

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Accel at Longmont		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160</p> <p>Based on record review and interviews, the facility failed to prevent misappropriation of property for one (#12) of two residents reviewed for missing property out of 24 sample residents.</p> <p>Specifically, the facility failed to protect Resident #12's electric tricycle from being stolen from behind a locked gate at the facility.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Resident Rights policy and procedure, dated August 2022, was provided by the regional nurse consultant (RNC) on 8/29/24 at 4:30 p.m. It read in pertinent part, The staff will abide by and protect resident rights in accordance with state and federal guidelines. In the event a resident rights issue is observed or alleged, staff will report the issue to the administrator. The administrator will pursue appropriate action which may include grievance investigation, customer service recovery, discussion with the resident.</p> <p>II. Resident #12</p> <p>A. Resident status</p> <p>Resident #12, age greater than 65, was admitted on [DATE] and discharged to another long term care facility on 8/12/24. According to the August 2024 computerized physician orders (CPO), diagnoses included chronic respiratory failure and dependence on supplemental oxygen.</p> <p>The 8/12/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15.</p> <p>B. Record review</p> <p>-Review of Resident #12's inventory sheet dated 11/3/23 revealed the inventory sheet did not include an electric tricycle.</p> <p>-Review of an updated resident inventory sheet dated 7/22/24 revealed the inventory sheet failed to include an electric tricycle.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A resident grievance report dated 7/29/24 was provided by the social services director (SSD) on 8/28/24 at 2:39 p.m. It read in pertinent part, Resident #12 is highly mad because his tricycle is not being replaced by the facility and he feels that the administrator is not helping him get his trike back. The tricycle was stolen from behind a locked gate at the facility. The nursing home administrator (NHA) stated that the facility was not liable, and per corporate, the facility would not replace the tricycle.</p> <p>A social service note dated 8/9/24 revealed Resident #12 had requested an unused electric wheelchair the facility had in storage in lieu of his electric tricycle after the facility failed to replace or reimburse the resident.</p> <p>C. Staff interviews</p> <p>The SSD was interviewed on 8/28/24 at 3:45 p.m. The SSD said the previous NHA agreed to store Resident #12's tricycle. She said since the tricycle was very big, it was stored, not in the main building, but in the nearby building. The SSD said that at some point, the tricycle was stolen and a police report was filed. She said, unfortunately, the tricycle was not located. She said the previous NHA did not reimburse the resident for the tricycle because the corporate managers did not allow the NHA to pay the full cost of the tricycle, which was estimated at \$4,000.00. The SSD said the previous NHA offered Resident #12 a few hundred dollars but the resident never accepted the money.</p> <p>The current NHA was interviewed on 8/29/24 at 5:30 p.m. The NHA said he was not aware of the situation with Resident #12's missing property as it had occurred prior to his time. He said the facility did not have a policy for personal property. The NHA said the admission policy that all residents signed did say that all personal items should be entered into the inventory sheet and updated with any changes.</p> <p>The RNC was interviewed on 8/29/24 at 4:30 p.m. The RNC said the facility had no policy for personal property responsibility. The RNC said a grievance was filed by Resident #12 about his missing tricycle. The RNC said the resident and the former NHA did not come to an agreement about the missing property.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160</p> <p>Based on record review and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one (#84) of five residents reviewed for quality of care out of 24 sample residents.</p> <p>Specifically the facility failed to:</p> <ul style="list-style-type: none"> -Ensure nursing staff did not remove Resident #84's peripherally inserted central catheter (PICC) line (a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart utilized for intravenous (IV) medication administration) prior to the completion of a physician prescribed course of antibiotics; and, -Provide care of Resident #84's PICC line per physician's orders and professional standards. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Peripherally Inserted Central Line Catheter (PICC) policy and procedure, dated August 2021, was provided by the regional nurse consultant (RNC) on 8/29/24 at 4:30 p.m.</p> <p>-The policy did not include information for PICC line care.</p> <p>The Antibiotic Stewardship policy and procedure, dated January 2022, was provided by the RNC on 8/29/24 at 4:30 p.m. It read in pertinent part, It is our policy to promote the appropriate use of antibiotics and reduce the possible adverse events associated with antibiotic use.</p> <p>II. Resident #84</p> <p>A. Resident status</p> <p>Resident #84, age greater than 65, was admitted on [DATE] and discharged home on 5/24/24. According to the April 2024 computerized physician orders (CPO), diagnoses included acute osteomyelitis of the mandible (infection in jaw bone) and inflammatory condition of the jaw.</p> <p>The 6/3/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. The MDS assessment indicated the resident was independent with transfers.</p> <p>B. Record review</p> <p>Resident #84's IV therapy care plan, initiated 4/11/24, revealed the resident required IV therapy. Interventions included initiating IV therapy as ordered and reporting significant changes to the physician.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The April 2024 CPO revealed the following physician's orders for IV antibiotics:</p> <p>Ertapenem 1 gram intravenously one time per day, ordered 4/11/24.</p> <p>PICC line dressing change every Friday on night shift or when it becomes damp, soiled, loose, or if the patient develops problems at insertion site that require further inspection, ordered 4/11/24.</p> <p>The medical director's (MD) admission note, dated 4/12/24, read in pertinent part, Infectious disease recommends IV ertapenem for right mandible osteomyelitis through 5/17/24.</p> <p>A nurse progress note, dated 4/19/24 and written by licensed practical nurse (LPN) #8, read in pertinent part IV antibiotics completed this morning. PICC line to be discontinued.