

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105664	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/19/2024
NAME OF PROVIDER OR SUPPLIER  Gainesville Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  4000 SW 20th Ave Gainesville, FL 32607	

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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49289</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure standards of professional practice were followed for administering tube feedings with the use of a tube feeding pump for 1 of 5 residents, Resident #7.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #7 documented the resident was admitted on [DATE] with diagnoses including cerebral infarction [a stroke], dysphagia [inability or difficulty swallowing], aphasia [inability to speak], and major depressive disorder.</p> <p>Review of the physician's order dated 3/11/2024 for Resident #7 read, Enteral Feeding: Jevity [a calorie dense, fiber-fortified therapeutic nutrition for long or short-term tube feeding] 1.5 65ml [milliliters]/hr [per hour] continuously x [times] 24 hrs [hours] with auto flush of 55ml/hr water x 24 hours.</p> <p>During an observation on 11/18/2024 at 6:32 AM Resident #7 no Enhanced Barrier Precaution (EBP) supplies (gowns) near Resident #7's room in the hallway or inside of Resident #7's room. Resident #7 was lying in bed awake with his feeding tube intact. The feeding tubing was connected to the feeding pump attached to a pole; a container of Jevity was hung on the pole. Resident #7's feeding pump was on, but the feeding was not running, read hold, on the monitor. Observed Staff B, Certified Nursing Assistant (CNA), without wearing a gown or gloves, come to the open door and ask Staff C, Licensed Practical Nurse (LPN) to come to help pull the resident up in bed. Staff B, CNA and Staff C, LPN entered the room, and without performing hand hygiene, or donning a gown and gloves, proceeded to Resident #7's bedside. Without wearing a gown or gloves, Staff C, LPN grabbed the bottom blanket on Resident 7's right side and Staff B, CNA grabbed the bottom blanket on Resident 7's left side and pulled Resident 7's body toward the head of the bed. Without wearing a gown or gloves, Staff C, LPN covered Resident #7 up to his chest with a top blanket and without performing hand hygiene, exited Resident #7's room and proceeded down the hallway to Station 2 nursing station and without performing hand hygiene, picked up some papers. Staff B, CNA, without wearing gloves or a gown, pulled the top blanket up to the resident's chest from the opposite side of the resident's bed. Without wearing a gown or gloves, Staff B, CNA pushed Resident #7's bed back against the wall, locked the bed, and pushed the bedside table across the resident's bed. At 6:35 AM Staff B, CNA, without performing hand hygiene, or wearing gloves or a gown, pushed the start button on the feeding pump and the resident's tube feeding resumed running.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/18/2024 at 6:47 AM Staff B, Certified Nursing Assistant (CNA) stated, I just turned [Resident #7's name] feeding back on. I stopped the feeding from running, before I performed care. I almost forgot to restart [Resident #7's name] feeding. I'm glad I remembered. I always pause the feeding tube pump before I do ADL [Activities of Daily Living] care with the residents on feedings. I re-start the feeding pump when I'm finished. I've been doing that since I started working here. No one told me not to.</p> <p>During an interview on 11/18/2024 at 7:12 AM Staff C, Licensed Practical Nurse (LPN) stated, [Staff B's name] is working with me today, she isn't supposed to touch the feeding tube pump at all. She is not supposed to pause the feeding or re-start the feeding. No CNAs are allowed to do that, only the nurses.</p> <p>During an interview on 11/18/2024 at 1:50 PM the Director of Nursing stated, The CNAs should never touch the feeding pump. They [the CNA] should get the nurse to pause the feeding, and when they [CNAs] are done, get the nurse again to re-start the pump.</p> <p>Review of the policy titled, Enteral Feeding, last reviewed 4/1/2024, read, Intent: It is the policy of the facility to provide adequate nutrition and hydration to ensure that residents attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with State and Federal regulation. Procedure: 7. The Nurse will review the Dietitians' recommendation with the Physician and obtain orders. 8. A Feeding Pump will be utilized for all Enteral Feedings, unless otherwise contraindicated. 10. Prior to the flushing of a feeding tube, the administration of medication via a feeding tube, or the providing of tube feedings, the nurse performing the procedure unsure the proper placement of the feeding tube. 11. Universal precautions and clean technique will be utilized when stopping, starting, flushing, and giving medications through the feeding tube.