STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155377	A. BUILDING 00 B. WING	11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEYMOUR CROSSING	707 S JACKSON PARK DR SEYMOUR, IN 47274

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00275165 and IN00270319. Complaint IN00275165 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00270319 - Unsubstantiated due to lack of sufficient evidence. Survey dates: November 20, 21, 26, 27, and 28, 2018. Facility number: 000272 Provider number: 155377 AIM number: 100274710 Census Bed Type: SNF/NF: 88 Total: 88 Census Payor Type: Medicare: 8 Medicaid: 71 Other: 9 Total: 88 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 29, 2018.	F 0000	**F 000** The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or of any violation or regulation. This provider respectfully requests the 2567 Plan of Correction be the letter of credible allegation and requests a desk review in lieu of a post survey revisit on or after December 14, 2018. -	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the			

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

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	resident's status. Based on record review and interview, the facility failed to accurately complete a Minimum Data Set assessment related to diagnoses. This deficient practice effected 2 of 21 residents reviewed. (Residents 42 and 68) Findings include: 1. The clinical record for Resident 42 was reviewed on 11/28/18 at 11:50 A.M. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 09/20/18, indicated the resident was cognitively intact. Diagnoses included, but were not limited to, congestive heart disease, hypertension, neurogenic bladder, diabetes, anxiety, and depression. The MDS indicated Resident 42 received hemodialysis. There were no diagnoses to support dialysis treatments. During an interview, on 11/28/18 at 04:16 P.M., the MDS Coordinator indicated she had never placed additional diagnoses codes on a Quarterly MDS assessment, she had only marked the pre-populated diagnoses that applied to the resident. After having checked with the Cooperate MDS Coordinator she indicated there should have been a supporting diagnosis for dialysis. During an interview, on 11/28/18 at 04:26 P.M., the MDS Coordinator indicated the facility followed the RAI (Resident Assessment Instrument) manual for MDS assessments. The facility did not have a policy regarding MDS assessments. 2. The clinical record for Resident 68 was reviewed on 11/27/18 at 09:11 A.M. A Significant Change MDS assessment, dated 10/16/18, indicated the resident was severely cognitively impaired and needed extensive assistance of two staff for bed mobility, transfers, dressing, toilet use, and	F 0641	**F 641 Accuracy of Assessments** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The assessments noted in the 2567 for Resident 42 and 68 have been modified with the correct information and re-transmitted to CMS. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected. An audit of the last 30 days of transmissions of MDS assessments will be completed by December 14, 2018 to review accuracy and proper coding. If any inaccuracies are discovered the assessments will be modified with the correct information and re-transmitted to CMS. **What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur?** MDS Coordinator will receive in service training from her consultant on proper coding and accuracy of the MDS assessments by December 14, 2018. The Director of Nursing or designee will review all assessments prior to submission	12/14/2018

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	personal hygiene. Diagnoses included, but were not limited to, stroke, dementia, coronary artery disease, and neurogenic bladder. The resident was always incontinent of bowel and had an indwelling catheter. A Quarterly MDS assessment, dated 08/17/2018, Active Diagnoses did not indicate the resident had a UTI (Urinary Tract Infection) in the last 30 days. The following Prescription Order for Resident 68 was provided by Unit Manager 2 on 11/28/18 at 01:35 P.M. The order, dated 07/21/18, indicated Resident 68 received Bactrim (antibiotic) 800-160 mg (milligrams) by mouth every 12 hours for UTI A Laboratory reports for Resident 68 were provided by the MDS Coordinator on 11/28/18 at 03:48 P.M. The urine culture report, dated 07/20/18, indicated the resident had two organisms, escherichia coli and proteus mirabilis, with over 100,000 CFU/ml (Colony Forming Unit per milliliter). An Event Report for Resident 68, dated 07/20/18, was provided by Medical Records on 11/28/18 at 03:56 P.M. The report indicated the resident had signs and symptoms, with an onset date of 07/19/18, of, "...either acute change in mental status or acute functional decline with no alternate diagnosis and leukocytosis..." During an interview, on 11/28/18 04:06 P.M., the MDS Coordinator indicated the UTI should have been documented on the MDS assessment. She did not have a policy regarding MDS assessments and followed the RAI manual. 3.1-31(c)(1)		to ensure accuracy. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Medical Records Coordinator will audit 4 completed MDS assessments per week for 4 weeks, then monthly for 6 months prior to transmission for accuracy of the assessments. Observations of the assessments will be logged on the MDS Accuracy audit tool (attachment labeled “A”) and findings will be discussed at the monthly QAPI meeting overseen by the Administrator or designee. If a threshold of 95% or greater is not met on the audit tool an action plan will be developed to ensure compliance.	

