STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146148	A. BUILDING _____ B. WING _____	02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY POINT CHRISTIAN VILLAGE	565 WEST MARION AVENUE FORSYTH, IL 62535

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS ANNUAL LICENSURE AND CERTIFICATION SURVEY.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide supervision during toileting to prevent a fall for one (R297) of four residents reviewed for falls on the sample list of 39. This failure resulted in R297 sustaining fractures of the left arm and left hip requiring emergency services and surgical repair. This failure also resulted in R297 having a decrease in mobility and pain. Findings include: R297's hospital history and physical dated 1/6/21 documents R297 was brought to the emergency room two days in a row after falling at home. The second fall occurred in the bathroom and his wife noticed seizure like activity. R297 had another seizure during the ride in the ambulance. R297 was also diagnosed with a right hip fracture. R297's Nursing note dated 1/13/21 at 12:36 PM documents R297 was admitted to the facility.	F 689	F689 1. Corrective actions which were done for the resident found to be affected by the deficient practice. V6 (CNA) was re-educated regarding not leaving R297 unsupervised on the toilet and to make sure she had necessary supplies or to call for assistance if she needed supplies rather than leave R297 unsupervised while she obtained supplies. V6 was re-educated on how to use the resident's Kardex to see the resident's fall risk status. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Residents fall risk and care plans were reviewed to identify other residents having	3/11/21

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

Electronically Signed | 03/05/2021

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F 689	Continued From page 1 R297's careplan dated 1/13/21 documents, "I am at risk for falls r/t (related to) decreased mobility, impaired balance, pneumonia, seizure disorder, dementia and personality and behavior disorder. I had several falls at home prior to my admission. I had 2 falls in 24 hrs prior to being admitted into the hospital." R297's Initial Report to Public Health form documents R297 was toileted by V6, Certified Nurse's Assistant. This report documents (R297) asked for privacy. This report documents V6 left and was waiting in the bedroom area waiting for R297 to turn on the call light. R297 turned on R297's call light and V6 entered the room. When entering the room there were no gloves in the room. V6 went to go get gloves and R297 tried to get up by self and fell. R297 sustained a left femur fracture and left humerus fracture. R297's nursing note dated 1/21/21 at 8:50 PM, documents R297 is alert with confusion. R297's nursing note dated 1/22/21 at 12:19 AM documents R297 fell in the bathroom. On 2/4/21 at 1:41 PM, V6 Certified Nurse's Assistant (CNA) stated, "(R297's) light went on and I got (R297) into the bathroom. (R297) asked me for a couple minutes of privacy. I stepped out of the room. (R297) had the call light. Then (R297) pushed it for me to come back in. There were no gloves so I went to go get the gloves. The gloves were in the hall closet. Then I went back into the room. When I went in his room, I heard an "ow" sound and then heard (R297) fall on the floor. So when I went in (R297) was on the floor. I yelled for help and then the	F 689	potential to be affected. 3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not reoccur: Direct care staff have been re-educated regarding the facility fall program, calling for assistance to obtain supplies rather than leaving residents unsupervised on the toilet while obtaining supplies, and how to access the Kardex and/or care plan to see the resident's fall risk status and whether the resident may be left unsupervised on the toilet. Additionally, the direct care staff will be re-educated on how to respond to residents who are left alone on the toilet and are care planned as requiring supervision. All residents determined to be at risk for falls will have their Kardex and Care plan reviewed to confirm that the care plan/Kardex addresses fall risk with appropriate, individualized interventions. The DON/designee and other members of the IDT team (as appropriate) will be re-educated on the fall management program. The DON/Designee will monitor 5 transfers to the toilet per week x4 weeks, then 3 transfers per week x 4 weeks, then 2 transfers per week x4 weeks to determine if staff appropriately stayed with the resident.	

