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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145234 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/14/2024 |
| NAME OF PROVIDER OR SUPPLIER Pearl Pavilion | | STREET ADDRESS, CITY, STATE, ZIP CODE 900 South Kiwanis Drive Freeport, IL 61032 | |
| 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 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>41639</p> <p>Based on observation, interview, and record review, the facility failed to provide a homelike environment during dining for 5 of 5 residents (R3, R7, R13, R22, R53) in the sample of 20 and 5 residents outside of the sample (R4, R21, R29, R40, R164).</p> <p>The findings include:</p> <p>On 11/13/24 at 12:10PM, R3, R4, R7, R13, R21, R22, R29, R40, R53 and R164 were being served their noon meal trays in the dining room. V14 and V15 (Certified Nursing Assistants) served all residents their meal on trays and did not remove any items onto the table. R13 stated, It feels like I'm in an institution or still in grade school when they serve our meals on a tray. I don't mind if they bring it to the table on the tray, but they should take everything off the tray and put it on the table to make it feel more like home. We are already stuck in a facility, but it should feel like home, not an institution. R40 and R53 agreed with R13's statement and stated if they had a choice, they wouldn't be served meals on a tray.</p> <p>On 11/14/24 at 10:57AM, V14 stated, We don't take the plates and cups or anything else off the trays at mealtimes. We should but we don't. It would be a more homelike environment if we did that, but we are told we can't do that. Management doesn't allow us to make any of those types of choices.</p> <p>On 11/14/24 at 11:08AM, V1 (Interim Administrator) stated, We were looking at taking the plates, silverware, and cups off the tray at mealtimes with the new dietary manager. We talked about offering the option to the residents, but we haven't implemented anything yet. We just have to figure out a system of how we will do it. It's definitely something we have considered but haven't implemented yet.</p> <p>The facility's policy tilted, Dignity dated 1/23 showed, Each resident will be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 145234 |
| | | If continuation sheet Page 1 of 28 |

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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>31615</p> <p>Based on observation, interview, and record review the facility failed to provide daily dressing changes, assess a resident for a change in condition, and notify the physician and family of a change in condition for 2 of 2 residents (R52 & R23) reviewed for quality of care in the sample of 20.</p> <p>The findings include:</p> <p>1. The Medication Review Report dated 11/13/24 for R52 showed, order date 11/8/24, santyl external ointment. Apply to right ankle topically every day shift every Monday, Wednesday, and Friday for wound care. Clean area with Wound Cleanser, pat dry, apply santyl, cover with ABD (abdominal pad dressing) and secure with kerlix.</p> <p>The Wound Care Physician's Note dated 11/11/24 for R52 showed, arterial wound of the right, medial ankle - full thickness. Wound size (Length x Width x Diameter): 1.9 x 1.0 x 0.3 cm. Dressing treatment plan: Primary Dressing - apply santyl once daily for 30 days. Secondary dressing - gauze roll (kerlix) 3.4 apply once daily for 16 days. Tubigrip apply once daily for 16 days: low pressure. Periwound treatment - skin prep apply once daily for 16 days.</p> <p>The Skin/Wound Note dated 11/11/24 for R52 showed, resident was seen by wound care provider today. Please see MISC (miscellaneous tab in computer charting) for measurements.</p> <p>The TAR (Treatment Administration Record) dated November 2024 for R52 showed a treatment order dated 11/8/24 for santyl external ointment, apply to right ankle topically every day shift every Monday, Wednesday, and Friday for wound care. Clean area with wound cleanser, pat dry, apply santyl, cover with ABD, and secure with kerlix. The order on the TAR was not changed on 11/11/24 to the wound care physicians note and treatment plan dated 11/11/24 to apply santyl once daily for 30 days. Secondary dressing - gauze roll (kerlix) 3.4 apply once daily for 16 days. Tubigrip (tubular dressing) apply once daily for 16 days: low pressure. Periwound treatment - skin prep apply once daily for 16 days. R52's November TAR (Treatment Administration Record) did not show the new orders for daily dressing changes; R52 did not have a daily dressing change completed on 11/12/24. The daily dressing change was completed after notifying the facility's staff about the order error. The November 2024 TAR showed, prior to talking to facility staff on 11/14/24, that a dressing change was not to be done today, only Monday, Wednesday, and Fridays.</p> <p>On 11/14/24 at 9:06 AM, V20 LPN (Licensed Practical Nurse/Wound Nurse) stated, R52 has an arterial wound to her right medial ankle. V20 stated R52 is seen weekly by the wound care physician. V20 stated they get wound care orders from the wound care physician's notes; his notes are uploaded into the computer. V20 read the most recent treatment order from the wound care physician note dated 11/11/24 which stated santyl once daily for 30 days. V20 reviewed R52's November TAR and stated the current order on the TAR was for santyl and a dressing change on Monday, Wednesday, and Friday.</p> <p>On 11/14/24 at 9:11 AM, R52 was laying on her back in bed with her heels on the bed and a white dressing intact to her right ankle.</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>On 11/14/24 at 9:13 AM, V2 DON (Director of Nursing) stated, wound care is provided Monday-Friday by the wound care nurse. The wound care physician comes in once a week on Monday. He writes his orders on the wound care notes that get scanned in. The wound care nurse updates his orders on the TAR (Treatment Administration Record).