

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105459	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/05/2024
NAME OF PROVIDER OR SUPPLIER  Nursing & Rehabilitation Center of New Port Richey		STREET ADDRESS, CITY, STATE, ZIP CODE 8417 Old County Rd 54 New Port Richey, FL 34653	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>30584</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure resident's right to be treated with respect and dignity for one resident (Resident #157) of 37 resident's sampled.</p> <p>Findings included:</p> <p>On 12/3/24 at 2:38 PM, Resident #157 was observed sitting in his room in a wheelchair next to his bed. He stated he is continent of bowel and bladder, but he needs assistance to transfer from his bed to get to the bathroom. The resident stated he has had diarrhea because of the antibiotics he is currently on since he was admitted . He stated it takes the staff forever to come when he presses his call bell to request assistance in getting to the bathroom when he has a bowel movement. Resident #157 stated he has waited for over an hour on many occasions and has to defecate in his brief, and then wait for staff to come and clean him up. He stated this is humiliating and wants to get out of the facility as soon as possible.</p> <p>On 12/4/24 at 9:43 AM, an observation of Resident #157 was conducted in the resident's room. The resident was sitting in his wheelchair next to his bed and pointed to the floor next to the bed on his left side and stated this poop had been on the floor since they changed him the previous night. A brown substance was observed all over the floor next to the resident's bedside. The resident stated he had just finished eating breakfast and confirmed he had to do so with this on the floor next to him. At this time, the surveyor pressed the call light. Staff I and J, both Certified Nursing Assistants (CNAs), responded immediately and were interviewed. When asked if the mess on the floor should be there since last night and through the resident's breakfast, they both stated this should have been cleaned and advised they would get housekeeping to do so immediately. Both Staff I, CNA and Staff J, CNA agreed this was not right and it should have been cleaned up the minute it occurred. (Photographic Evidence Obtained)</p> <p>On 12/4/24 at 12:42 PM an interview was conducted with Staff K, Licensed Practical Nurse (LPN) at the nurses station. When asked what staff would be responsible for cleaning up and incontinent bowel or feces spill on the floor during incontinence care of the resident, Staff K, LPN stated the CNA's who changed the resident should have immediately started cleaning it up and then housekeeping would finish. Staff K LPN also stated the resident should never have been made to eat breakfast with that on the floor.</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/5/24 at 11:36 AM, an interview was conducted with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) about staff who provide incontinence care are expected to pick up the solid substance on the floor and then ask housekeeping to come clean the remaining immediately. The NHA confirmed the staff should have cleaned this up immediately and they should not have brought his food tray in and left that on the floor.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30584</p> <p>On 12/4/24 at 9:43 AM, an observation of Resident #157 was conducted in the resident's room. The resident was sitting in his wheelchair next to his bed and pointed to the floor next to the bed on his left side and stated this poop had been on the floor since they changed him the previous night. A brown substance was observed all over the floor next to the resident's bedside and it appeared to be feces. The resident stated he had just finished eating breakfast and confirmed he had to do so with this on the floor next to him. At this time, the surveyor pressed the call light. Staff I and J, both Certified Nursing Assistants (CNAs), responded immediately and were interviewed. When asked if the mess on the floor should be there since last night and through the resident's breakfast, they both stated this should have been cleaned and advised they would get housekeeping to do so immediately. Both Staff I, CNA and Staff J, CNA agreed this was not right and it should have been cleaned up the minute it occurred. (Photographic Evidence Obtained)</p> <p>On 12/4/24 at 12:42 PM an interview was conducted with Staff K, Licensed Practical Nurse (LPN) at the nurses station. When asked what staff would be responsible for cleaning up and incontinent bowel or feces spill on the floor during incontinence care of the resident, Staff K, LPN stated the CNA's who changed the resident should have immediately started cleaning it up and then housekeeping would finish. Staff K LPN also stated the resident should never have been made to eat breakfast with that on the floor.