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F 689	Continued From page 2 nurse came down. (R297) was sent to the emergency room. After the fall, the (V2, Director of Nursing) trained me to the look at the care plan before providing cares and to make sure I have gloves and everything I need before going into the room. I didn't know (R297) had a history of falls. If I would have known (R297) had a history of falls I would have stayed with (R297) in the bathroom or left the door cracked to ensure (R297) didn't get up." R297's Hospital History and Physical dated 1/22/21 documents R297 was diagnosed with a left proximal left humerus (arm) and left proximal femur (hip) fracture due to a fall. These records also documents that the left hip fracture required surgery to repair it. R297's Nursing Note dated 1/27/2021 at 2:05 PM documents R297 was readmitted to the facility from the hospital with a diagnosis of left humerus (arm) fracture and left femur (hip) fracture. On 2/2/21 at 11:30 AM, R297 was lying in bed. R297's left arm was in a sling. R297 appeared confused. On 2/5/21 at 10:10 AM, R297 was sitting up in a chair. R297's left arm was in a sling. At that time, R297 stated, " I'm not very well, I hurt all over. My left shoulder and my right shoulder hurt. My left hip and my right hip hurt. I am not getting around very well, it hurts too much to move." R297's care plan with a revision date of 1/27/21 documents that R297 now requires two assist with walker and R297 is non-weight bearing to the left upper extremity. On 2/5/21 at 10: 06 AM, V2 Director of Nursing	F 689	4. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent: The DON will present the results of audits to the QAPI committee monthly x3 months. The QAPI committee will make recommendations as to whether further audits/interviews or other actions are necessary to maintain compliance. 5. Correction actions will be completed by: March 11, 2021	

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F 689	Continued From page 3 stated when R297 first came to the facility R297 required one assist for transfer since his recent fractures he requires two assist. When we investigated the fall on 1/22/21 we talked to V6 CNA about what V6 should do in the future if there are not gloves in the room. V2 stated that V6 should make sure all supplies are available or push the call light to have someone bring the needed supplies so that R297 is not left alone.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §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;	F 758		3/11/21

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F 758	Continued From page 4 §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 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to implement non-pharmacological interventions prior to administering as needed antianxiety and hypnotic medications for one (R298) of five residents reviewed for psychotropic medications on the sample list of 39. Findings include: R298's physician orders include an order dated 1/16/21 for Alprazolam (antianxiety) 0.25 milligrams, give 1 tablet by mouth every 24 hours as needed for Anxiety. Physican orders also include orders dated 1/20/21 for Diphenhydramine Hydrochloride 25 milligrams by mouth every 24 hours as needed for insomina and Melatonin (hypnotic) 5 milligrams by mouth	F 758	F758 1. Corrective actions which were done for the resident found to have been affected by the deficient practice: R298 was reviewed and staff were educated to provide non-pharmalogical interventions to R298 despite her demand for the medication prior. R 298 is no longer a resident in the community. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The facility reviewed prn psychotropic	

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F 758	Continued From page 5 every 24 hours as needed for insomnia. These orders document to administer the Diphenhydramine and the Melatonin together. R298's Medication Administration Record dated January of 2021 includes behavior monitoring for Insomnia, Feeling Down/Tearfulness, and Restlessness. This MAR lists nonpharmacological interventions to be used for these behaviors. R298's Medication Administration Record (MAR) documents R298 recievied Alpazolam on 1/19/21 at 8:04 PM, 1/22/21 at 8:44 PM, and 1/31/21 at 7:18 PM. This MAR documents R298 received Diphenhydramine and Melatonin on 1/21/21 at 7:37 PM. This MAR nor R298's medical record documents that nonpharmacological interventions were attempted prior to administration of these medications. On 2/4/21 at 9:54 AM, V7 Social Service Director stated the facility policy states that we will try the nonpharmacological interventions prior to giving as needed psychotropic medications. The facility's Psychotropic Medication Use - Management Policy dated 2/20/18 documents, "Anti-psychotic Medications are not warranted based on diagnosis alone. Anti-psychotic medications man be indicated if: Multiple non-pharmacological approaches have been attempted but did not relieve the symtoms which are presenting a danger or significant distress."	F 758	medication orders. At the time of the annual survey, there were two prn orders. There are currently no prn psychotropic medication orders. The community has re-educated the nursing team to this practice to educate to providing non pharmalogical interventions prior to giving a prn psychotropic. 3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and not reoccur: The DON/Designee will re-educate nurses on documenting and providing non pharmalogical interventions prior to giving a prn psychotropic. The DON/Designee, will conduct 5 audits a week to confirm that non pharmalogical interventions are being provided prior to medication being given if there is a resident in the community that has an order. This will be done x4 weeks, then 3 audits per week for 4 weeks, then 2 audits a week for 4 weeks. 4. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent: The DON will present the results of the audits to the QAPI monthly x 3 months. The QAPI committee will make a recommendation as to whether further audits/interviews or other actions are necessary to maintain compliance.	

