Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 18, 2021

Mr. Shawn Hallisey, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

Dear Mr. Hallisey:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 22, 2021**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475014 | A. BUILDING _____ B. WING _____ | C 09/22/2021 |

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| BURLINGTON HEALTH & REHAB | 300 PEARL STREET BURLINGTON, VT 05401 |

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| E 000 | Initial Comments<br><br>An unannounced onsite annual emergency preparedness review was conducted, in conjunction with the annual recertification survey, by the Division of Licensing & Protection on 9/22/2021. There were no regulatory deficiencies identified as a result of the review. | E 000 | The filling of this plan of correction does not constitute an admission of the allegations set forth in the statements of deficiencies.<br>Queen City Rehab has prepared and executed a plan of correction as evidence of the facilities continued compliance with applicable federal and state laws. | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced onsite annual recertification survey and investigation of 5 complaints was conducted by the Division of Licensing & Protection on 9/20-9/22/2021. Citations at the Immediate Jeopardy level were identified, and the facility was notified on 9/22/21 of the Immediate Jeopardy. On 9/22/21, the facility submitted an immediate corrective action plan which was to be completed on 9/23/21. On 9/29/21, an onsite evaluation of the corrective actions was completed and found the facility had removed the imediate risk to residents as stated, on 9/23/21. The following regulatory deficiencies were identified as a result of the survey. | F 000 | The facility is requesting an IIDR for F-578 and F-658 | |
| F 578 SS=J | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the | F 578 | Resident #37 has been readmitted to the facility and is at baseline. The Nurse Practitioner was re-educated on following physician ordered resident advanced directives. Residents who are DNRs in the facility are at risk for this alleged deficient practice. Residents Advanced Directives will be followed per their physician's orders | 9/22/21 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shawn T. Tallesey — TITLE: Administrator — (X6) DATE: 10/19/2021

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.

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| F 578 | Continued From page 1<br>requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.<br>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based upon observation, interview, and record review, the facility failed to ensure the resident's right to request, refuse, and/or discontinue treatment was implemented, as indicated in a "Do Not Resuscitate" [DNR] order, for 1 resident [Res. #37] of 31 residents with DNR orders. This citation is at the immediate jeopardy level due to significant risk of serious harm as a result of the noncompliance to this resident and the 30 other residents with DNR orders. Findings include: | F 578 | A house wide audit of all residents advanced directives was conducted to ensure they have current physician orders.<br>All facility staff and contracted MD's and NP's were re-educated on ensuring resident's advanced directives are followed as per their physician orders. DNS/designee will randomly audit code blue events to ensure that the resident's physician ordered advanced directives were followed.<br>These audits will be conducted 3xweek x 1 week, weekly x4 weeks, then monthly x 2 months.<br>Results of the audits will be presented to the QAPI committee for further review and recommendations. Administrator will be responsible for this POC.<br><br>**TAG F 578 POC Accepted on 10/16/21 by L. Lovell/P. Cota** | 9/23/21<br><br>9/23/21 |

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| F 578 | Continued From page 2<br><br>A review of Res. #37's medical record reveals the resident has complex medical issues and diagnoses that include: Major Depressive Disorder and Anxiety Disorder. An interview was conducted with Res. #37 on 9/22/21 at 4:19 PM. The resident reported that on 8/18/21 his/her heart stopped and s/he had stopped breathing. S/he stated that s/he wanted nothing done to him/her, that s/he had obtained a DNR [Do Not Resuscitate] order in March 2021 that was signed by him/her, the doctor, and was notarized. The resident stated the DNR status is reviewed with him/her weekly. S/he stated that s/he was "mad" when s/he realized s/he "had been brought back". S/he stated when his/her "heart stops, I am done". The resident further stated that even if his/her heart stopped or breathing stopped due to a drug overdose, s/he did not want to be given life-saving measures, including chest compressions. During the interview, the resident pointed to a bracelet on his/her right wrist. The clear plastic bracelet contained a strip of pink/orange paper, upon which was printed in black capital letters "Do Not Resuscitate".<br><br>A review of Res. #37's Minimum Data Sheet, dated 6 days after Res. #37 signed his/her DNR directive on 3/19/21, contains a Brief Interview for Mental Status [BIMS], which is used to assess a resident for cognitive impairment. The BIMS assessed Res. #37 as cognitively intact, rating the resident with a score of '15', the highest score possible.<br><br>Per record review, Res. #37's medical records included both a paper chart in a binder, located at the Nurses' Station on Res. #37's unit, and an electronic medical record, also accessible at the | F 578 | | |