</p> <p>On 12/5/24 at 11:36 AM, an interview was conducted with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) about staff who provide incontinence care are expected to pick up the solid substance on the floor and then ask housekeeping to come clean the remaining immediately. The NHA confirmed the staff should have cleaned this up immediately and they should not have brought his food tray in and left that on the floor.</p> <p>45951</p> <p>A tour of the facility was conducted on 12/5/24 at 11:06 AM with The Maintenance Director and the Environmental Services and Laundry Lead. During the tour, the following were observed:</p> <ul style="list-style-type: none"> <li>- The shower room on the C-hallway had two shower walls with a pink/brown colored substance near the bottom of the walls. The Environmental and Laundry Lead stated her staff cleaned the shower walls daily, but the substance continually returned after three or four showers.</li> <li>- The shower room on the E-hallway had one shower wall with a pink/brown colored substance near the bottom of the wall.</li> <li>- A vanity sink and cabinet was observed in the soiled utility room on the F-hallway. The bottom of the cabinet had fallen through to the floor and there was a large amount of black substance on the bottom of the cabinet and floorboards underneath. Also observed was a bath basin overflowing with water and water was actively leaking from the pipe coming from the sink into the bath basin. The Maintenance Director stated he was unaware of this issue before this tour.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Upon entering the dirty side of the facility laundry room, the surveyor observed numerous pillows in a pile leaning on the top of a floor polishing machine. The Environmental and Laundry Lead stated they had too many pillows at the facility and she had nowhere else to store them. In this same room, observed behind the two washing machines was a large buildup of foreign objects, including gloves, a spray bottle, caps, lint, and debris. The The Maintenance Director confirmed he was responsible for cleaning behind the washing machines and the last time he cleaned the area was approximately a month prior.</p> <p>- Upon entering the clean side of the facility laundry room, the surveyor observed three dryers. The Maintenance Director stated the third dryer had been broken for the better part of the year and they were not actively working on fixing it because it was very old, and the parts were not available. He stated they were waiting to hear from corporate about removing this dryer or replacing it. Upon inspection of the two working dryers, there was a large amount of multicolored, unidentified material melted and burned on the inside of the dryer's drums. The Maintenance Director stated he cleaned the drums monthly but agreed it should be done to remove the matter to not contaminate clean laundry. Upon inspection of the lint traps of both dryers, a large buildup of lint was present in both. The Environmental and Laundry Lead stated they cleaned the lint trap areas two times per day, at the end of each shift, 3:00 PM and 11:00 PM. She further stated the last time the lint traps were cleaned was the night of 12/4/24. Further inspection of the dryers revealed dryer number two had a gasket which was ripped/worn in multiple places.</p> <p>Photographic Evidence Obtained</p> <p>50082</p> <p>Based on observations and interviews, the facility failed to provide a safe, clean, comfortable, and homelike environment in the facility laundry room, two of four facility shower rooms, one of four soiled utility rooms, and two resident rooms (#108 and #217) of 64 resident rooms.</p> <p>Findings included:</p> <p>During the initial tour on 12/3/24 at 8:09 AM, room [ROOM NUMBER] was observed to have lifting baseboard, broken and heavily scratched floor tiles, and rust on the toilet riser in the resident bathroom. (Photographic Evidence Obtained).</p> <p>On 12/5/24 at 1:26 PM a follow up tour of room [ROOM NUMBER] was conducted with the facility's Maintenance Director. The Maintenance Director agreed that the lifting baseboards, broken and heavily scratched floor tiles, and rusting toilet riser cause concerns and need to be repaired/replaced. The Maintenance Director also stated he had been working on rooms that had the most damage first and he has not kept documentation of the rooms he had completed work on.</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50783</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure Minimum Data Set (MDS) Comprehensive Assessments contained accurate information for two residents (Resident #46 and Resident #77) of 37 sampled residents.</p> <p>Findings included:</p> <p>An interview with Resident #46 was conducted on 12/3/24 at 1:14 PM. Resident #46 was observed with a discolored area of green and tan to right side of her head above right eyebrow extending to right side of her head. Resident #46 stated I fell out of the wheelchair and broke my neck.</p> <p>A review of Resident #46's 5-Day MDS assessment dated [DATE] revealed under Section J - Health Conditions Resident #46 had no falls since admission or prior assessment.