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to provide appropriate incontinence care for a resident with a history of	F 0690	**F 690 Bowel/Bladder Incontinence, Catheter, UTI** **What corrective action(s) will**	12/14/2018

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	frequent UTI's (Urinary Tract Infections). This deficient practice effected 1 of 3 residents reviewed for UTI's. (Resident 68) Findings include: An observation of incontinence care for Resident 68 was conducted on 11/26/18 at 11:34 A.M. Staff included CNA (Certified Nurse Aide) 7 and QMA (Qualified Medication Aide) 8 and LPN (Licensed Practical Nurse) 9. The resident was laying on an air bed. The staff washed their hands and donned gloves. The CNA and QMA rolled the resident onto her left side. The bed sheet was noted to have a round wet area about eighteen inches in diameter. The CNA dipped a clean dry wash cloth in a pan of water and squirted soap on the cloth. She washed the buttock area wiping the rectum and turning wash cloth. Feces was noted on the wash cloth. She put the dirty cloth in a clear plastic bag, dipped another clean cloth in the pan of water and rinsed the buttock area of the resident. She patted the area dry with a clean towel then rolled the wet sheet up, tucked it under the side of the resident. The LPN applied ointment to the resident's back side. The CNA placed a clean sheet and fresh brief under the resident then she and the QMA rolled the resident to her other side. The LPN applied more ointment to the resident's back side. The CNA and QMA cleaned the resident's pubic area. The CNA dipped a clean dry wash cloth into the same tub of water, squirted soap on the wet cloth and cleaned the area around the urinary catheter tubing and the pubic area. The CNA put the soiled wash cloth in the plastic bag and picked up a clean dry wash cloth. She dipped the cloth in the tub of water and rinsed the pubic area of the resident. The CNA dried the area with a towel then coiled up the resident's oxygen tubing and laid it on the oxygen		**be accomplished for those residents found to have been affected by the deficient practice?** Resident 68 was given appropriate incontinence care under direct supervision of the Clinical Education Coordinator. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents with a history of frequent UTI's and requiring incontinence care have the potential to be affected by the deficient practice. All residents with frequent UTI's and requiring incontinence care will be observed by the Clinical Education Coordinator during incontinence care to ensure it is appropriately done. **What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur?** Clinical Education Coordinator or designee will provide in service training to all nursing staff on appropriate incontinence care by December 14, 2018. The Clinical Education Coordinator or designee will conduct weekly rounds to ensure incontinence care is provided correctly. **How will the corrective action(s) be monitored to**	

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	apparatus in the room. The CNA continued to help dress the resident assisting with her pants, cami, deodorant, shirt, and brief. The CNA and QMA rolled the resident side to side and placed the hoyer lift sling under the resident. They taped the brief in place, touched the urinary catheter tubing, applied gripper sleeves to both of the resident's lower legs, applied her shoes, touched the hoyer lift, touched the catheter bag and held it by the hooks, hooked the bag to the hoyer lift, and assisted the resident into her wheelchair. The CNA hung the catheter bag on the back of the wheelchair then changed her gloves. No handwashing or hand sanitizing was noted throughout the procedure nor were gloves changed or the wash water changed. The clinical record for Resident 68 was reviewed on 11/27/18 at 09:11 A.M. A Significant Change MDS (Minimum Data Set) assessment, dated 10/16/18, indicated the resident was severely cognitively impaired and needed extensive assistance of two staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. Diagnoses included, but were not limited to, stroke, dementia, coronary artery disease, and neurogenic bladder. The resident was always incontinent of bowel, had an indwelling catheter, and was morbidly obese. The Care Plan for Resident 68 was provided by Medical Records on 11/28/18 at 03:06 P.M. The Care Plan for the indwelling urinary catheter indicated the goal was to manage the catheter care appropriately. The following Prescription Orders for Resident 68 were provided by Unit Manager 2 on 11/28/18 at 01:35 P.M.:		**ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Pericare audit tool (attachment labeled “B”) will be used weekly for 4 weeks and then monthly for 6 months to ensure compliance with incontinence care. The findings of the audit tool will be reviewed monthly in the Quality Assurance meeting led by the Administrator. If a threshold of 95% or greater is not achieved an action plan will be developed to ensure compliance.	