</p> <p>Review of the April 2024 medication administration record (MAR) revealed Resident #84 missed three doses of the antibiotic (on 4/20/24, 4/21/24 and 4/22/24) because the resident's PICC line had been removed.</p> <p>A medication error report dated 4/23/24, revealed that Resident #84's PICC line had been removed on 4/19/24 without a physician's order and prior to the prescribed stop date for the antibiotic (stop date was 5/17/24).</p> <p>-Furthermore, a physician was not notified of the error until 4/22/24.</p> <p>A nurse progress note dated 4/23/24 revealed that Resident #84's PICC line was replaced on 4/23/24.</p> <p>An infectious disease consult note dated 4/24/24, read in pertinent part, Continue on ertapenem one gram IV every 24 hours, for a minimum six-week course through 5/17/24.</p> <p>-Review of the May 2024 MAR revealed that Resident #84's PICC line dressing was not changed every seven days as ordered. The dressing changes on 5/10/24 and 5/17/24 were not completed.</p> <p>IV. Staff interviews</p> <p>Physician's assistant (PA) #1 was interviewed on 8/29/24 at 9:40 a.m. PA #1 said they had not been able to determine why LPN #8 thought the facility had a physician's order to remove Resident #84's PICC line on 4/19/24. PA #1 said if a PICC line was unintentionally pulled, it would need to be replaced within a couple hours to prevent missing any doses of antibiotics.</p> <p>PA #1 said a provider needed to be notified immediately if a PICC line was mistakenly removed because it was not a simple task to replace the PICC line. PA #1 said a specialized person needed to be called in or the resident had to be sent out to have it replaced. PA #1 said the resident might also require an additional follow-up with the infectious disease physician based on the antibiotic therapy progression. PA #1 said, with certain medications that require a PICC line, there is often blood work monitoring required. PA #1 said missed doses could affect the trough level (concentration of a medication level in the blood). PA #1 said missed doses of antibiotics could lower the trough level, which could cause the medication to not work properly.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The wound care nurse (WCN) who was also overseeing the facility's infection control program, was interviewed on 8/29/24 at 12:56 p.m. The WCN said it was her understanding that any resident on antibiotics was on the antibiotic stewardship program to track and trend infections. The WCN said a PICC line should have the dressing changed every seven days, with an order to also change as needed (PRN) if the dressing became compromised.</p> <p>The WCN said the dressing should be changed every seven days to prevent infection of the insertion site.</p> <p>The WCN said it was important not to miss any doses of an antibiotic because of trough levels or the potential for increase or spread of the infection. The WCN said any missed dose of an antibiotic should be reported to a physician.</p> <p>The RNC was interviewed on 8/29/24 at 4:30 p.m. The RNC said a PICC line should not be removed without a physician's order. The RNC said if a PICC line was removed prior to the completion of antibiotic therapy it should be reported and replaced as quickly as reasonably possible. The RNC said a PICC line that was not replaced right away could cause a delay in the resident's antibiotic treatment.</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160</p> <p>Based on interviews, record review, and observations, the facility failed to provide two of five residents (#85 and #140) out of 24 sample residents, with the timely and necessary treatment and services to prevent and manage facility-acquired deep tissue pressure injuries (DTI) that resulted in the development of infection and sepsis, and required hospitalization . Cross-reference F880 (Infection Prevention and Control), F882 (Infection Preventionist) and F867 (Quality Assurance and Performance Improvement).</p> <p>RESIDENT #85</p> <p>Resident #85, who had a diagnosis of diabetes, kidney disease, and generalized muscle weakness, was admitted to the facility on [DATE] for rehabilitation and strengthening. Resident #85 was assessed on admission with intact skin of the lower extremities, feet, and heels, and a stage 2 pressure injury to her coccyx/sacrum. She was evaluated at moderate risk of developing pressure injuries due to a history of previous pressure injury and stroke.</p> <p>On 11/16/23, nine days after admission, a weekly skin assessment documented bilateral heel discoloration. However, the resident's primary care physician (PCP) did not become aware of the resident's skin condition until 11/20/23. In a note that day, the PCP documented the resident had deep tissue injury (DTI) changes to both heels and right lower extremity cellulitis (skin infection), ascending on the right calf. The resident was sent to the hospital where she was diagnosed with cellulitis and sepsis from cellulitis, as well as a trauma injury to the right big toe, a stage 3 pressure injury on her coccyx/sacrum, and unstageable pressure injuries to her right and left heel. She was treated with intravenous (IV) antibiotics and spent a week in the hospital, including one day in the intensive care unit (ICU).</p> <p>Record review revealed the facility failed to provide the resident with timely and necessary services to prevent the development of the resident's heel wounds and to promote the healing of her coccyx/sacral wound. Specifically:</p> <p>-While an 11/16/23 assessment revealed discoloration to bilateral heels and a nursing note the same day documented the physician was notified of the resident's DTI injuries, a change of condition assessment was not completed, and a PCP note on 11/20/24, four days later, indicated the physician was unaware of the heel wounds, citing new wounds on feet have not been seen before.</p> <p>-While the resident's care plan for skin integrity was initiated on 11/7/23, and included interventions to assist the resident in turning and repositioning frequently and to off-load heels, there was insufficient evidence these interventions were implemented. Further, the discovery of bilateral heel discoloration on 11/16/23 did not trigger the facility to consider new interventions to prevent further skin breakdown despite being noted as a problem on the care plan.</p> <p>-While a review of the medication and treatment administration records (MAR and TAR) revealed orders for the resident's coccyx/sacral wound, there was no treatment order for the resident's heels in November 2023.