</p> <p>An interview was conducted on 12/5/24 at 10:36 AM with the facility's Director of Nursing (DON). The DON stated she was aware of Resident #46's fall on 10/13/24 and the resident sustained a fracture from the fall. The DON also stated Resident #46 had just come out of the dining room and was sitting in her wheelchair prior to the falling.</p> <p>An observation was conducted on 12/3/24 at 1:32 PM of Resident #77 lying in bed with a palm guard to her right hand. Resident #77 was observed to have contractures of both hands. Resident #77's left thumb extended horizontally resting between the first and second knuckle with the first digit extending downward. The third, fourth, and fifth digits on the resident's left hand were curled against the palm just below the thumb side of hand. The resident's right thumb was extended outwards with the index finger, third, fourth and fifth digits curled against the palm of the hand. Resident #77's bilateral wrists were contracted at an angle with the hands and arms contracted at the elbows into the residents chest area.</p> <p>Review of Resident #77's medical record revealed Resident #77 has diagnoses of contracture of left wrist, contracture of left hand, contracture of right wrist, and contracture of right hand.</p> <p>A review of Resident #77's Care Plan revealed a Focus, last revised on 7/27/24, Resident #77 has an Activities of Daily Living (ADL) self-care deficit related to chronic medical conditions, confusion, dementia, and impaired balance, with ADL needs and participation varying. Interventions included to don a flat cloth splint to the resident's left hand as tolerated (initiated 11/25/24) and don a palm guard splint to the resident's right hand as tolerated (initiated 11/22/24.)</p> <p>A review of Resident #77's MDS assessment dated [DATE] revealed under Section GG - Functional Abilities and Goals, Resident #77 had no functional limitation in range of motion to the upper extremities.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48176</p> <p>Based on record review and interview, the facility failed to develop a Baseline Care Plan within 48 hours of admission for one (Resident #75) of 37 sampled residents.</p> <p>Findings included:</p> <p>Review of Resident #75's medical record revealed Resident #75 was admitted to the facility on [DATE]. Review of Resident #75's medical record did not reveal a Baseline Care Plan.</p> <p>On 12/5/24 Staff F, Licensed Practical Nurse (LPN) and Minimum Data Set (MDS) Coordinator provided a copy of Resident #75's Baseline Care Plan and stated it was the one done after the original admission. Review of the Baseline Care Plan revealed it was dated 12/1/24.</p> <p>An interview was conducted on 12/5/24 at 11:57 AM the Facility Administrator (FA). The FA stated Baseline Care Plans should be completed with the admission assessment, within 24 hours. Some of the information comes from hospital records, therapy, and staff, but a main component is to speak to and evaluate the resident. The FA also stated the Baseline Care Plan for Resident #75 dated 12/1/24 was not acceptable because the expectation is they are to be done within 24 hours.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>50783</p> <p>Based on interviews, observations, and record review, the facility failed to provide appropriate equipment to maintain range of motion and mobility for one resident (Resident #77) of one resident sampled for limited range of motion.</p> <p>Findings included:</p> <p>An observation was conducted on 12/3/24 at 1:32 PM of Resident #77 lying in bed with a palm guard to her right hand. Resident #77 was observed to have contractures of both hands. Resident #77's left thumb extended horizontally resting between the first and second knuckle with the first digit extending downward. The third, fourth, and fifth digits on the resident's left hand were curled against the palm just below the thumb side of hand. The resident's right thumb was extended outwards with the index finger, third, fourth and fifth digits curled against the palm of the hand. Resident #77's bilateral wrists were contracted at an angle with the hands and arms contracted at the elbows into the residents chest area.</p> <p>Review of Resident #77's medical record revealed Resident #77 has diagnoses of contracture of left wrist, contracture of left hand, contracture of right wrist, and contracture of right hand.</p> <p>A review of Resident #77's Care Plan revealed a Focus, last revised on 7/27/24, Resident #77 has an Activities of Daily Living (ADL) self-care deficit related to chronic medical conditions, confusion, dementia, and impaired balance, with ADL needs and participation varying. Interventions included to don a flat cloth splint to the resident's left hand as tolerated (initiated 11/25/24) and don a palm guard splint to the resident's right hand as tolerated (initiated 11/22/24.)</p> <p>An observation was conducted on 12/3/24 at 2:00 PM of Resident #77 with no palm guard applied to the right hand or flat cloth to left hand.