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	11/10/18 - Ceftriaxone 1 gram, injection for UTI 10/08/18 - Keflex 500 mg (milligram), by mouth, every 12 hours for UTI 08/23/18 - Ceftriaxone 1 gram, injection for UTI 07/21/18 - Bactrim 800-160 mg, by mouth, every 12 hours for UTI 05/24/18 - Cefuroxime axetil 500 mg, by mouth, every 12 hours for UTI During an interview, on 11/28/18 at 12:48 P.M., Unit Manger 2 indicated Resident 68 had a history of frequent UTI's. During an interview, on 11/28/18 at 03:23 P.M., CNA 6 indicated when doing incontinence care she would gather the supplies, wash her hands and don gloves. If the resident was laying in bed, undo their brief, put soap on a wet wash cloth, wash the pubic area from front to back, rinse, then dry with a clean towel. Apply cream if it was ordered. Roll the resident to one side, get a wash cloth add soap, clean rectal area, rinse, and dry, and apply cream if needed. Roll the bedding and tuck it under the resident, apply clean linens on that same side with a clean brief. Roll the resident the opposite way, remove soiled linens, unroll the clean brief and clean linens, fasten the brief and apply a new sheet and blanket if required. Take all the bags and tie them up. Dispose of her gloves, wash her hands, dispose of the bags in the soiled utility room. The current "PERINEAL CARE" policy, with a review date of 03/2012, was provided by the Administrator on 11/28/18 at 04:18 P.M. The policy indicated, "...wash urethral area first...Change water in basin...Clean anal area..." 3.1-41(a)(2)			

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F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be			

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	extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to provide adequate clinical documentation of an increase in behaviors related to an increased psychotropic medication dosage, and failed to provide adequate documentation of attempts to use non-pharmalogical interventions prior to a medication increase. This deficient practice effected 1 of 5 residents reviewed for unnecessary medications. (Resident 31) Findings include: Resident 31's clinical record was reviewed on 11/25/18 at 08:42 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 09/06/18, indicated the resident was moderately cognitively impaired. Diagnoses included, but were not limited to, hypertension, aphasia, cerebrovascular accident (stroke), anxiety, depression, and COPD (Chronic Obstructive Pulmonary Disease). A review of the resident's orders included an order with a start date of 08/30/18 for Trazodone (an antidepressant, sometimes used to treat insomnia) 25 mg (milligrams) by mouth at bedtime that was increased to 50 mg at bedtime on 10/08/18. During an interview, on 11/27/18 at 12:51 P.M., the Social Services Director indicated the Trazodone medication was increased because the resident was having more insomnia. The resident	F 0758	**F 758 Free from Unnecessary Psychotropic Meds/PRN Use** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 31 was assessed and determined not to have been affected by the deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents receiving psychotropic medications have the potential to be affected by the deficient practice. All residents receiving psychotropic medications in the past 30 days were reviewed by the Social Service Director to ensure adequate clinical documentation and adequate documentation of non-pharmacological interventions were in place for any medication increases. **What measures will be put in to place or what systemic**	12/14/2018