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49289</b></p> <p>Based on observation, interview, and record review the facility failed to prevent the possible spread of infection when failing to perform hand hygiene or use appropriate personal protective equipment (PPE) when performing care for 2 of 11 residents, Residents #7 and #9 on Enhanced Barrier Precautions.</p> <p>Findings include:</p> <p>1) Review of the medical record for Resident #7 documented the resident was admitted on [DATE] with diagnoses including cerebral infarction [a stroke], dysphagia [inability or difficulty swallowing], aphasia [inability to speak], and major depressive disorder.</p> <p>Review of the physician's order dated 3/11/2024 for Resident #7 read, Enteral Feeding: Jevity [a calorie dense, fiber-fortified therapeutic nutrition for long or short-term tube feeding] 1.5 65ml [milliliters]/hr [per hour] continuously x [times] 24 hrs [hours] with auto flush of 55ml/hr water x 24 hours.</p> <p>Review of the physician's order dated 4/22/2024 for Resident #7 read, Enhanced Barrier Precautions [EBH] due to G-tube [Gastrostomy tube inserted through the belly that brings nutrition directly to the stomach], every shift.</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 - Few</p>	<p>During an observation on 11/18/2024 at 6:32 AM Resident #7 had no EBP supplies (gowns) near Resident #7's room in the hallway or inside of Resident #7's room. Resident #7 was lying in bed awake with his feeding tube intact. The feeding tubing was connected to the feeding pump attached to a pole; a container of Jevity (the name of the calorie-dense, fortified nutritional tube feeding) hung on the pole. Resident #7's feeding pump was on, but the feeding was not running, read hold, on the monitor. Observed Staff B, Certified Nursing Assistant (CNA), without wearing a gown or gloves, come to the open door and ask Staff C, Licensed Practical Nurse (LPN) to come to help pull the resident up in bed. Staff B, CNA and Staff C, LPN entered the room, and without performing hand hygiene, or donning a gown and gloves, proceeded to Resident #7's bedside. Without wearing a gown or gloves, Staff C, LPN grabbed the bottom blanket on Resident 7's right side and Staff B, CNA grabbed the bottom blanket on Resident 7's left side and pulled Resident 7's body toward the head of the bed. Without wearing a gown or gloves, Staff C, LPN covered Resident #7 up to his chest with a top blanket and without performing hand hygiene, exited Resident #7's room and proceeded down the hallway to the Station 2 nursing station and without performing hand hygiene, picked up some papers. Staff B, CNA, without wearing gloves or a gown, pulled the top blanket up to the resident's chest from the opposite side of the resident's bed. Without wearing a gown or gloves, Staff B, CNA pushed Resident #7's bed back against the wall, locked the bed, and pushed the bedside table across the resident's bed. At 6:35 AM Staff B, CNA, without performing hand hygiene, or wearing gloves or a gown, pushed the start button on the feeding pump and the resident's tube feeding resumed running. Without performing hand hygiene Staff B, CNA grabbed the bag of dirty linen from the floor, exited Resident #7's room, proceeded down the hallway, and without performing hand hygiene used her employee badge, and pushed the door open with her bare hands through two secured glass doors to the laundry room. At 6:36 AM Staff B, CNA returned to the 200 Hall and without performing hand hygiene, opened a drawer in the cart containing EBP (gowns and gloves), rearranged the packages of gowns and boxes of gloves and closed the drawer to the cart.</p> <p>During an interview on 11/18/2024 at 6:36 AM Staff C, Licensed Practical Nurse stated, [Resident #7's name] is on tube feedings so he is on Enhanced Barrier Precautions. I didn't put the EBP supply cart outside his room yet. We just moved him from over there [pointing down the 200 Hall to another room with an EBP supply cart outside]. I didn't wash my hands or wear a gown and gloves when I took care of him. I should have washed my hands and put on a gown and gloves before I moved him up in the bed because he has a feeding tube.</p> <p>During an interview on 11/18/2024 at 6:47 AM Staff B, Certified Nursing Assistant stated, I'm supposed to wash my hands before and after I take care of the resident. I didn't wash my hands, and I didn't wear a gown or gloves when I changed him [Resident #7], the bedding, or pulled him up in bed and I should have. He is on Enhanced Barrier Precautions because of his feeding tube.</p> <p>2) Review of the medical record for Resident #9, documented the resident was admitted on [DATE] with diagnoses including neuromuscular dysfunction of the bladder [a condition that occurs when the nerves and muscles that control the bladder don't work together properly] injury of cervical spinal cord [damage to the bundle of nerves in the neck that sends and receives signals from the brain], epilepsy [a disorder in which nerve cell activity in the brain is disturbed, causing seizures], Type 2 Diabetes Mellitus [a long-term condition in which the body has trouble controlling blood sugar and using it for energy], and viral hepatitis B [a serious liver infection caused by the hepatitis B virus.