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>RESIDENT #140</p> <p>Resident # 140, who had a diagnosis of sacral fracture, peripheral vascular disease, and idiopathic neuropathies, was admitted to the facility on [DATE]. Resident #140 was admitted to the facility with intact skin on the lower extremities, feet, and heels. At the time of admission, he was assessed at mild risk for pressure injuries due to a history of skin tears, stroke, and left-sided weakness.</p> <p>On 8/12/24, two days after admission and during the wound care nurse (WCN) assessment, a blister to the right foot, DTI was noted. On 8/21/24, nine days later, the wound care physician assessed the resident and documented the resident had a large DTI on his right first toe and right heel. On 8/25/24, the daily skilled nurse's note read the resident's right foot had become edematous and painful to touch with bruising to the right fourth toe and new right foot swelling with edema and pain.</p> <p>On 8/27/24, Resident #140 developed altered mental status, fever, and chills and was sent to the hospital where he was diagnosed with cellulitis due to an infected right heel wound. He spent one night in the ICU and was administered IV antibiotics.</p> <p>Record review revealed the facility failed to provide the resident with timely and necessary services to prevent and manage the resident's pressure injuries. Specifically:</p> <ul style="list-style-type: none"> -Record review revealed no evidence the resident's heels were off-loaded, even though heel off-loading was documented on his admission care plan. -Record review revealed the resident's daily skilled notes failed to accurately reflect the resident's skin condition. -Record review revealed staff failed to ensure the physician was timely notified of resident changes in condition. <p>The facility's systemic failure to provide Resident #85 and Resident #140 with timely interventions and necessary treatment and services to prevent and manage pressure injuries created an immediate jeopardy situation with the likelihood of serious harm to other residents with similar conditions.</p> <p>Findings include:</p> <p>I. Immediate Jeopardy</p> <p>A. Findings of immediate jeopardy</p> <p>RESIDENT #85</p> <p>The facility failed to prevent the development of pressure injuries for Resident #85. The resident was admitted to the facility on [DATE]. She was identified to be at moderate risk for pressure injuries due to her diagnosis of diabetes and kidney disease. Although she had a stage 2 coccyx/sacral wound, she did not have any injuries on her legs, feet, or heels.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>However, an 11/16/23 assessment revealed discoloration to bilateral heels, and on 11/20/23, a physician's note revealed the nurse asked the physician to see lesions on the resident's feet. The note read the resident had new deep tissue injury (DTI) wounds to both heels and ascending cellulitis to the right calf. The physician wrote that the resident is a diabetic and was at risk for diabetic foot infection that could threaten life or limb. The resident was sent to the emergency room for further evaluation.</p> <p>While in the hospital, the resident was diagnosed with cellulitis and sepsis from cellulitis as well as a trauma injury to the right big toe, a stage 3 coccyx/sacral pressure injury, and unstageable pressure injuries on her right and left heel. The resident was hospitalized for a week but her wounds did not heal and she was admitted to hospice on 11/28/23.</p> <p>Record review revealed the facility failed to provide the resident with timely and necessary services to prevent the development of the resident's heel wounds and to promote the healing of her coccyx/sacral wound. Specifically:</p> <p>-While an 11/16/23 assessment revealed discoloration to bilateral heels and a nursing note the same day documented the physician was notified of the assessment, a change of condition assessment was not completed, and a physician note on 11/20/24, four days later, indicated the physician was unaware of the heel wounds, citing new wounds on feet have not been seen before.</p> <p>-While the resident's care plan for skin integrity was initiated on 11/7/23, and included interventions to assist the resident in turning and repositioning frequently and to off-load heels, there was insufficient evidence these interventions were implemented. Further, the discovery of bilateral heel discoloration on 11/16/23 did not trigger the facility to consider new interventions to prevent further skin breakdown despite being noted as a problem on the care plan.</p> <p>-While a review of the medication and treatment administration records (MAR and TAR) revealed orders for the resident's coccyx/sacral wound, there was no treatment order for the resident's heels in November 2023.</p> <p>RESIDENT #140</p> <p>Resident #140 was admitted to the facility on [DATE]. He did not have any wounds on his legs and feet. On 8/12/24, the WCN completed a skin assessment and noted a blister to right foot, DTI.</p> <p>On 8/21/24 the wound care physician (WCP) documented the resident had an unstageable deep tissue injury (DTI) to the right first toe, and unstageable DTI to the right heel.</p> <p>Record review revealed the facility failed to provide the resident with timely and necessary services to prevent the development of the resident's pressure injuries. Specifically:</p> <p>-Record review revealed no evidence the resident's heels were off-loaded, even though heel off-loading was documented on his admission care plan.</p> <p>-Record review revealed the resident's daily skilled notes did not accurately reflect the condition of the resident's skin.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-Record review revealed staff failed to ensure the physician was timely notified of resident changes in condition.</p> <p>The medical director (MD) was interviewed about Resident #85's and #140's DTIs that developed after admission. The MD said that all pressure-related injuries were avoidable if appropriate care had been provided. She said if residents developed pressure-related injuries it meant interventions for prevention were not followed. She further said, even though both residents had comorbidities, such as diabetes for Resident #85 and vascular disease for Resident #140, all developed pressure injuries were avoidable.</p> <p>The facility's systemic failure to provide Resident #85 and Resident #140 with timely interventions and necessary treatment and services to prevent and manage pressure injuries created an immediate jeopardy situation with the likelihood of serious harm to other residents with similar conditions.