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	developed pneumonia recently. She was more anxious so they increased her antianxiety medication too. Her medications were up for review on December the 5th of this year. Resident 31's Care Plan titled: "Behavioral Symptoms: Track episodes of Insomnia" was provided by the Social Services Director on 11/28/18 at 12:33 P.M. The goal of the Care Plan was that the resident would have less than weekly episodes of Insomnia. Interventions included, but were not limited to, "Intervention #1 Assess pain and comfort", "Intervention #2 Provide calm and quiet environment", and "Intervention #3 Offer fluids and snacks". An Event Report titled "Hot Charting", dated 10/08/18 at 04:14 P.M., indicated there was an order obtained to increase the Trazodone to 50 mg by mouth at bedtime. The resident reported having nightmares and the goal was to eliminate nightmares and aide in sleeping. Resident 31 had an open ended order, with a start date of 07/06/17, to track episodes of insomnia on night shift. The order contained a section for nursing staff to initial that they were tracking episodes of insomnia, but there was no place to document whether the resident actually experienced an episode of insomnia, any attempted interventions for insomnia, or if attempted interventions were effective. In addition, there were no progress notes, observations, or event reports that indicated the resident had experienced increased episodes of insomnia, or that non-pharmalogical interventions had been attempted for an increase in insomnia. During an interview, on 11/28/18 at 12:18 P.M., the Social Services Director indicated that they try to		**changes will be made to ensure that the deficient practice does not recur?** All nursing staff will receive in service training by the Clinical Education Coordinator or designee by December 14, 2018 on psychotropic medication increases and appropriate documentation and non-pharmacological interventions required prior to said increases. The Social Service Director will monitor nursing documentation and any new orders on psychotropic medications to ensure the deficient practice does not recur. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Unnecessary Medications audit tool (attachment labeled “C”) will be used by the Social Service Director weekly for 4 weeks and then monthly for 6 months to ensure compliance. The audit tool will be presented in the monthly Quality Assurance meeting led by the Administrator and if a threshold of 95% or greater is not met an action plan will be developed to ensure compliance.	

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	educate staff that they shouldn't automatically call and get a medication, or an increase in medications if a resident was exhibiting a behavior. They were to try non-pharmalogical interventions first and try to determine contributing factors. The nurse should not have called and got that order. There was no documentation of an increase in sleeplessness or insomnia prior to the Trazodone medication increase. During an interview, on 11/28/18 at 03:54 P.M., the Administrator indicated the Corporate Nursing Consultant indicated there was no policy in place related to increasing a medication without supporting documentation of behaviors or the attempt of non-pharmacological interventions. 3.1-48(a)(6)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide			

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	separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to store medications appropriately related to undated medications. This deficient practice effected 2 of 3 medication carts reviewed. (B Hall short and C Hall long) Findings include: During an observation of the B Hall short medication cart, on 11/28/28 at 09:37 A.M., a three fourths full bottle of liquid Neurontin (a nerve pain medication) medication was opened and undated. During an observation of the C Hall long medication cart, on 11/28/18 at 09:56 A.M., the following medications were opened and undated: a box of Brovana (a breathing medication) containing individual vials of liquid solution a three fourths full bottle of liquid oxybutynin (a bladder medication) a Breo (inhalation powder) inhaler During an interview, on 11/28/18 at 09:37 A.M., Unit Manager 2 indicated medications should have an opened date on them. The current facility policy titled "Medication Storage Guidance" dated November 2018, was provided by the Director of Nursing on 11/28/18 at 11:18 A.M. The policy indicated, "...Breo Ellipta	F 0761	**F 761 Label/Store Drugs and Biologicals** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by the deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents requiring medications indicating that they should be labeled with an open date have the potential to be affected by the deficient practice. All medication carts and refrigerators designated to store medications were audited to ensure anything requiring an open date had one. **What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur?** All nursing staff will receive in service training on medication	12/14/2018