</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 - Few</p>	<p>Review of the physician's order dated 8/20/2024 for Resident #9 read, Foley cath [catheter] (Indwelling) to straight bag drainage, (specify size 16fr [French] and 10cc [cubic centimeters balloon] for diagnosis of urine retention. Check for patency. Every shift.</p> <p>Review of the physician's order dated 9/9/2024 for Resident #9 read, Enhanced Barrier Precautions for Indwelling Cath.</p> <p>During an observation on 11/19/2024 at 11:22 AM there was an Enhanced Barrier Precautions sign posted on Resident #9's door. There was a clear three drawer container outside the door with gowns and gloves visible. Resident #9 was lying in bed and awake. Observed Staff D, Certified Nursing Assistant (CNA) standing to the left side of the resident's bed, wearing gloves only and no gown. Observed Staff E, Occupational Therapist (OT) pushing the Hoyer Lift [a device that helps caregivers safely move patients from one surface to another] down the hall and into Resident 9's room and without performing hand hygiene, donned gloves but no gown. Staff E, OT proceeded to the right side of Resident 9's bed and assisted with positioning Resident #9 to transfer from the bed to the Geri-chair [a large padded chair designed to help patients with limited mobility] positioned at the end of the bed. With gloves but no gown, Staff D, CNA picked up Resident 9's urinary catheter and hung it on the lift, below the bladder, before proceeding with the transfer from the bed to the chair. Without performing hand hygiene or wearing a gown, Staff E, OT and Staff D, CNA lowered Resident #9 to the chair, and Staff E, OT, without wearing a gown, and Staff D, CNA, without wearing a gown, unhooked each side of the lift and removed the transfer blanket from under the resident. Staff D, CNA, without wearing a gown, unhooked the foley catheter bag from the Hoyer Lift and secured the urinary catheter to the side of the resident's chair below the bladder. Staff E, OT removed her gloves and without performing hand hygiene, exited the room and pushed the Hoyer lift down the hallway and parked the device along the wall. Staff E, OT, without performing hand hygiene, then proceeded back down the hallway past Resident #9's room.</p> <p>During an observation on 11/19/2024 at 11:31 AM Staff D, CNA while wearing gloves, but no gown assisted Resident #9 with his personal hygiene and oral care set up. Without wearing a gown, Staff D, CNA placed a hand brace on Resident #9's left hand, gathered Resident #9's toothbrush and placed it in the resident's hand, and applied toothpaste to the toothbrush. Wearing the same pair of gloves, Staff D, CNA gathered some trash in the resident's room and placed it in the trashcan by the door. Without changing her gloves or performing hand hygiene, Staff D, CNA grabbed Resident #9's urinal, containing small drops of yellow liquid in it, and placed the urinal up to Resident 9's mouth so he could spit the toothpaste into the urinal. Resident #9 refused to spit into his urinal, and Staff D, CNA grabbed Resident 9's Styrofoam cup of water for the resident to spit his toothpaste into. At 11:37 AM, while still wearing the same pair of gloves, Staff D, CNA, went into the Resident's bathroom and wet a washcloth, and without wearing a gown, proceeded to help Resident #9 wash his face. At 11:39 AM Resident #9 asked Staff D, CNA to go into his lockbox in his drawer and get him some personal items and cash. Wearing the same pair of gloves, Staff D, CNA retrieved the personal items, opening and closing the residents' nightstand drawers, and brought the items and cash over to Resident #9 and placed the items on his lap. Without wearing a gown, Staff D, CNA then reclined Resident 9's chair, placed a pillow under his feet, and adjusted his clothing. At 11:42 AM Staff D, CNA removed her gloves, and without a gown or performing hand hygiene, pulled up Resident #9's blanket to cover him and wheeled Resident #9 down to the main dining room. Staff D, CNA placed Resident #9's wheelchair at the table he requested and without performing hand hygiene, exited the dining room and proceeded back down the hallway.</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 - Few</p>	<p>During an interview on 11/19/2024 at 11:29 AM Staff E, Occupational Therapist stated, I was wearing gloves. I don't need to wear a gown, I was just transferring the resident, not performing care. I didn't wash my hands. I wash my hands here and there, but truthfully, I'm too busy taking care of the residents, and half the time the hand sanitizers in the hallways aren't working or they put soap in them instead of hand sanitizer. This place is awful about that. If they don't provide hand sanitizer, it's hard to perform hand hygiene like I should.