</p> <p>B. Notice of immediate jeopardy</p> <p>On 8/28/24 at 11:30 a.m., the nursing home administrator (NHA) was informed of the findings of immediate jeopardy under F686, Pressure Injuries.</p> <p>C. Facility plan to remove immediate jeopardy</p> <p>The facility submitted a plan to remove the immediate jeopardy on 8/28/24 at 6:17 p.m. The plan read:</p> <p>All residents in the facility identified as high risk for skin breakdown based on their risk assessment score started and completed 8/28/24.</p> <p>Identify responsible staff/what action taken:</p> <p>Resident #85 is no longer in (the facility) and will not be assessed. Risk assessment for Resident #140 was not assessed due to being admitted to the hospital on 8/27/24.</p> <p>The regional nurse consultant (RNC) immediately on 8/28/24 provided education to wound nurse on implementation of interventions based on risk scores.</p> <p>All nurses and certified nurse aid(e)s scheduled today will be educated on implementation of pressure injury prevention interventions and will be completed by the end of 8/28/24.</p> <p>A full facility skin sweep was conducted on 8/28/24 assessing current residents'skin conditions and will be documented as completed by 8/28/24.</p> <p>Pressure Ulcer Risk assessments will be completed on current residents to identify those at high risk for skin breakdown and interventions put in place by the end of 8/28/24.</p> <p>Interventions will be implemented on 8/28/24 to prevent the development of new wounds or deterioration of existing wounds.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interventions will be added to certified nurse aid(e)s Point of Care Device for documentation by the end of 8/28/24.</p> <p>Minimum Data Set nurse is auditing care plans for residents identified as high risk for appropriate interventions and will make changes as necessary by the end of 8/28/24.</p> <p>Staff that have not received the education will be provided with education on implementation of pressure injury prevention interventions prior to the start of their next shift, and followed up on by the administrator.</p> <p>Nurse will round on assigned residents twice per shift to verify interventions are being followed by staff and turn in the audit form to DON/designee at the end of their shift.</p> <p>All newly admitted patients receive a skin assessment and Risk assessment completed on admission. Necessary interventions are put in place at the time a need is identified. The admission will be reviewed in the next morning clinical meeting. Skin assessments are done weekly ongoing, and the risk assessment is completed weekly three times after admission then quarterly and with change of condition.</p> <p>D. Removal of immediate jeopardy</p> <p>The facility plan was accepted by the state survey agency on 8/28/24 at 6:17 p.m., based on the systemic changes outlined in the above plan to ensure pressure injuries would be immediately addressed through assessment, monitoring, and treatment. The immediate jeopardy situation was removed; however, the deficient practice remained at a G level, isolated, actual harm.</p> <p>II. Professional references</p> <p>A. Classification of pressure injuries</p> <p>According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA: 2019, retrieved from https://www.internationalguideline.com/guideline on 7/30/24, Pressure ulcer classification is as follows:</p> <p>Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage)</p> <p>Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk).</p> <p>Category/Stage 2: Partial Thickness Skin Loss</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.</p> <p>Category/Stage 3: Full Thickness Skin Loss</p> <p>Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable.</p> <p>Category/Stage 4: Full Thickness Tissue Loss</p> <p>Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable</p> <p>Unstageable: Depth Unknown</p> <p>Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.</p> <p>Suspected Deep Tissue Injury: Depth Unknown</p> <p>Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.</p> <p>According to the Basic Nursing third edition, Treas, L.S., [NAME], K.L., & [NAME], M.H. (2022), page 1214, Healthy people regularly shift position to maintain comfort. However, many patients are unable to move without assistance. They require a change of position at least every two hours to prevent skin breakdown, muscle discomfort, damage to superficial nerves and blood vessels, and contractures.</p> <p>III. Facility policy</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The Prevention of Pressure Injuries policy and procedure, revised July 2018, was received from the regional nurse consultant (RNC) on 8/27/24 at 12:27 p.m. It read in pertinent part:</p> <p>Any significant abnormal findings are reported to the resident physician and resident or responsible party. Abnormal findings are to be documented in the medical record. Actions taken to be documented in the medical record, along with a summary of all notified with their responses. Care plans will be updated on a routine basis and with significant changes in condition.</p> <p>IV. Resident #85</p> <p>A. Resident status on admission</p> <p>Resident #85, age older than 65, was admitted to the facility on [DATE] from the hospital. According to the November 2023 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus and chronic kidney disease.</p> <p>The 11/27/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 12 out of 15. She required substantial to maximal assistance from two staff members for transfers.</p> <p>The care plan for skin integrity was initiated on 11/7/23 with interventions to turn and reposition frequently, off-load heels, and position the resident properly.</p> <p>The medication administration (MAR) and treatment administration records (TAR) for November 2023 revealed there were no treatment orders for the resident's heels.</p> <p>A skin assessment completed on admission (11/7/23) revealed Resident #85 had a stage 2 coccyx/sacral wound; however, her skin was intact to her lower extremities, heels, and feet.</p> <p>A review of the daily skilled nurse's notes revealed no documentation of any changes in the resident's skin before 11/16/23 (see below). A review of daily skilled nurses notes for November 2023 mentioned that coccyx/sacral wound care was ordered; however, there was no mention of skin breakdown to the resident's heels from 11/8/23-11/11/23. There was no daily skilled note documented for 11/15/23.