</p> <p>An observation was conducted on 12/4/24 at 8:00 AM of Resident #77 lying in bed with no palm guard to the right hand and no flat cloth to left hand observed. Resident #77's palm guard was observed on the nightstand at bedside.</p> <p>An observation was conducted on 12/4/24 at 1:10 PM of Resident #77 lying in bed with a palm guard applied to the right hand and no flat cloth to left hand.</p> <p>An observation was conducted on 12/5/24 at 8:47 AM of Resident #77 lying in bed with a palm guard applied to the right hand and no flat cloth to left hand. Resident #77 was unable to open her hands on her own or move her fingers when prompted.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 12/5/24 at 10:06 AM with Staff P, Certified Nursing Assistant (CNA) and Restorative Nursing Assistant (RNA). Staff P, CNA stated her responsibilities as a Restorative Nursing Assistant is to apply splints and assist with range of motion (ROM) exercises, among other duties. Staff P, CNA also stated she has been working with Resident #77 for a few months and assists the resident with passive ROM (PROM) exercises for the upper and lower extremities. Staff P, CNA stated she also applies a hand roll to the resident's right hand and gauze to the left hand because there is no way to get anything else in the resident's hand. Staff P, CNA stated she applies Resident #77's splints five days a week unless she is pulled to the floor to work as a CNA, which usually occurs at least three times a week. Staff P, CNA also stated when she is working as a CNA on the floor, there is no staff to cover her duties as an RNA because they are short on staff.</p> <p>An observation was conducted on 12/5/24 at 12:10 PM of Resident #77 lying in bed with no palm guard to the right hand and no flat cloth to left hand observed. Resident #77's palm guard was observed on the nightstand at bedside.</p> <p>An observation was conducted on 12/5/24 at 5:00 PM of Resident #77 lying in bed with no palm guard to the right hand and no flat cloth to left hand observed. Resident #77's palm guard was observed on the nightstand at bedside.</p> <p>An observation was conducted on 12/6/24 at 9:00 AM of Resident #77 lying in bed with a palm guard to her right hand and gauze applied to her left hand.</p> <p>Review of Resident #77's Point of Care (POC) Tasks revealed the following documentation:</p> <ul style="list-style-type: none"> <li>- Task: Nursing Rehab: Assistance with palm guard daily: Assistance was provided on eight of 30 days between 11/5/24 and 12/14/24. No refusals were documented.</li> <li>- Task: Nursing Rehab: Assistance with flat cloth to left hand daily: Assistance was provided on 11 of 30 days between 11/5/24 and 12/14/24. No refusals were documented.</li> </ul>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45951</p> <p>Based on observations, interviews, and record review, the facility failed to ensure physician orders for tube feeding were followed and failed to ensure tube feeding was administered in a proper manner for one resident (Resident #31) of one resident reviewed for tube feeding.</p> <p>Findings included:</p> <p>Review of the facility's policy titled Enteral Nutrition, date revised January 2014 revealed adequate nutritional support through enteral feeding will be provided to residents as ordered and central supply will be responsible for ordering all tube feeding supplies.</p> <p>Repeated requests for the facility's procedure for proper hanging and labeling of tube feeding supplies was not granted by the end of the survey week.</p> <p>During a tour of the facility conducted on 12/3/24 at 9:55 AM, Resident #31 was observed with a tube feeding bag hanging. Closer observation revealed a bottle of Jevity 1.5 formula sitting on the bedside table. There were no labels, date, or time written on the bag or the bottle. The tube feeding machine was set for the tube feeding to instill at 80 milliliters per hour (mL/hr) and for the water flush to instill at 150 mL every 4 hours (Photographic Evidence Obtained).</p> <p>Resident #31 was initially admitted to the facility on [DATE] and was last readmitted on [DATE]. He had a medical history significant for respiratory failure, malnutrition, dysphagia, and encephalopathy.</p> <p>Initial record review for Resident #31 revealed the physician orders for tube feeding included an order written on 11/12/24 for Enteral Tube: Continuous tube feeding of: Jevity 1.5 at 80 ml/hr and an order written on 10/29/24 for Enteral Tube: Flush tube with 180 ml of water every 4 hours.</p> <p>Review of Resident #31's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he had a Brief Interview of Mental Status score of 14, which indicates he was cognitively intact. This MDS Assessment documented that he was receiving tube feeding and had suffered weight loss since being admitted to the facility.</p> <p>Review of Resident #31's Care Plan revealed there were care plans in place regarding requires tube feeding related to dysphagia and poor oral intake and at risk for aspiration related to complaints of difficulty or pain with swallowing, feeding tube.