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| F 578 | Continued From page 3 | F 578 | | |

Nurses' Station. Per observation, Res. #37's printed DNR order dated 3/19/21 was located immediately inside the binder cover in a clear plastic sleeve. The orders read "(If patient/resident has no pulse and/or no respirations)"-an 'X' is marked next to "DNR/Do Not Attempt Resuscitation (Allow Natural Death)". Further record review revealed a printed copy of Res. #37's face sheet located in the binder, with the entry "DNR" located under Advance Directives. Review of Res. #37's electronic medical record also contained a scanned photographic copy of the resident's DNR order and the face sheet listing the resident as DNR. A list was requested and provided by the facility of all residents with DNR status, and among the 31 residents listed was Res. #37.

Review of the facility's policy and procedure titled 'Cardiac and/or Respiratory Arrest', Section 2.2 reads "If there is a DNR order: Do not initiate CPR/AED".

Review of Res. #37's medical record dated 8/18/21 reveals an entry by the Nurse Practioner [NP] who was on Res. #37's unit. The entry reads:
"Sitting writing notes when an LNA [Licensed Nursing Assistant] notified me at approx. 4:25 that the resident was difficult to arouse and breathing funny. Found unconscious and breathing in an irregular Cheyne-stokes pattern*. Call placed to 911. Deep sternal rubbing, loud verbal stimulus without response, repositioned, back board place no change. Apneic periods [moments without any breath], loss of pulse. AED applied [Automated External Defibrillator- a portable medical device that analyzes the heart rhythm of a person in sudden cardiac arrest] analyzed directed chest

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| F 578 | Continued From page 4 | F 578 | | |

compressions [part of CPR: Cardiopulmonary Resuscitation]. Narcan IM administered approx. 4:40. Compressions for approx. 5 mins between 4:40-4:45 when analyzer stated clear. Police arrived and then EMT arrived around 4:50. [Res. #37] then started to arouse."
*['In addition to heart failure and stroke ...Cheyne-Stokes respirations are also a clinical sign seen in people who are in the process of dying' https://www.sleepfoundation.org/sleep-apnea/cheyne-stokes-respirations]

Nurses Notes dated the next day, 8/19/21 record "[Res. #37] returned from ER last night at 10:45 PM via ambulance stretcher ... [Res. # 37] is very upset that [s/he] received CPR. States [his/her] chest and back hurt, and [s/he] did not want to go through this again, and that is why [s/he] has a DNR order."

Physician Progress notes from the facility's Medical Director, who oversees the Nurse Practioner, dated 8/19/21 also record 'respiratory arrest, witnessed arrest 8/18. CPR initiated...UDS [Urine Drug Screen] negative. Labs negative. Returned to facility. Met with patient. Denies drug ingestion...Patient alert, oriented, complains of chest pain from CPR. 'I'M A DNR'...significant pain from CPR..."

An interview was conducted with the facility's Staff Educator on 9/22/21 at 8:09 AM. The Staff Educator stated that after the incident, all staff were sent an email stating where to find DNR information on a resident's chart and to check a resident's chart prior to initiating CPR. The Staff Educator provided a list of all the staff who received the email, and the NP who initiated the