</p> <p>B. Resident status following admission - Skin changes identified on 11/16/23 - development of a pressure injury to the resident's right heel - facility failures</p> <p>1. Skin changes identified on 11/16/23</p> <p>An occupational therapy note, dated 11/16/23, nine days after admission, read in pertinent part, bleeding right heel during therapy session.</p> <p>A weekly skin assessment dated [DATE] documented discoloration to bilateral heels and a laceration to the right foot.</p> <p>A note by licensed practical nurse (LPN) #4 on 11/16/23 at 6:22 p.m. documented, Resident notified nurse of open skin area on right heel. Fluid filled blister broke, deep tissue injury (DTI) visible. Primary care physician (PCP) power of attorney (POA), wound nurse notified.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>2. Facility failures</p> <p>The weekly skin assessment on 11/16/23 (see above) did not document the description and measurements of new skin wounds. (It also did not document how the resident obtained the laceration.)</p> <p>The care plan was revised on 11/16/23 with a mention of heel discoloration and skin tear.</p> <p>However, the care plan did not document the location (right or left heel) of the discoloration. Further, no additional interventions were added to the care plan to address the new pressure wound.</p> <p>Review of the resident's record from admission on 11/7/23 to 11/16/23 revealed no evidence that the care plan intervention for off-loading (see above) was followed.</p> <p>A review of the resident's record revealed that although the nurse's note documented the PCP was notified of the resident's right heel injury and skin tear on 11/16/23 (see above), there was no documentation of PCP follow-up or of additional attempts to notify the PCP of the resident's skin breakdown.</p> <p>C. Discovery on 11/20/23 - development of additional pressure injuries and cellulitis - facility failures</p> <p>1. On 11/20/23 at 7:15 p.m., a physician progress note written by PCP #1 documented in part:</p> <p>[A]sked to see lesions on feet that may not wait for wound care. New wounds on feet have not been seen before. Resident #85 has DTI changes (approx 6 centimeters) to bilateral heels and lateral calcaneal (large bone at the end of the foot), ascending cellulitis on the right calf. Right calf is tender, mildly warm and red.</p> <p>At risk for diabetic infection that may threaten life or limb. Ascending erythema (redness of skin) is also a concern for cellulitis (skin infection). Resident #85 to be sent to the emergency room for evaluation to rule out osteomyelitis (inflammation of the bone due to infection).</p> <p>The admission hospital record, dated 11/21/23, revealed the resident was diagnosed with cellulitis and sepsis from cellulitis. Upon admission to the hospital, the following wounds were identified: trauma injury to the right big toe measured 2.0 by 2.0 by 0.1 cm, stage 3 pressure injury on coccyx/sacrum 3.0 by 3.0 by 0.2 cm, unstageable (pressure injury) on right heel measured 5.5 by 15.5 cm, and unstageable (pressure injury) on left heel measured 4.5 by 5.5 cm.</p> <p>The hospital record revealed the resident was administered intravenous (IV) antibiotics and spent a week in the hospital including one day in the intensive care unit (ICU).</p> <p>2. Facility failures</p> <p>A review of the resident's progress notes, daily skilled nurses's notes, and skin assessments revealed there was no further documentation of discoloration to the resident's heels after 11/16/23 until the physician's note above on 11/20/23. A review of the resident's November MAR and TAR revealed no orders addressing the skin breakdown of the resident's heels identified on 11/16/23.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The resident's record revealed daily skin assessments were not completed with accuracy to ensure Resident #85's pressure injuries were timely managed. Further, the facility failed to ensure timely notification to the PCP after the evidence of a DTI was identified on 11/16/23.</p> <p>D. Interviews</p> <p>1. The facility's MD was interviewed on 8/28/2024 at 8:52 a.m. The MD said the pressure injuries Resident #85 developed had been facility-acquired and were preventable. She said pressure injury wounds developed when protocol and care plans were not being followed by staff. The MD further said the expectation was that any change of condition (in the resident's skin) would have been documented and reported the same day to either an on-site physician or the on-call team.</p> <p>2. The wound care physician (WCP) was interviewed on 8/28/24 at 4:13 p.m. The WCP said she had initially observed Resident #85 on 11/8/23 to have only a stage 2 coccyx/sacral wound. She said she was unaware the resident had been hospitalized on [DATE] due to a wound infection.</p> <p>The WCP said she had no reason to believe Resident #85 was at risk of developing heel wounds as she was not bed-bound. She concluded that the resident's heel wounds were unavoidable because the resident had a diagnosis of diabetes.</p> <p>-However, see above. The resident entered the facility without any pressure injuries to her heels, review of the resident's record revealed daily skin assessments were not completed with accuracy, there was no evidence the resident was turned and repositioned as care planned, and new interventions were not considered when the resident's bilateral heel discoloration,DTI was identified.</p> <p>3. Physician assistant (PA) #1 was interviewed on 8/29/24 at 9:40 a.m. PA #1 said that the pressure injuries Resident #85 developed were facility-acquired and had proper interventions been completed the injuries should not have developed.</p> <p>V. Resident #140</p> <p>A. Resident record review, observations, and interview</p> <p>Resident #140, age older than 65, was admitted to the facility from the hospital on 8/10/24. According to the August 2024 CPO, his diagnoses included sacral fracture, peripheral vascular disease, and idiopathic neuropathies.</p> <p>According to the 8/16/24 MDS assessment, the resident was alert and oriented with a BIMS score of 15 out of 15.</p> <p>Resident #140 was interviewed on 8/27/24 at 9:20 a.m. Resident #140 said he developed multiple wounds on his right foot after he was admitted to the facility. Resident #140 said he had not had anything wrong with his foot before being admitted . Resident #140 said he developed a wound on his right heel from his feet being pushed against the footboard of the bed. (Per the MDS assessment, the resident's height was 6 feet 4 inches.) The resident said he also developed sores on his toes because the staff did not help him move.