</p> <p>During a tour of the facility conducted on 12/4/24 at 10:10 AM, Resident #31 was observed with a tube feeding bag hanging, dated/timed 12/4/24 at 4:00 AM. Further observation revealed there was no label on the bag or bottle present to indicate what the tube feeding formulary was. The tube feeding machine was set for the tube feeding to instill at 80 mL/hr and for the water flush to instill at 150 mL every 4 hours. A secondary tour was conducted on 12/4/24 at 1:46 PM and the same settings were programmed for Resident #31's tube feeding and water flush. (Photographic Evidence Obtained).</p> <p>(continued on next page)</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with Staff E, Registered Nurse (RN) on 12/4/24 at 1:55 PM regarding this resident's physician orders. Staff E, RN stated they were using the tube feeding bag tubing because the bottle tubing was out of stock. She said the night shift staff were responsible for changing the tubing and they poured the bottled tube feeding formulary into the bag since the facility did not have the correct tubing to connect to/spike the bottle of tube feeding. She said Resident #31 had an order to receive Jevity 1.5 tube feeding formulary. When asked how she knew the formulary in the bag was in fact Jevity, being that there was no indication on the bag or bottle present, she again stated Resident #31 had an order to receive Jevity 1.5. She then confirmed the tube feeding formulary should have been written on the bag along with the date and time it was started. The surveyor then asked Staff E, RN, to review and confirm the physician orders for Resident #31's tube feeding and water flush. She verbalized Resident #31 had an order for Jevity 1.5 to run at 80 mL/hr and for a water flush to run at 150 mL/4 hr. The surveyor again asked her to confirm the orders in the computer. Staff E, RN independently reviewed Resident #31's orders and verbalized the Jevity 1.5 order was for 80 mL/hr, and the water flush order was for 180 mL every 4 hours. The surveyor asked Staff E, RN to confirm on Resident #31's tube feeding machine if the rate for the water flush was 150 mL every 4 hours or 180 mL every 4 hours. Upon observation of the tube feeding machine, Staff E, RN confirmed the water flush rate was programmed incorrectly and that it was running at 150 mL every 4 hours instead of 180 mL every 4 hours. Staff E, RN then reprogrammed the water flush rate and then returned to the computer to re-confirm the order was 180 mL every 4 hours, which she also confirmed had been written on 10/29/24.</p> <p>Interviews were conducted with the facility's Assistant Director of Nursing on 12/5/24 at 10:45 AM and with the facility's Director of Nursing and Administrator on 12/5/24 at 1:00 PM. All agreed Resident #31's tube feeding bag should have been labeled properly, with the start date and time and tube feeding formulary. They also agreed the water flush had been running at the incorrect rate until surveyor intervention.</p>		

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NAME OF PROVIDER OR SUPPLIER  Nursing & Rehabilitation Center of New Port Richey		STREET ADDRESS, CITY, STATE, ZIP CODE  8417 Old County Rd 54 New Port Richey, FL 34653	

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50082</p> <p>Based on observations, interviews, and record and policy review, the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to them for one resident (Resident #19) of 37 sampled residents.</p> <p>Findings included:</p> <p>On 12/4/24 at 9:00 AM, the surveyor observed refresh eye drops at the bedside of Resident #19 while observing medication administration with Staff A, Licensed Practical Nurse (LPN). Resident #19 stated, I use the eye drops often and keep the lid loose so it's easy to access. Staff A, LPN stated he was not aware Resident #19 had medication at the bedside and confirmed in the medical record Resident #19 was not assessed and did not have a care plan in place to have medication at the bedside. Staff A, LPN removed the medication from Resident #19's room.</p> <p>On 12/4/24 at 3:22 PM during an interview with the Director of Nursing (DON), she stated a physician order for self-administration and a nursing assessment would be required and the medication would be kept in a lock box in the resident's room. The DON confirmed the facility did not have any residents with orders for self-administration of medication.</p> <p>Review of the electronic medical record (EMR) confirmed Resident #19 did not have a physician order or nursing assessment for medication self-administration.</p> <p>A review of the facility policy titled Medication Storage and Labeling last revised 1/2024 revealed under Procedure, 1.) Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. Only persons authorized to prepare and administer medication have access to locked medications.</p>