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| F 578 | Continued From page 5<br>CPR on Res. #37 was not included on the list. The Staff Educator stated the facility's Administrator [ADM] and Director of Nursing Services [DNS] at the time of the incident both spoke with the NP after the incident.<br><br>An interview was conducted with the facility's ADM on 9/22/21 at 9:06 AM. The ADM stated he was out of state at a company function on 8/18/21 and upon his return he spoke with the NP about the incident. He also stated that he did not provide education related to DNR status and that he was unaware if the DNS at the time had done so.<br><br>An interview was conducted with the DNS at the time of incident on 9/22/21 at 9:20 AM. The DNS stated that the NP was "not specifically educated" by the DNS, and the DNS did not realize the Medical Director overseeing the NP and NP were not part of email group who received the DNR education.<br><br>An interview was conducted with the NP on 9/22/21 at 8:48 AM. The NP stated she received education regarding where DNR information is located on a resident's chart and to check for DNR information. The NP stated that she received the education from the Staff Educator. [As noted above, the Staff Educator stated that she educated staff via an email, which the NP was not included on. The Staff Educator also stated the NP was spoken to by the ADM and the DNS at the time, who both stated they did not educate the NP on DNR status.]<br><br>An interview was conducted with the facility's Medical Director who oversees the NP on 9/22/21 at 9:38 AM. The Medical Director stated that he | F 578 | | |

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| F 578 | Continued From page 6<br>did not give any education to the NP regarding DNR status and procedures at the facility.<br><br>Per interview with the ADM, the current DNS, the Medical Director, and the Staff Educator, and per record review, there was no documentation that the NP received any education regarding DNR status, procedures, and resident rights after the incident with Res. #37 on 8/18/21. | F 578 | | |
| F 657 SS=E | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review | F 657 | Resident's 36,48,38,2 remain in the center. These 4 residents have had their care plan meetings conducted.<br><br>All residents that require care plans have the potential to be effected by the alleged deficient practice.<br><br>A house wide audit was conducted to ensure all residents had care plans conducted that included the interdisciplinary team and resident/ resident representative.<br><br>The Director of Social Services was re-educated on documentation of participation of all required members of the Interdisciplinary Team including the resident and resident representatives in care plan meetings.<br><br>The Administrator/designee will conduct random audits of care plan scheduling and completion to assure compliance. These audits will be conducted weekly x4, then monthly x 2.<br><br>Results of these audits will be brought to the QAPI committee for review and recommendations as needed. | 10/22/21 |

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| F 657 | Continued From page 7<br>assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews and medical record reviews, the facility failed to provide evidence of the participation of all required members of the Interdisciplinary Team (IDT) including the resident and resident representative(s) in care plan meetings, or that meetings had been taking place at all, for 4 of 21 sampled residents. Resident #2, 36, 38 and 48. Findings include:<br><br>1. Per interview on 9/20/21, resident #36 who is alert and oriented, stated "I've been here since December and I have not attended a care plan meeting, no one has ever told me about it." Per record review there was no documentation in the medical record indicating that a care plan meeting had taken place, although there was a care plan in place for the resident.<br><br>During an interview on 9/22/21 at 9:12 AM with the Social Service Director, who reports she has only been in this position for 3 weeks, could not locate any documentation of care plan meetings taking place. This was later confirmed by the Regional Director of Clinical Services on 9/22/21 at 12:10 PM that in fact, there was nothing in the resident record to indicate care plan meetings had been taking place since the resident was admitted in December of 2020.<br><br>2. Per interview on 09/20/21, Resident #2 states "I do participate in care plan meetings, but it's been a while since I've been to one." Record review indicates that the resident had three admissions to this facility, the first on 09/20/20, the second on 01/12/21 and the most current | F 657 | **TAG F 657 POC Accepted on 10/16/21 by L. Lovell/P. Cota** | |

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| F 657 | Continued From page 8<br>admission on 06/26/21. The only documentation of a care plan meeting is an interdisciplinary note dated 01/13/21 at 10:30 AM, which was a 72-hr. meeting that took place within a few days of the second admission.<br><br>3. Per interview on 09/21/21 at 09:55 AM, Resident #38 states "I have not been to a care plan meeting for a year and a half." Record review indicates that this resident has been at this facility off and on since 07/27/2010 and the most current admission was 05/18/2021. The is no documentation of any care plan meeting.<br><br>4. Review of Resident #48's record reflects a care plan nurse note dated 8/19/2021 at 05:33 which states "Resident's care plan has been reviewed by this Registered Nurse(RN) and is current. Resident is on track to meet goals of care at this time. Wounds improving but not healed. Seen weekly by wound Nurse Practitioner (NP). Nursing to follow plan of care through next review or until change in condition." This note reflects one of the many focus care areas, however there is no indication that any interdisciplinary care plan meetings took place.<br><br>Interview on 09/21/21 at 03:15 PM with the Director of Nursing and Regional Director of Clinical Services as well as an interview 09/21/21 03:10 PM with the Social Service Director confirmed that there was no documentation related to providing the resident and resident representative, with advance notice of care planning conferences to enable resident/resident representative participation, and no documentation that these interdisciplinary team meetings took place for all residents listed above. | F 657 | | |