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Resident #140 said the staff was not consistent with dressing changes. He said staff routinely told him that he would see a WCN or physician, but he had not seen either the wound nurse or the physician when he asked to see them to answer his questions.</p> <p>Observations revealed Resident #140 lying in the bed with his feet touching the footboard. His right heel was covered with a blue foam boot. There was a purple discoloration on the tip of his right first toe and a white piece of tape on his right second toe labeled with a nurse's initials, dated 8/25.</p> <p>B. Resident status on admission</p> <p>A skin assessment completed on admission on 8/10/24 revealed Resident #140's skin was intact, except for a skin tear and hematoma to his left elbow.</p> <p>A care plan for physical mobility, initiated on 8/10/24, revealed the resident had impaired mobility due to a history of stroke and history of cardiovascular disease. Interventions included to provide an appropriate level of assistance. The 8/16/24 MDS assessment revealed the resident's level of assistance was substantial to maximal assistance and two staff assistance for transfers.</p> <p>A care plan for skin breakdown was initiated on 8/10/24, revealing that the resident was at risk for actual skin breakdown due to a history of stroke and cardiovascular disease and a history of bruising and skin tears.</p> <p>-Although the care plan noted the resident was confined to a chair most of the time, required extensive assistance with bed mobility and transfers, and had left-sided weakness, he was assessed at mild risk for skin breakdown.</p> <p>-Interventions initiated on admission 8/10/24 included off-loading heels, positioning the resident properly, inspecting skin and completing a head-to-toe assessment every week and documenting results, as well as inspecting skin daily with care and bathing, and reporting any changes to the nurse.</p> <p>C. Resident status after admission - development of pressure injury on the resident's right heel, right first toe - facility failures</p> <p>1. Skin breakdown 8/12/24</p> <p>On 8/12/24, two days after admission, a WCN assessment read in part, blister to right foot, DTI.</p> <p>On 8/12/24, the care plan was updated to add a new blister.</p> <p>-However, the location and the cause were not documented and the update did not reference DTI. Further, no new interventions were added to the care plan, and the resident's orders were not updated with any new treatments until 8/14/24 when the wound care physician (WCP) assessed the resident (see below).</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 8/14/24, the WCP documented an unstageable DTI to the right great toe, measuring 1.0 by 0.5 centimeters (cm), and trauma injury to the right second toe. The WCP recommended to cleanse the wound daily, apply skin prep, off-load, and avoid constrictive footwear, and the orders for daily wound care were entered on the MAR.</p> <p>Notwithstanding the above documentation by nursing and the WCP of skin breakdown, the August 2024 daily skilled nurse's notes section revealed no documented skin concerns from 8/12/24 to 8/16/24. Further, there were no documented daily skilled nurse's notes on 8/15/24 and 8/17/24.</p> <p>On 8/15/24, the resident was ordered to receive sugar-free liquid protein (Prostat) 30 milliliters (ml) by mouth two times a day for wound healing (unstageable DTI).</p> <p>-Although a review of the resident's MAR for August 2024 revealed the Prostat was documented as routinely given, an interview with LPN #1 on 8/27/24 at 8:48 a.m. revealed the resident frequently refused the liquid protein, preferring a protein shake provided by his family. (A refusal was observed on 8/27/24 at 8:48 a.m.)</p> <p>-However, the resident's record revealed no evidence that the resident's refusals and preference for another protein supplement were communicated to the PCP.</p> <p>On 8/17/24, the resident's care plan was updated again to turn and reposition the resident frequently.</p> <p>-However, despite the resident's mobility limitations, there was no evidence that repositioning was offered to the resident, and staff interviews (see below) indicated it was unclear how frequently it was to be done. See also the resident interview above; Resident #140 said that the staff did not help him move.</p> <p>2. Skin breakdown 8/21/24</p> <p>On 8/21/24, the WCP documented Resident #140 still had an unstageable DTI to the right great toe that measured at 0.9 by 1.0 dcm, trauma injury to the right second toe, but also a new pressure wound unstageable DTI on the right heel that measured 3.0 x 6.0 cm. Orders were entered for right heel wound care every three days, cleanse with wound cleanser, and pat dry. Apply foam dressing and off-load while in bed.</p> <p>On 8/22/24, the care plan was updated with interventions to off-load heels as allowed and apply boot to the right foot when out of bed.</p> <p>-However, none of the care plan updates after admission indicated staff had considered the resident's height and the footboard on his bed. See resident interview and observation above.</p> <p>On 8/25/24, the daily skilled nurses note documented concerns for a right heel wound, right second toe wound, and bruising to the right fourth toe with new right foot swelling (edematous +3 and painful to touch).</p> <p>3. Change of condition 8/27/24</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 8/27/24 (during the survey), the care plan was updated with an intervention to document weekly treatments and to include measurements for every wound. However, on this date, the resident experienced a change in condition and was transferred to the hospital. Specifically:</p> <p>On 8/27/24 at 3:19 p.m., LPN #1 documented that during therapy it was observed that Resident #140 was altered from baseline and unable to complete tasks normally. Vital signs were taken and revealed that Resident #140 had a fever (100.7 F) and hypotension (a low blood pressure of 97/65). The physician was notified of Resident #140's status and the resident was sent to the emergency department via ambulance.</p> <p>The hospital emergency room records dated 8/27/24 at 8:24 p.m. read in pertinent part, cellulitis of right lower limb, severe sepsis without septic shock, purulent (pus-like drainage which is a sign of infection) drainage along heel with streaking erythema superiorly. Resident #140 was admitted to the ICU and treated with antibiotics.