</p> <p>During an observation on 11/19/2024 at 11:30 AM a hand sanitizer dispenser was hung on the wall outside of Resident #9's room. When pressing the hand sanitizer button, hand sanitizer liquid was dispensed. Observed another hand sanitizer dispenser secured on the wall across from Resident #9's room in the 200 Hall to be functioning and when pressing the button, hand sanitizer liquid was dispensed.</p> <p>During an interview on 11/19/2024 at 11:45 AM Staff D, Certified Nursing Assistant (CNA) stated, I did a lot of things I shouldn't have while doing ADL [Activities of Daily Living] care with [Resident #9's name]. I didn't wash my hands before I put on my gloves or after I took them off. I wasn't wearing a gown while performing care and transferring [Resident #9's name] and I should have. I shouldn't have grabbed his dirty urinal to have him spit his toothpaste into. I should have washed my hands and changed my gloves when handling the trash before I did more care with him. I don't know why I did all that, I should have known better. He's on Enhanced Barrier Precautions because he has a foley catheter.</p> <p>During an interview on 11/18/2024 at 1:50 PM the Director of Nursing stated, I expect the staff to wash their hands or use hand sanitizer before and after care of every resident. The staff don't have to wear a gown or gloves for lifting residents up in bed, transferring them, or any of those things when they are on Enhanced Barrier Precautions. They only have to wear a gown and gloves if they are doing things like catheter care or hooking up and unhooking the feeding tube or performing wound care; nothing else is considered high contact.</p> <p>During a follow up interview on 11/19/2024 at 2:02 PM the Director of Nursing (DON) stated, Staff don't have to wear gowns when they are caring for a resident with tube feedings or foley catheters and they only have to wear gloves, not a gown, when changing their linen or transferring residents. Staff would need to wear a gown only if the resident with a foley or feeding tube had an actual infection, MDRO [Multi-Drug-Resistant Organism]. Neither of these residents [Resident #7's name and Resident #9's name] have an actual infection. The DON verified that the EBP policy is to wear appropriate PPE [Personal Protective Equipment] gowns and gloves when performing high-risk activities, including during toileting and incontinence care, changing linens, and transferring residents with urinary catheters, feeding tubes, or when performing wound care. The DON stated, I train the staff to wear gloves and a gown if they are performing direct care of the feeding tube or foley catheter, that's what the policy says. I interpret the policy that gowns are needed if they have an actual infection, as I said yesterday. The DON confirmed that staff should be wearing gloves when handling trash and should be performing hand hygiene before donning gloves and after doffing gloves.</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 - Few</p>	<p>Review of the internet website page titled, U.S. [United States] Centers for Disease Control and Prevention: Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), last updated internet website page last updated 7/4/2024, read, Enhanced Barrier Precautions: Nursing home residents with wounds and indwelling medical devices [for example: urinary catheters and feeding tubes] are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated . Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care: any skin opening requiring a dressing. Reference: <a href="https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html">https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html</a></p> <p>Review of the facility signage from the U.S. Department of Health and Human Services Centers for Disease Control and Prevention, read, STOP: Enhanced Barrier Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities: Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: Central line, urinary catheters, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing.</p> <p>Review of the policy titled, Hand Hygiene, last reviewed 4/1/2024, read, Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applied to all staff working in all locations within the facility. Policy Explanation and Compliance Guidelines: 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. 6. Additional considerations: a. the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves. Hand Hygiene Table: Before applying and after removing personal protective equipment (PPE), including gloves; Before and after handling clean or soiled dressing, linens, etc.; When, during resident care, moving from a contaminated body site to a clean body site.</p> <p>Review of the policy titled, Enhanced Barrier Precautions, last reviewed 4/1/2024 read, Standard: It is the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definition: Enhanced barrier precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. 2. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. C. Ensure access to alcohol-based hand rub in every resident room. 3. High-contact resident care activities include: c. Transferring, d. Providing hygiene, e. Changing linens, f. Changing briefs or assisting with toileting.</p>		