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| F 658<br>F 658<br>SS=J | Continued From page 9<br>Services Provided Meet Professional Standards<br>CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based upon observation, interview, and record review, the facility failed to ensure the services provided or arranged by the facility, as outlined by the comprehensive care plan, meet professional standards of quality regarding a "Do Not Resuscitate" [DNR] order, for 1 resident [Res. #37] of 31 residents with DNR orders. This citation is at the immediate jeopardy level due to significant risk of serious harm to this resident and the 30 other residents with DNR orders, as a result of the noncompliance. Findings include:<br><br>Per review of the Vermont Department of Health Do Not Resuscitate/ Clinician Orders for Life Sustaining Treatment [DNR/COLST] form - Instructions for Clinicians Completing Vermont DNR/COLST:<br>"Health care professionals, health care facilities, and residential care facilities must honor a DNR order or a DNR identification unless the professional or facility believes in good faith, after consultation with the patient, agent, or guardian, where possible and appropriate:<br>- That the patient wishes to have the DNR Order revoked, or<br>- That the patient with the DNR indemnification or order is not the individual for whom the DNR order was issued. Documentation of basis for belief in medical record is required. " | F 658<br>F 658 | Resident #37 has been readmitted to the facility and is at baseline. The Nurse Practitioner was re-educated on following physician ordered resident advanced directives. Residents who are DNRs in the facility are at risk for this alleged deficient practice. Residents Advanced Directives will be followed per their physician's orders<br><br>A house wide audit of all residents advanced directives was conducted to ensure they<br>have current physician orders.<br>All facility staff and contracted MD's and NP's were re-educated on ensuring resident's advanced directives are followed as per their physician orders.<br>DNS/designee will randomly audit code blue events to ensure that the resident's physician ordered advanced directives were followed.<br>These audits will be conducted 3xweek x 1 week, weekly x4 weeks, then monthly x 2 months.<br>Results of the audits will be presented to the QAPI committee for further review and recommendations. Administrator will be responsible for this POC.<br><br>**TAG F 658 POC Accepted on 10/16/21 by L. Lovell/P. Cota** | 9/23/21 |

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| F 658 | Continued From page 10<br><br>Review of Res. #37's Care Plan reveals the resident identified as "The resident has an advanced directive of DNR", with the goal listed as "The resident's advanced directives will be honored".<br><br>Review of the facility's policy and procedure titled 'Cardiac and/or Respiratory Arrest', Section 2.2 reads "If there is a DNR order: Do not initiate CPR/AED".<br>Per record review, Res. #37's medical records included both a paper chart in a binder, located at the Nurses' Station on Res. #37's unit, and an electronic medical record, also accessible at the Nurses' Station. Per observation, Res. #37's printed DNR order dated 3/19/21 was located immediately inside the binder cover in a clear plastic sleeve. The orders read "(If patient/resident has no pulse and/or no respirations)"-an 'X' is marked next to "DNR/Do Not Attempt Resuscitation (Allow Natural Death)". Further record review revealed a printed copy of Res. #37's face sheet located in the binder, with the entry "DNR" located under Advance Directives. Review of Res. #37's electronic medical record also contained a scanned photographic copy of the resident's DNR order and the face sheet listing the resident as DNR. A list was requested and provided by the facility of all residents with DNR status, and among the 31 residents listed was Res. #37.<br><br>Review of Res. #37's medical record dated 8/18/21 reveals an entry by the Nurse Practioner [NP] who was on Res. #37's unit. The entry reads:<br>"Sitting writing notes when an LNA [Licensed Nursing Assistant] notified me at approx. 4:25 that | F 658 | | |

