident #75 was hospitalized from 08/05/19 through 08/26/19 and was noted with a weight of 139 lb upon readmission. Resident #75's weight on 08/26/19 was 143 lb and on 09/04/19 was 142.5 lb, which evidenced a significant weight loss of 11.8%, since admission. Review of nutritional progress note dated 09/09/19 at 11:31 A.M. revealed Resident #75 had had a weight change of 15.4% loss in the past 90 days. The note revealed the dietician recommend Magic Cup (frozen high calorie supplement) at meals to prevent further loss. Review of Resident #75's physician order dated 09/09/19 revealed to include a Magic Cup with all meals. Review of a nutrition progress note dated 09/16/19 at 3:24 P.M. revealed Resident #75 had a coccyx wound, needed additional protein, and was receiving 15 grams of protein from Magic cups ordered three times a day, with meals. Observation of Resident #75 on 09/18/19 at 8:23 A.M. revealed State tested Nursing Assistants (STNAs) #70 and #125 were passing meal trays which included Resident #75's tray. The breakfast tray was observed without the Magic Cup. STNA #75 revealed Magic Cups came from the kitchen and she did not think Resident #75 was ordered them. STNA #125 revealed Resident #75 did not get them in the morning and she only remembered him getting them at lunch.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 16453 Based on medical record review, resident and staff interviews, the facility failed to ensure adequate treatment of one resident (#85) of one for psychosocial well being. The facility census was 95. Findings include: Review of Resident #85's medical record identified admission occurred on 08/14/19 following hospitalization for amputation of his right leg. The record revealed Resident #85 had the diagnosis of bipolar disorder (mental health condition). Review of an physician visit dated 08/15/19 identified Resident #85 was admitted to the facility following identification of gangrene of the right foot with maggot infestation resulting in below the knee amputation. The physician wrote an order to consult with the facility psychiatrist due to the diagnosis of bipolar disorder. Review of progress note dated 08/29/19 at 6:25 P.M. identified Resident #85 appeared agitated when asked to perform therapy. The notes identified Resident #85 was smoking more and refusing care. The notes identified the physician felt he needed to see his psychiatrist. The progress note further revealed a call would be placed on 08/30/19 for a meeting with Resident #85's sister. Progress note dated 08/30/19 at 2:33 P.M. revealed at the meeting with Resident #85's sister she requested for him to receive a psychiatry evaluation because she believed he was escalating with care refusal and anger. Resident #85's sister revealed he was exhibiting similar behavior prior to his last inpatient psychiatric hospitalization . Progress note dated 09/02/9 at 1:28 P.M. revealed the Social Services Designee (SSD) #101 was informed by staff Resident #85's younger brother passed away on 09/01/19. Progress note dated 09/04/19 at 9:21 A.M. revealed Resident #85's psychiatrist office called the facility and scheduled an appointment for 09/10/19 at 6:00 P.M. and was placed on the cancellation list to get in early if able, Resident #85 and his sister were made aware. Further review of Resident #85's progress notes through 09/16/19 identified Resident #85 had not been to see his psychiatrist. Interview with Resident #85 on 09/16/19 at 3:55 P.M. confirmed he missed a psychiatry appointment because there was a lack of communication in the facility between staff and residents. Resident #85 revealed the facility never scheduled transportation for his appointment, therefore it was missed. Interview with Licensed Practical Nurse (LPN) #171 on 09/18/19 at 12:12 P.M. confirmed Resident #85 was not provided transportation from the facility and missed his psychiatry appointment on 09/10/19 at 6:00 P.M. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the facility appointment scheduler on 09/18/19 at 2:59 P.M. revealed she did not schedule Resident #85's appointment or transportation because she was not aware of it. The scheduler revealed the facility did not provide transporting that late in the evening as the appointment was scheduled for 6:00 P.M.

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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. 16453 Based on medical record review, review of hospital discharge records, and staff interview, the facility failed to ensure a resident received ordered medications. This affected one resident (#94) of six reviewed for medications. The facility census was 95. Findings include: Review of Resident #94's medical record identified admission to the facility occurred on 07/28/19, with diagnoses including; Chronic Obstructive Pulmonary Disease (COPD), and oxygen dependence. Review of Resident #94's hospital discharge instructions dated 08/16/19 identified Resident #94 returned to the facility at 10:20 P.M. The instructions included a medication order for Duoneb inhalation solution for Nebulizer four times a day. Review of Resident #94's Medication Administration Record (MAR) dated 08/17/19 revealed the Duoneb treatment was not completed for the 12:00 A.M., 6:00 A.M. and 12:00 P.M. dose. Interview with Licensed Practical Nurse (LPN) #165 on 09/19/19 at 2:00 P.M. confirmed she worked the day shift on 08/17/19 and had to obtain Resident #94's medications from the facility Pyxis system when she arrived. LPN #165 confirmed there was no evidence Resident #94 received his albuterol Nebulizer medications as ordered by the physician on 08/17/19. This deficiency substantiated complaint OH000106695.

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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. 37805 Based on observation, staff interview, and review of facility policy, the facility failed to ensure food was stored properly when staff failed to cover foods stored in the freezer. This had the potential to affect all 95 residents that resided in the facility who consumed food from the kitchen. Findings include: Observation on 09/16/19 at 10:36 A.M. revealed a metal cart sitting in the walk-in freezer. On the shelf of the cart there were five baking sheet trays with breaded fish and one baking sheet tray with hushpuppies. None of the baking sheet trays were covered to protect the food. Interview on 09/16/19 at 10:37 A.M., with the Executive Chef (EC) #172 revealed all foods stored in the walk-in freezer were to be covered to protect the food. EC #172 confirmed there were five trays of breaded fish and one tray of hushpuppies stored on a metal cart, in the walk-in freezer, uncovered. Review of a facility policy titled, Food Safety, most recent revision date 11/28/17, revealed staff were to store food in a clean, safe and sanitary manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366176	A. Building B. Wing	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Elyria	1212 South Abbe Road Elyria, OH 44035

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 16453 Based on medical record review, observations, staff interview, and facility policy review, the facility failed to ensure infection control was maintained during a pressure ulcer dressing change for one resident (#75) of three residents reviewed for infection control. The facility census was 95. Findings include: Review of Resident #75's medical record identified admission to the facility occurred on 04/19/19 with medical diagnoses including; B cell lymphoma, feeding tube, and pressure ulcer stage 4 (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) to sacrum with sepsis. The resident was identified as being cognitively intact. Observation of Resident #75's wound dressing change on 09/17/19 at 11:21 A.M., with Registered Nurse (RN) #19 and State tested Nursing Assistant (STNA) #116 revealed following following removal of the old dressing RN #19 changed gloves, however did not perform hand washing between the soiled gloves and placing on the new pair. Interview with RN #19 on 09/17/19 at 11:45 A.M. confirmed he did not clean his hands following the removal of the old dressing and changing gloves to place the clean dressing on. The interview further confirmed Resident #75 was currently on isolation precautions for Clostridium difficile (c-diff/infection). Review of the facility hand hygiene policy identified the facility utilized Lippincott procedures from the Internet for all facility policies. The policy identified washing with soap and water is appropriate when the hands are viably soiled or contaminated with with blood or other body fluids, when exposure to potential spore-forming pathogens, such as c-diff is strongly suspected or proven. The policy identified the hand washing should be preformed when moving from contaminated body site to clean body site during care.