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50082</p> <p>Based on interviews and record reviews, the facility failed to explain the arbitration agreement to the resident and/or his or her responsible party (RP) in a form and manner that could be understood, including in a language the resident and his or her RP could understand; for two residents (Resident #359 and Resident #66) of three residents sampled for arbitration agreements.</p> <p>Findings included:</p> <p>On 12/5/24 at 9:57 AM arbitration agreements were reviewed with Staff B, Admissions Director (AD). Staff B, AD presented the electronic version of the arbitration agreement for Resident #359 and Resident #66. The documents were electronically signed by Staff B, AD but not signed by Resident #359, Resident #66, or by either resident's RP. Staff B, AD stated, I didn't have the resident sign the arbitration agreement because it was all verbally explained to the resident on admission, and no one is agreeing or disagreeing with arbitration. They are just explained the process. I offer a copy of any form they sign. At 10:15 AM Staff B, AD stated she just had Resident #359 sign the arbitration agreement at that time.</p> <p>On 12/5/24 at 10:46 AM, Resident #359 was asked how the arbitration agreement was explained to him and if he understood it was voluntary. Resident #359 replied, I don't know, she just said it was something that I needed to sign from admission.</p> <p>On 12/5/24 at 10:58 AM, Resident #66, who was admitted on [DATE], stated she did not remember being informed about the process of arbitration upon admission and did not sign a document accepting or declining the arbitration agreement.</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>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951</b></p> <p>Based on observations, interviews, and record review, the facility failed to maintain an effective infection control and prevention program to prevent the spread of infection by 1.) failing to follow Enhanced Barrier Precautions during catheter care for one resident (Resident #31) of one resident reviewed for catheter care, 2.) failing to ensure resident's meals were delivered in a clean and sanitary manner during one of three meal observations, and 3.) failing to maintain the facility laundry area in a clean and sanitary manner in one of one laundry room.</p> <p>Findings included:</p> <p>Review of the facility's policy titled Infection Control Transmission Based Precautions, date revised February 2024, revealed Enhanced Barrier Precautions can be applied to residents with indwelling medical devices.</p> <p>Review of the facility's policy titled Catheter Care-Quality of Care, date revised January 2024, revealed the facility will maintain infection control guidelines related to catheter care to minimize catheter associated infections.</p> <p>Review of the facility's procedure titled Indwelling Male Urinary Catheter Care Competency, undated, revealed the following proper steps for performing catheter care: Catheter waterproof barrier/pad, have resident check the water temperature; place barrier pad under the perineal area before washing; apply soap to wet washcloths; using soapy washcloth wash beginning at insertion site and moving around entire genital area from top to base using a clean area of the washcloth for each stroke; use a clean washcloth to rinse soap; hold catheter near insertion site to prevent pulling when handling and cleanse catheter tubing using clean are of washcloth; dry genital area moving from front to back with a dry cloth or towel.</p> <p>During a tour the facility conducted on 12/3/24 at 9:55 AM, the surveyor observed Resident #31 had a catheter present. Further observation revealed an orange sign posted on the wall behind the head of the bed which stated Resident #31 was on Enhanced Barrier Precautions.</p> <p>Resident #31 was initially admitted to the facility on [DATE] and was last readmitted on [DATE]. He had a medical history significant for respiratory failure, urinary tract infections (UTI), and encephalopathy.</p> <p>Review of Resident #31's Care Plan revealed there were care plans in place regarding at risk for UTI related to catheter use and at risk for injury/infection related to presence of catheter secondary to urinary retention.</p> <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>A catheter care observation was conducted on 12/4/24 at 2:08 PM with Staff D, CNA (Certified Nursing Assistant). Staff D, CNA stated she had worked at the facility for approximately one month. Staff D, CNA filled a bath basin with warm water and soap and gathered washcloths and a towel. She donned gloves, but no isolation gown. Upon approaching Resident #31's bedside, the surveyor observed the orange Enhanced Barrier Precautions sign was still present. Staff D, CNA wet the washcloths in the soapy water and then set the towel and the washcloths on the resident's abdomen. Staff D, CNA used one washcloth and wiped down Resident #31's scrotum, between his legs, and around the base of his penis. She then used a second soapy washcloth to clean his penis in an up-and-down motion and around the meatus. She then used a new soapy washcloth to clean the catheter tubing from the meatus in an outward motion. Staff D, CNA performed this step a second time with an additional soapy washcloth and then used this washcloth to re-clean Resident #31's meatus. She then removed the towel from Resident #31's abdomen and used it to dry his perineal area.