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F 758	Continued From page 6	F 758	5. Correction Actions will be completed by: March 11, 2021	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer medications as ordered and according to manufacturer instructions. There were 25 opportunities with three errors, resulting in a 12 percent error rate. This affects 2 residents (R2 and R21) out of 12 residents observed in the medication pass on the sample list of 39. Findings include: 1. The facility's pharmacy-supplied product information sheet for Azopt ophthalmic drops dated 2/4/21 documents, "If you use other eye medicines, they should be used at least 10 minutes before or after this medicine. On 2/2/21 at 4:03 pm, V9, Licensed Practical Nurse (LPN), administered Azopt 1 percent ophthalmic solution to R2, one drop in each eye for the treatment of Glaucoma with high eye pressure. At 4:04 pm, V9 administered Brimonidine Tartrate 0.2 percent ophthalmic solution to R2, one drop in each eye for the	F 759	F759 1. Corrective actions which were done for the resident found to have been affected by the deficient practice: R2 was assessed and was not affected. R21 was not affected as the nurse did prime the insulin pen prior to administration of the insulin. V9 (LPN) and V4 (LPN) were immediately re-educated. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The facility reviewed medication orders and determined that all residents who have orders for eye drops or insulin (administered by an insulin pen) have potential to be affected by a similar deficient practice.	3/11/21

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F 759	Continued From page 7 treatment of Glaucoma with high eye pressure. V9 failed to wait 10 minutes between different types of eye drops as required by the manufacturer for the previous (Azopt) medication to absorb. 2. The facility's pharmacy-supplied product information sheet for Brimonidine Tartrate dated 2/4/21 documents, "If you are using another eye medicine, you should wait at least 10 minutes in between using each medicine." On 2/2/21 at 4:05 pm, after administering Azopt opthalmic solution and Brimonidine Tartrate opthalmic solution to R2 at 4:03 pm and 4:04 pm, respectively, V9, LPN, administered Refresh Optive (non-medicated, artificial tears) ophthalmic drops to R2, one drop in each eye, failing to wait 10 minutes as required by the manufacturer for the previous medication (Brimonidine Tartrate) to absorb. On 2/4/21 at 1:09 PM, V8, Registered Pharmacist, stated, "Usually the recommendation is to wait 5 minutes between drops. We don't supply the package inserts (manufacturer product information sheet), we just send the bottle itself to the facility. If there are any patient-specific instructions, we would include those on the label of the bottle." On 2/5/21 at 10:56 am, V2, Director of Nursing, stated, "The nurses should probably follow the manufacturer's instructions but I can see what the doctor says." On 2/5/21 at 3:00 pm, V2 stated, I have not heard anything back from the doctor." 3. The manufacturer's product information sheet for Humalog KwikPen (fast acting insulin)	F 759	3. The measures the facility will take or systems the facility alter to ensure that the problem will be corrected and will not reoccur. The DON/Designee will re-educate nurses on correct use of insulin pens including the need to prime the pen according to manufacturer's recommendations. The DON/Designee will re-educate nurses on administering eye drops with the appropriate amount of time allowed between drops per the manufacturer's recommendations. The DON/Designee, Pharmacy Nurse Consultant and Regional Nurse will conduct 5 audits a week to confirm that eye drops are given with the appropriate amount of time in between drops according to the manufacturer's recommendations x4 weeks, then 3 audits per week for 4 weeks then 2 audits a week for 4 weeks. The pharmacy Nurse Consultant will conduct random general medication passes to determine medications are administered as ordered on each scheduled visit. 4. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent: The DON will present the results of the	