</p> <p>D. Interviews</p> <p>1. The WCN was interviewed on 8/27/24 at 2:29 p.m. The WCN said she conducted a skin assessment on newly admitted residents but was not aware of a timeframe for her assessment to occur. She said Resident #140's heel tissue had been closed during the first skin assessment she conducted on 8/12/24. Therefore, the resident's heel wound would be considered facility-acquired. The WCN said the WCP mentioned the toe wounds may have bee[TRUNCATED]</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>48112</p> <p>Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for two of five certified nurse aides (CNA) reviewed.</p> <p>Specifically, the facility did not complete a performance review for CNA #1 and CNA #2.</p> <p>Findings include:</p> <p>I. Record review</p> <p>CNA #1 was hired on 2/28/23. A request for a performance review was made on 8/27/24.</p> <p>-The facility was unable to provide documentation indicating a performance review for CNA #1 was completed in the past 12 months.</p> <p>CNA #2 was hired on 11/29/22. A request for a performance review was made on 8/29/24.</p> <p>-The facility was unable to provide documentation indicating a performance review for CNA #2 was completed in the past 12 months.</p> <p>II. Staff interviews</p> <p>The human resources director (HRD) was interviewed on 8/29/24 at 4:28 p.m. The HRD said each department lead was responsible for completing an annual performance review for their staff. She said a performance review was not completed for CNA #1 and CNA #2.</p> <p>The regional nurse consultant (RNC) was interviewed on 8/29/24 at 4:36 p.m. The RNC said a performance review was not completed for CNA #1 and CNA #2.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>51160</p> <p>Based on observations, record review and interviews, the facility failed to ensure it was free of a medication error rate of five percent (%) or greater.</p> <p>Specifically, the medication administration observation error rate was 16.67%, or five errors out of 30 opportunities for error.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Medication Guidelines On Clinical Practice policy and procedure, revised January 2020, was provided by the regional nurse consultant (RNC) on 8/29/24 at 4:30 p.m. It read in pertinent part, Staff will provide medications in accordance with standard practice guidelines.</p> <p>II. Medication error observations</p> <p>On 8/27/24 at 8:38 a.m. licensed practical nurse (LPN) #1 was observed preparing and administering medications for Resident #5. The resident had a physician's order for Aspercreme (lidocaine) (a medication used for pain) 4 % topical patch, one time per day, apply one patch to left knee for pain due to fall.</p> <p>-LPN #1 documented that he gave the medication, however, he did not apply the patch to Resident #5's left knee.</p> <p>On 8/27/24 at 8:48 a.m. LPN #1 was observed preparing and administering medications for Resident #140. The resident had physician's orders for the following medications:</p> <p>-Lidocaine 4 % topical patch one time per day, apply one patch to the sacrum;</p> <p>-Metoprolol tartrate (a blood pressure medication) 25 milligrams (mg) tablet one tablet by mouth two times per day. Hold if systolic BP (blood pressure) is less than 100 millimeters of mercury (mmHg), hold if pulse less than 60 beats per minute (bpm); and,</p> <p>-Prostat sugar-free liquid protein 30 milliliters (ml) by mouth two times per day, for wound healing.</p> <p>LPN #1 attempted to place the lidocaine patch on Resident #140's knee. Resident #140 said he did not want the patch on his knee because his neck hurt. LPN #1 proceeded to apply the lidocaine patch to the resident's left lateral neck.</p> <p>-However, the physician's order was for the lidocaine patch to be applied to Resident #140's sacrum.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Accel at Longmont		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-LPN #1 failed to verify Resident #140's heart rate or blood pressure prior to administration of the metoprolol tartrate.</p> <p>-Additionally, LPN #1 documented the resident's heart rate was 62 bpm, however, the morning vital signs obtained by a certified nurse aide (CNA) were documented as a heart rate of 80 bpm and a blood pressure reading of 147/80.</p> <p>-Resident #140 refused the Prostat liquid protein, however, LPN #1 documented the medication was given.</p> <p>On 8/28/24 at 9:50 a.m. LPN #2 was observed preparing and administering medications for Resident #15. The resident had a physician's order for carbidopa ER (extended release) 25 mg-levodopa 100 mg tablet, two tablets by mouth three times per day (8:00 a.m., 12:00 p.m. and 4:00 p.m.) for Parkinson's disease.</p> <p>-The medication was administered to Resident #15 at 9:50 a.m., 50 minutes after the allowed medication administration window.</p> <p>III. Staff interviews</p> <p>LPN #2 was interviewed on 8/28/24 at 10:00 a.m. LPN #2 said she had a two hour window to administer medications from their ordered timeframe. She said Resident #15's carbidopa-levodopa medication was ordered at 8:00 a.m. and could be given between 7:00 a.m. and 9:00 a.m.</p> <p>-However, the medication was administered at 9:50 a.m., outside the two- hour medication administration window (see observation above).</p> <p>Physician assistant (PA) #1 was interviewed on 8/29/24 at 9:40 a.m. PA #1 said of all medications, Parkinson's medications should be given on time. PA#1 said that it was extremely important to administer carbidopa/levodopa on time. PA #1 said the reason it was important was because of the half-life (the time it takes for the amount of a drug's active substance in your body to reduce by half) of the medication. PA #1 said even small delays could cause a significant increase in Parkinson's disease symptoms, such as tremors or difficulty swallowing. PA #1 said administering the 8:00 a.m. dose at 9:50 a.m. had been a medication error.</p> <p>PA #1 said if a lidocaine patch was prescribed for the sacral area it should not be applied to a different area. PA #1 said a different physician's order would be required to place a lidocaine patch on a different area of the body. PA #1 said if a medication was refused or not given it should not be documented as given. PA #1 said any medication refusals required notification of a provider.</p> <p>The RNC was interviewed on 8/29/24 at 4:30 p.m. The RNC said medication should be administered as it was prescribed. The RNC said a lidocaine patch should be placed on the part of the body specified in the physician's order, not just anywhere on a resident's body. The RNC said timed and extended release medications should be administered within a two hour window of the prescribed administration time.</p>		