</p> <p>After the observation was complete, the surveyor asked Staff D, CNA, about the Enhanced Barrier Precautions sign hanging behind the bed. She stated she was unaware of why the sign was there and that if it was something more serious, there would be a cart by the door with [isolation] gowns.</p> <p>Interviews were conducted with the facility's Assistant Director of Nursing on 12/5/24 at 10:45 AM and with the facility's Director of Nursing and Administrator on 12/5/24 at 1:00 PM. All agreed the catheter care was not performed per proper procedure and Staff D, CNA should have worn an isolation gown while performing the catheter care.</p> <p>During a tour of the facility conducted on 12/3/24 at 12:28 PM, an observation was conducted of Staff L, Dietary Aide pushing a cart with three lunch meal trays from the kitchen to the B-hallway. While walking with the cart, a spoon fell out of a silverware pack. Staff L, Dietary Aide stopped, picked the spoon up, placed it back on the meal tray, and continued pushing the cart to the B-hallway. The surveyor then observed Staff L, Dietary Aide leave the cart and return to the kitchen without telling any other staff that the spoon fell . At 12:29 PM, the surveyor observed the facility's Assistant Director of Nursing (ADON) retrieve the meal cart and push it to the end of the B-hallway. The ADON began to distribute the meal tray, but the surveyor intervened, telling the ADON the spoon had fallen onto the floor and Staff L, Dietary Aide put it back on the tray without alerting anyone. The ADON removed the spoon and other silverware from the tray and stated she would go to the kitchen and get the resident new silverware.</p> <p>An interview was conducted on 12/3/24 at 2:45 PM with the facility's Certified Dietary Manager. She stated she conducted an in-service with the kitchen staff following the above incident regarding anything that falls to floor must be discarded.</p> <p>A tour of the facility was conducted on 12/5/24 at 11:06 AM with the facility's Maintenance and Environmental Services Director and the Environmental Services and Laundry Lead. During this tour, the surveyor reviewed the facility's laundry area. Upon entering the dirty side of the laundry room, the surveyor observed numerous pillows in a pile leaning on the top of a floor polishing machine. The Environmental and Laundry Lead stated they had too many pillows at the facility and she had nowhere else to store them. In this same room, observed behind the two washing machines was a large buildup of foreign objects, including gloves, a spray bottle, caps, lint, and debris. The Maintenance Director confirmed he was responsible for cleaning behind the washing machines and the last time he cleaned the area was approximately a month prior.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45951</p> <p>Based on interview and record review, the facility failed to maintain resident's vaccination records, including consents, in an adequate manner for two residents (Resident #66 and 75) of five residents reviewed for vaccination records.</p> <p>Findings included:</p> <p>Review of the facility's policy titled Infection Control Immunizations-Influenza, last revised February 2024, revealed the facility shall provide pertinent information about significant risks and benefits of vaccines to residents in accordance with regulations and a resident's refusal of the vaccine shall be documented on the Informed Consent and placed in the resident's medical record.</p> <p>Review of Resident #66's medical record revealed she was admitted to the facility on [DATE]. Resident #66 signed the Influenza vaccination consent form on 8/10/24, indicating she declined the vaccination. There was no staff member name/title present on the form indicating influenza education was provided by a staff member and there was no response documented on the form indicating Resident #66 was proved a Vaccination Information Sheet.</p> <p>Review of Resident #75's medical record revealed she was originally admitted to the facility on [DATE] and was last readmitted to the facility on [DATE]. Resident #75's electronic medical record Immunization tab indicated she declined the COVID-19 vaccination on 11/22/24, however, there was no consent form present in her record indicating the resident declined the vaccine.</p> <p>An interview was conducted with the facility's Infection Preventionist on 12/5/24 at 10:25 AM. She independently reviewed Resident #66 and Resident #75's medical records and confirmed Resident #66's Influenza consent form should have had a staff signature present. She also confirmed she was unable to find Resident #75's COVID-19 consent form indicating the resident declined the vaccine.</p>		