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| F 658 | Continued From page 11<br>the resident was difficult to arouse and breathing funny. Found unconscious and breathing in an irregular Cheyne-stokes pattern*. Call placed to 911. Deep sternal rubbing, loud verbal stimulus without response, repositioned, back board place no change. Apneic periods [moments without any breath], loss of pulse. AED applied [Automated External Defibrillator- a portable medical device that analyzes the heart rhythm of a person in sudden cardiac arrest] analyzed directed chest compressions [part of CPR: Cardiopulmonary Resuscitation]. Narcan IM administer approx. 4:40. Compressions for approx. 5 mins between 4:40-4:45 when analyzer started clear. Police arrived and then EMT arrived around 4:50. [Res. #37] then started to arouse."<br>*['In addition to heart failure and stroke ...Cheyne-Stokes respirations are also a clinical sign seen in people who are in the process of dying'*<br>https://www.sleepfoundation.org/sleep-apnea/cheyne-stokes-respirations]<br><br>Nurses Notes dated the next day, 8/19/21 record "[Res. #37] returned from ER last night at 10:45 PM via ambulance stretcher ... [Res. # 37] is very upset that s/he received CPR. States his/her chest and back hurt, and s/he did not want to go through this again, and that is why s/he has a DNR order."<br><br>Physician Progress notes from the facility's Medical Director, who oversees the Nurse Practioner, dated 8/19/21 also record "respiratory arrest, witnessed arrest 8/18. CPR initiated...UDS [Urine Drug Screen] negative. Labs negative. Returned to facility. Met with patient. Denies drug ingestion...Patient alert, oriented, complains of chest pain from CPR.'I'M A DNR'...significant pain | F 658 | | |

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| F 658 | Continued From page 12<br>from CPR..."<br><br>An interview was conducted with Res. #37 on 9/22/21 at 4:19 PM. The resident reported that on 8/18/21 his/her heart stopped and s/he had stopped breathing. S/he stated that s/he wanted nothing done to him/her, that s/he had obtained a DNR order in March 2021 that was signed by him/her, the doctor, and was notarized. The resident stated the DNR status is reviewed with him/her weekly. S/he stated that s/he was "mad" when s/he realized s/he "had been brought back". S/he stated when his/her "heart stops, I am done". The resident further stated that even if his/her heart stopped or breathing stopped due to a drug overdose, s/he did not want to be given life-saving measures, including chest compressions. During the interview, the resident pointed to a bracelet on his/her right wrist. The clear plastic bracelet contained a strip of pink/orange paper, upon which was printed in black capital letters "Do Not Resuscitate". | F 658 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: | F 880 | All residents have the potential to be effected by this alleged deficient practice. All Licensed nurses have had hand hygiene competencies completed.<br><br>All staff have been re-educated on hand washing after donning and doffing gloves to help prevent the development and transmission of communicable diseases and infection.<br><br>The CNE/designee will conduct random audits of hand hygiene to assure compliance. These audits will be conducted weekly x4, then monthly x 2.<br><br>Results of these audits will be brought to the QAPI committee for review and recommendations as needed. | 10/22/21 |

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| F 880 | Continued From page 13<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. | F 880 | **TAG F 880 POC Accepted on 10/16/21 by L. Lovell/P. Cota** | |

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| F 880 | Continued From page 14<br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, it was determined that the facility failed to ensure that staff consistently implemented handwashing after donning and doffing gloves to help prevent the development and transmission of communicable diseases and infections for 1 of 3 units in the survey sample. Findings include:<br><br>On 9/20/21 at 8:45 AM, on the 5th floor, the RN donned clean gloves at the medication cart then accessed the computer on the top of the medication cart to review resident #23's medication administration record (MAR). The RN opened the medication drawer on the medication cart, gathered medications and poured medications into a plastic medication cup. Without changing his/her gloves, picked up the plastic medication cup and an already poured glass of water with her/his left gloved hand, locked the medication cart with her/his right gloved hand, and placed a ring of keys in his/her back scrubs pants pocket. The RN proceeded to Resident #23's room, entered the room, greeted the resident and handed the resident the plastic medication cup with medications and the glass of | F 880 | | |