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NAME OF PROVIDER OR SUPPLIER Accel at Longmont		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 S Fordham St Longmont, CO 80503	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160</p> <p>Based on observations and interviews, the facility failed to follow proper infection prevention practices during patient care and medication administration.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Perform appropriate hand hygiene during medication administration; and, -Clean multi-resident use vitals monitoring equipment in between residents. <p>Findings include:</p> <p>I. Professional reference</p> <p>The Centers for Disease Control and Prevention (CDC) (2024), Clinical Safety: Hand Hygiene for Healthcare Workers, was retrieved on 9/9/24 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html. It read in pertinent part,</p> <p>Perform hand hygiene before touching a patient, after touching a patient or their surroundings, immediately after glove removal.</p> <p>According to Treas, L.S., [NAME], K.L., & [NAME], M.H. (2022.) Basic Nursing: Thinking, Doing and Caring, (Third edition), pages 1601, 1604-1605, Use standard precautions to prevent the transmission of infection. Implement measures to prevent healthcare-associated infections (HAIs). HAIs are the leading complication of healthcare and one of the ten leading causes of death in the United States. Hand hygiene can remove transient flora (microbes acquired by touching objects or people).</p> <p>II. Observations</p> <p>On 8/27/24 at 8:38 a.m. medication administration was observed in the presence of licensed practical nurse (LPN) #1. LPN #1 did not perform hand hygiene prior to entering the resident room. LPN # 1 donned gloves and administered eye drops into both of Resident #5's eyes.</p> <ul style="list-style-type: none"> -After administering the eyedrops, LPN #1 removed her gloves, did not perform hand hygiene, and proceeded to administer oral medications to Resident #5. <p>During the medication administration, LPN #1 attempted to take Resident #5's heart rate with a facility pulse oximeter (finger probe that measures heart rate and oxygen level). The equipment was not working properly. LPN #1 left the resident's room to obtain his personal pulse oximeter.</p> <ul style="list-style-type: none"> -LPN #1 did not perform hand hygiene upon exiting or re-entering the room. -LPN #1 did not clean the facility equipment or his own before or after use on Resident #5. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/27/24 at 8:48 a.m. medication administration was observed in the presence of LPN #1. LPN #1 walked from Resident #5's room to medication cart #1 and prepared medications for Resident #140 without performing hand hygiene.</p> <p>-LPN #1 entered Resident #140's room without performing hand hygiene. An opened cup of applesauce was on the dresser with the lid open and a spoon resting in the cup. LPN #1 handed the resident the cup of applesauce and spoon to use to take the medications. LPN #1 completed administration of the oral medications, then placed a lidocaine patch on Resident #140's neck.</p> <p>-LPN #1 exited the room without performing hand hygiene and proceeded to medication cart #1.</p> <p>On 8/28/24 at 9:50 a.m. medication administration was observed in the presence of LPN #2. LPN #2 prepared medications for Resident #15 without performing hand hygiene. LPN #2 entered Resident #15's room without performing hand hygiene, then proceeded to administer oral medications.</p> <p>On 8/28/24 at 9:23 a.m. medication cart #2 was observed in the presence of LPN #6. While LPN #6 was standing at medication cart #2, a staff member walking down the hallway stopped and picked up a pill off the floor near the medication cart. LPN #6 took the pill from the staff member and threw it into a trash can attached to the medication cart.</p> <p>-After disposing of medication from the floor, LPN #6 proceeded to prepare medications for residents without performing hand hygiene.</p> <p>III. Staff Interview</p> <p>The wound care nurse (WCN), who was also overseeing the facility's infection control program was interviewed on 8/29/24 at 12:56 p.m. The WCN said hand hygiene should be used prior to administering resident care. The WCN said hand hygiene should be used prior to administering medications, especially eye drops, to prevent the spread of infection. The WCN said hand hygiene should occur after the removal of gloves and prior to providing care for a different resident.</p> <p>The WCN said vital signs monitoring equipment (blood pressure cuffs, pulse oximeters) should be cleaned after each resident with cavi wipes.</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>37166</p> <p>Based on record review and interviews, the facility failed to employ an infection control preventionist (ICP) who had completed specialized training in infection prevention and control which had the potential to affect all residents residing in the facility at the time of the survey.</p> <p>Specifically, the facility failed to have a qualified ICP involved with the facility's infection prevention and control program.</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>The Centers for Disease Control and Prevention (CDC), Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, (updated 5/8/23) was retrieved on 9/4/24 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html-read in pertinent part,</p> <p>Nursing homes should assign one or more individuals with training in infection prevention and control (IPC) to provide on-site management of the IPC program. Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the IPC risk assessment.</p> <p>II. Record review</p> <p>The infection preventionist's (IP) certification for training specific to infection prevention and control was requested on 8/26/24 from the nursing home administrator (NHA) for the wound care nurse (WCN), who was the acting IP.</p> <p>-The facility was unable to provide documentation that the wound care nurse had completed specialized training in infection prevention and control (see interviews below).</p> <p>III. Staff interviews</p> <p>The WCN was interviewed on 8/29/24 at 5:10 p.m. The WCN said she was the acting IP but she had not yet completed her certification. She said she was enrolled in a training program but had not completed it yet.</p> <p>The regional nurse consultant (RNC) was interviewed on 8/29/24 at 5:30 p.m. The RNC said she was providing assistance in the building since the director of nursing (DON) quit a few days prior. She said she was not aware that the WCN had not completed her IP training.</p>