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F 759	Continued From page 8 documents, "Prime your pen before each injection." "Priming your pen removes air from the needle and cartridge, and ensures the pen is working correctly." "If you do not prime you pen you may get too much or too little insulin." "Turn the dose knob to 2 units, hold the pen with the needle pointing upwards, gently tap the cartridge, push the dose knob until it stops and the counter reads zero." On 2/4/21 at 12:02 pm, V4, LPN, prepared an insulin injection for R21 by placing a new needle on the tip of R21's Humalog KwikPen, and turning the dose knob to 5. V4 stated (V4) was ready to administer the insulin shot to R21 and began to move towards R21. At this point, the procedure was halted by (surveyor) and questioned V4 if it was required to prime the pen before administering the injection. V4 hesitated, then replied that, "Yes, I should prime the pen before the shot." Only then did V4 prime the insulin pen as required by the manufacturer to ensure an accurate dose.	F 759	audits to the QAPI committee monthly x3 months. The QAPI committee will make recommendations as to whether further audits/interviews or other actions are necessary to maintain compliance. 5. Corrections actions will completed by: March 11, 2021	
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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	F 761		3/11/21

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F 761	Continued From page 9 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 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to properly store controlled substances behind 2 separate locks. This failure has the potential to affect all 52 residents residing in the facility. Findings include: On 2/2/21 at 12:01 pm, accompanied by V4, Licensed Practical Nurse (LPN), there was an unlocked refrigerator in the medication room on the facility's 100 B Hall. This unlocked refrigerator contained four 1 milliliter (ml) vials of Lorazepam (schedule IV (4) medication) 2 milligram (mg) per ml. The 4 vials were in a plastic bag with a label documenting "house stock." The single lock securing these vials was on the medication room door. On 2//2/21 at 12:01 pm, V4, LPN, stated, "Yes we do consider Lorazepam to be a controlled substance. I don't know if I have a key for the refrigerator." V4 did eventually locate a key for the refrigerator inside the locked narcotic cabinet on	F 761	F761 1. Correction actions which were done for the resident found to have been affected by the deficient practice: The refrigerator was immediately locked. The nurse (V4) was immediately re-educated regarding storage of controlled medications and the need for the refrigerator to be locked. No residents were affected by this deficient practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility reviewed the number of Controlled Drugs requiring storage in a locked refrigerator and determined all residents could be potentially affected by a similar deficient practice. 3. The measures the facility will take or	

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F 761	Continued From page 10 the wall of the medication room. On 2/2/21 at 3:00 pm, V1, Administrator, stated, "I should write up (discipline) every one of my nurses because they know that fridge has to be locked, I have given them inservice (training) after inservice." The facility policy Controlled Substance Medication Receipt, Storage, Handling and Record Control dated 7/31/13 documents, "Store medications listed in Schedules II, III, IV, and V under double lock." On 2/5/21 at 10:10 am, V10, Licensed Practical Nurse, stated, "When a medication has a label for house stock, it can be used for any resident in the facility who gets a physician's order for it." The facility's Resident Census and Conditions of Residents dated 2/4/21 documents 52 residents reside in the facility.	F 761	systems the facility will alter to ensure that the problem will be corrected and will not reoccur: The DON/Designee will re-educate nursing staff on regulation/policy requiring controlled medications to be double locked, including those that must be refrigerated. Additionally, the DON/Designee will educate nurses as to the location of the key to refrigerator. The maintenance director will check locks on all refrigerators to ensure that they are properly working, keys are available. The DON/Designee will audit refrigerators in medication storage rooms to confirm that they are locked if they contain any controlled drugs. Audits will be done daily for 4 weeks, then 3x a week for 4 weeks, and then 2x for 2 weeks. 4. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent: The DON will present the results of the audits to the QAPI committee monthly x3 months. The QAPI committee will make recommendations as to whether further audits/interviews or other actions are necessary to maintain compliance. 5. Correction actions will be completed by: March 11, 2021	

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	146148	A. BUILDING _____ B. WING _____	02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY POINT CHRISTIAN VILLAGE	565 WEST MARION AVENUE FORSYTH, IL 62535

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F 880	Continued From page 11	F 880		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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 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;	F 880		3/11/21

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F 880	Continued From page 12 (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 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to observe their infection prevention policies for isolation of infectious disease by not donning gloves and gown prior to entering a room where a resident (R11) diagnosed with Clostridium difficile resided. This failure has the potential to affect 14 residents (R3, R21, R23, R25, R31, R35, R36, R38, R41, R148, R149, R150, R151, and R152) residing on the	F 880	F880 1. Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: The nurse was immediately educated to follow appropriate transmission-based	