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| F 880 | Continued From page 15 | F 880 | | |

water. The resident took the medications, drank the water and handed the empty medication cup and water cup back to the nurse. The RN placed the empty used medication cup inside the empty used plastic drinking cup and pulled his/her left hand glove off over the cups. The RN then placed the left handed glove with the empty used cups into his/her gloved right hand and pulled the right handed glove off over the left handed glove that contained the empty used medication cup and empty used plastic drinking cup. The RN left Resident #23's room with the removed gloves and empty plastic cups enclosed in his/her left hand and proceeded to the medication cart without perform hand hygiene. The RN threw the used gloves, medication cup and drinking cup into the trash on the side of medication cart. At the medication cart, with his/her right hand, used the computer mouse to access the MAR on the computer to get Resident #23, two other medications that the resident asked for. The RN applied clean gloves without performing hand hygiene, opened the medication cart and removed a bottle of medication and a blister pack of medication, poured the medication into a clean medication cup, poured a glass of water, picked up the medication cut and glass of water with her/his left hand and locked the medication cart with her/his right hand. The RN brought the medication cup and a glass of water to the resident. After the resident took the medications and drank the water, the RN took the used medication cup and the used drinking cup and again took his/her gloves off, encompassing the cups, exited the residents room and returned to the medication cart without performing hand hygiene. While at the medication cart the RN threw the used gloves and cups into the trash on the side of the medication cart and once again

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| F 880 | Continued From page 16<br>accessed the computer without performing hand hygiene. The RN applied new gloves and prepared medications and poured a glass of water for Resident #67, entered the residents room, administered the medication, collected the used medication cup and drinking cup. The RN disposed of the used gloves and cups in the residents bathroom trash and at that time used soap and water and washed her/his hands before exiting the residents room.<br><br>Interview on 9/20/21 at 9:08 AM, with the RN regarding her/his failure to perform hand hygiene every time she/he donned or doffed gloves revealed confirmation by the RN that she/he failed to adhere to safe hand hygiene practices.<br><br>Interview on 9/22/21 at 3:45 PM with the Infection Control Practitioner revealed that the RN failed to follow facility policy and procedure for appropriate hand hygiene practices by performing hand hygiene when donning and doffing gloves and between tasks. | F 880 | | |

# Clinical (QAPI) Quality Assurance Performance Improvement Plan

**Facility Name:** QCNR **Date QAPI *Initiated*: 10/11/21** **Date QAPI *Completed*: 10/14/21**

**Define (reason for QAPI plan): State survey tag**

***Or* choose one of the following:** QAPI Facility Identified Focus ☐Regional Monthly Report QM Trigger Request ☐System Focus X2567/POC Related

**Goal (what is to be accomplished): Prevent infection and disease from transmitting**

| **Meeting Date: AREAS OF IMPACT/FOCUS** | **ROOT CAUSE and/or BARRIERS TO COMPLIANCE and/or IMPLEMENTATION** | **ACTION ITEMS** | **GOAL DATE & RESPONSIBLE PERSONS** | **Dated PROGRESS/REVISION updates** |
|---|---|---|---|---|
| 10/13/21 | Nurse wearing gloves at med cart during survey. Nurse failed to perform hand hygiene. He went into Three | Nurse was re-educated on hand hygeine. | 10/14/21 CNE/ Designee | **Completed** |
| | residents rooms and failed to perform hand hygiene between rooms. Nurse failed to perform hand hygiene | All house re-education will be completed for hand hygiene. | 10/14/21 | **Completed** |
| | when doffing gloves. | RN/LPN will have hand hygiene competencies completed. | 10/14/21 | **Completed** |
| | | All department heads to do random hand hygiene Audits | On going | **Bring to QAPI monthly** |

**CMS Manual System: F865.§483.75(h)** Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. [§483.75(h) was implemented November 28, 2016 (Phase 1)] The above document was created by or at the request of the QAPI Committee and falls within the Disclosure of information.

Rev. 9/18

Shawna Parker RN, CNE