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	Inhalation Powder...Date the inhaler when removed from the foil pouch and discard after 6 weeks after removal from foil tray or when the dose counter reads [0], whichever comes first...Brovana Inhalation Solution...Opened or unopened pouches may be stored at 68 degrees to 77 degrees for no more than 6 weeks or until the expiration date, whichever is sooner..." The current facility policy titled "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" with a revision date of 01/01/13, was provided RN 3 on 11/28/18 at 11:45 A.M. The policy indicated, "...Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened..." An undated document titled "Oxybutynin hydrochloride 5 mg [milligrams]/ 5 ml [milliliters] Oral Solution- Patient Information Leaflet" was provided by the Administrator on 11/28/18 at 04:59 P.M. The document indicated "...5. How to store Oxybutynin...Discard after 30 days of first opening..." 3.1-25(j)		storage and dating by the Clinical Education Coordinator or designee by December 14, 2018. The Clinical Education Coordinator or designee will conduct weekly rounds to ensure medications requiring open dates are labeled appropriately. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Medication Storage Review audit tool (attachment labeled “D”) will be completed weekly for 4 weeks and then monthly for 6 months by the Clinical Education Coordinator or designee to ensure compliance. The findings of the audit tool will be presented in the monthly Quality Assurance meeting led by the Administrator and if a threshold of 95% or greater is not met an action plan will be developed to ensure compliance.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and 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 infections. §483.80(a) Infection prevention and control			

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	program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin			

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	lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation and interview, the facility failed to follow appropriate infection control guidelines related to nebulizer treatments and linen handling. This deficient practice effected 1 of 2 observations for nebulizer treatments and 1 of 3 linen handling observations. (Resident 65) Findings include: 1. During an observation, on 11/26/18 at 09:01 A.M., LPN (Licensed Practical Nurse) 4 sanitized her hands and retrieved Resident 65's medications per the physicians orders and gave them to Resident 65. She washed her hands, donned gloves, listened to Resident 65's lungs, and obtained an oxygen saturation level. She obtained the nebulizer mouthpiece from a plastic bag hanging on the night stand, filled the mouthpiece with the medication solution, and gave it to the	F 0880	**F 880 Infection Prevention and Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to have been affected by the deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the deficient practice. Clinical Education Coordinator or designee will	12/14/2018

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	resident. After the treatment was over she returned the nebulizer mouthpiece to the plastic bag, listened to the resident's lungs, obtained an oxygen saturation level, removed her gloves, and washed her hands. During an interview, on 11/27/18 at 03:30 P.M., LPN 5 indicated when giving a resident a nebulizer treatment she would listen to their lungs, take their oxygen level, set up the nebulizer treatments, and give it to the resident. During the treatment she would listen to their lung sounds and then again after. After the treatment, she would clean the mouthpiece before putting it back into the plastic bag. During an interview, on 11/27/18 at 03:33 P.M., the DON (Director of Nursing) indicated the nursing staff should rinse the canister (mouthpiece) after use. The current facility policy titled "Nebulizer Treatment" with a revision date of 01/2015, was provided by the DON on 11/27/18 at 03:42 P.M. The policy indicated, "...17. When therapy completed, the nebulizer medicine cup should be wiped dry with alcohol pad and placed in a clear plastic bag..." 2. On 11/27/18 at 03:17 P.M., HSK (Housekeeping) 10 was observed carrying 2 clear plastic bags of dirty linens that were wadded up in the bottom of the bags, draped over their shoulder, and up against her shirt. She walked down the hall to the staff hall that leads to the laundry room. During an interview, on 11/28/18 at 03:23 P.M.,CNA (Certified Nurse Aide) 7 indicated when transporting dirty linens staff were to put the linens in clear plastic bags, tie them shut, carry them away from their body, and put them in the		provide all staff with in service training on infection control by December 14, 2018. **What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur?** Clinical Education Coordinator and/or designee(s) will conduct infection control rounds weekly in addition to conducting skills validations for breathing treatments on all nurses by December 14, 2018. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Infection Control audit tool (attachment labeled “E”) will be used weekly by the Clinical Education Coordinator or designee for 4 weeks and then monthly for 6 months to ensure compliance. The findings of the audit tool will be presented in the monthly Quality Assurance meeting led by the Administrator and if a threshold of 95% or greater is not met an action plan will be developed to ensure compliance.	

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	soiled utility room. The current "LAUNDRY/LINEN" policy, with a reviewed date of 02/2012, was provided by the Administrator on 11/28/18 at 04:18 P.M. The policy indicated, "...Soiled linen...Carry away from body to prevent soiling uniform..." 3.1-18(a) 3.1-19(g)(1)			