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F 880	Continued From page 13 same unit as R11 on the sample list of 39. Findings include: On 2/3/21 at 10:52 am, V3, Licensed Practical Nurse, entered the room of R11. V3 did not don gloves nor an isolation gown. R11's room had a sign on the door jamb documenting to "see the nurse before entering" the room, and a second sign on the door documenting R11 was isolated with "contact precautions." V3 continued into the room of R11 and into the bathroom to wash hands. Upon exit from the bathroom, V3 prepared to obtain a blood glucose level from R11. As V3 moved towards R11, the procedure was halted by (surveyor) and questioned V3 if R11 was isolated with precautions of some kind given the signs on the door. V3 then backed out of the room, looked at the signs on the door and door jamb, then looked into the computer chart for R11 and stated, "Oh, yes, (R11) is receiving an antibiotic for C-diff (Clostridium difficile)." V3 then asked a co-worker to obtain some gowns because there were no gowns in the drawer set in R11's room. The sign on R11's door for contact isolation documented, "Clean hands before entering room and when leaving room, place gloves on before entering room and discard before exit, put on gown before entering room and discard before exit, do not use gown for more than one resident." On 2/3/21 at 11:05 am, R11 stated, "I had loose stools last night." R11's Skilled Daily Nurses Notes dated from 1/10/21 through 2/5/21 document R11 has a medical diagnosis of Recurrent C-diff (Clostridium	F 880	precautions for R11 including performing hand hygiene before entering the room, and donning gown and gloves. R11 no longer requires contact precautions for C-diff infection. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The Director of Nursing and Infection Preventionist reviewed infection data and determined residents who require transmission-based precautions and the other resident residing on the same hall(s) have potential to be affected by a similar deficient practice. 3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not reoccur: The Infection Preventionist/designee will complete training for staff who enter residents' room on Standard Precautions, Transmission-Based Precautions, using appropriate PPE correctly including performing hand hygiene prior to donning PPE. The Infection Prevention nurse will complete training for staff as the directed in service states: Clean Hands, Use of PPE correctly, How to DONN PPE Correctly, and How To Doff PPE correctly are the videos that will be	

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F 880	Continued From page 14 difficile). The facility's policy Infection Prevention and Control Manual Guidelines for CDI, Clostridioides (Clostridium) difficile (C-diff) Associated Disease, dated 6/18/20, documents, "C-diff is considered by the CDC (Centers for Disease Control and Prevention) as an urgent threat in the United States. C-diff is a bacteria that will cause inflammation of the colon and cause life-threatening diarrhea. C-diff is spread through the feces and mainly transferred to patients by the hands of healthcare personnel who have touched a contaminated surface or item." This policy further documents, "Contact precautions should be used for patients with diarrhea and can be discontinued when diarrhea ceases for 48 hours. Gloves should be used when entering the room. Gowns should be worn when entering the room and with physical contact with the resident or the resident's environment is anticipated." This policy also documents, "The facility should have a system in place for alerting healthcare workers and visitors that a resident is on isolation precautions without compromising that resident's privacy. Limit time outside of the room for a resident with symptoms." On 2/3/21 at 10:30 am, R11 attended the resident group interview. Also in attendance were R3, R31, and R38. On 2/5/21 at 1:03 pm, V2, Director of Nursing, stated, "The nurse (V3) on this unit (100 A section) takes care of all the residents from around the corner (rooms 201, 202, and 203) up to this door (double door dividing 100 A section from 100 B section)."	F 880	completed. A root cause analysis was conducted with the QAPI team and will be utilized and incorporated into the intervention plan. A Quality Assurance Audit Tool to monitor has been developed for compliance. The Infection Preventionist/designee will complete 5 audits weekly x4 weeks, then 3 audits weekly x4 weeks then 2 audits weekly x4 weeks to confirm the associates perform hand hygiene and donn appropriately before entering a room where a resident is on transmission-based precautions. 4. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent: The DON/Infection Preventionist/designee will present a summary of the results weekly to the QAPI committee weekly during the pandemic. The methods for improvement and overall performance will be discussed by the team to achieve improved results. Monthly, specific audits will be reviewed as well to ensure appropriate recommendations are made as necessary. 5. Correction actions will be completed by: March 11, 2021	

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F 880	Continued From page 15 The facility's Resident List Report dated 2/3/21 documents R3, R21, R23, R25, R31, R35, R36, R38, R41, R148, R149, R150, R151, and R152 reside on the rooms described by V2, where V3, LPN, was working.	F 880		