</p> <p>The Face Sheet dated 11/13/24 for R52 showed diagnoses including dementia, peripheral venous insufficiency, varicose veins, hypertension, morbid obesity, hypothyroidism, delusional disorders, osteoarthritis, acquired club foot, atherosclerosis of native arteries of right leg with ulceration of ankle.</p> <p>The Care Plan dated 9/19/24 for R52 showed, the resident has an alteration in skin integrity and is at risk for additional and/or worsening of skin integrity issues related to: history of venous ulcers, impaired cognition, incontinence of bladder, incontinence of bowel, comorbidities, resistance to wound care. Location: left medial buttock Date initiated 4/22/24. R52 did not have a care plan in place for her vascular wound to her right medial ankle. Resident is a new admission. Date initiated: 11/20/23. Order and give treatments if applicable according to physicians order.</p> <p>The Wound Policy (11/2023) showed, wounds will be treated based on etiology of wound. The goals of wound treatment are to: a. Keep the ulcer bed moist and the surrounding skin dry; b. Protect the ulcer from contamination; and c. Promote healing.</p> <p>2. R23's census report shows she was sent out on 8/6/24 and 10/29/24.</p> <p>R23's progress notes were reviewed and show no nursing notes or assessments for 8/6/24. On 8/5/24 she was seen by the NP (Nurse Practitioner) and 8/9/24 she was readmitted to the facility following a hospitalization for a UTI (Urinary Tract Infection).</p> <p>A nursing note for 10/29/24 by V9 LPN notes R23 was sent to the ER (emergency room) for evaluation, states her vaginal area is on fire and is a 10/10 on pain scale. Called for non-emergency transport and left with paperwork. No assessment or physician/family notifications were noted.</p> <p>On 11/13/24, at 1:38 PM, V9 said any change of condition of a resident is documented in the progress notes, and should include vital signs, what happened and what lead up to the change, and any pertinent information. The note should also include the notification of family, and the MD, and the DON.</p> <p>On 11/14/24 at 9:28 AM V2 said any change of condition should be a narrative in the residents record. It should include the signs and symptoms, vital signs, and when the physician was notified and what the orders were. There should also be documentation of calling the family. This is important to complete so the record reflects what happened to the resident and the next nurse will know what is going on, for continuity of care.</p> <p>The facility's 4/2022 policy for change in condition physician notification overview guidelines documents these guidelines were developed to ensure that: 1. All significant changes in resident status are thoroughly assessed and physician notification is based on assessment findings and is to be documented in the medical record. 2. Medical care non-emergency problems are communicated to the attending physician and family in a timely, concise, and thorough manner. Nursing Documentation A. any calls to and from physician will be documented in the nurse's notes indicating information conveyed and received.</p> <p>(continued on next page)</p> | | |

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| F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | 20042 | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36186</p> <p>Based on observation, interview and record review the facility failed to transfer a resident in a safe manner (R25) and failed to supervise a resident walking unassisted down the hallway and update their care plan after a fall (R52). This applies to two of three residents reviewed for safety/supervision in the sample of 20.</p> <p>The findings include:</p> <p>1. The face sheet for R25 shows she was admitted to the facility with diagnoses to include type 2 Diabetes Mellitus, chronic obstructive pulmonary disease and hypertension. The facility assessment dated [DATE] shows R25 to have moderate cognitive impairment and requires substantial assistance with transferring from bed to chair.</p> <p>On 11/13/24 at 12:02 PM, V14 and V15 both CNA's (Certified Nursing Assistants) were assisting R25 out of bed for lunch. V14 pulled R25 up to a sitting position and applied a gait belt around the waist of R25. V14 and V15 then put their arms under R25's arms and lifted R25 up. R25 was not completely bearing weight and she was lowered back to the bed. V14 told R25 she needed to stand up to get into the wheelchair. V14 and V15 again lifted R25 under her arms and held onto R25's pants and lifted her over to the wheelchair and sat her down. R25 was again not bearing her weight on her legs. Neither V14 or V15 had their hands on the gait belt.</p> <p>On 11/13/24 at 9:24 AM, V14 and V15 said R25 has bad days transferring and they need to try several times to get her to help with the transfer. V14 said she had her hand on the gait belt, but the resident hates the gait belt so much, they just use her pants to hang onto her.</p> <p>On 11/13/24 at 3:20 PM, V2 Director of Nursing said the staff should never lift the residents under their arms, it could cause an injury. V2 said if a resident is having a hard time with a transfer, the therapy staff should be consulted to determine the safest way to transfer the resident.</p> <p>The facility care plan for R25 dated 2/20/23 shows limited to extensive assist with transfers.</p> <p>The facility policy dated 1/1/2024 for gait-transfer belt shows the purpose is to transfer or ambulate an individual with lower extremity weakness safely. 9. the resident is lifted up with use of transfer/gait belt and assisted to chair.</p> <p>20042</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>2. On 11/12/24 at 9:37 AM, R52 walked up the hall from her room to the nurses desk. R52 hunched over at the desk and was holding onto it. R52 stated, Today is just not a good day. Where are those two that sit here. At 9:40 AM, V9 LPN (Licensed Practical Nurse) walked past R52, up to the nurses desk, and started looking through drawers. The surveyor stated to R52 that maybe V9 could help her. V9 looked up and stated, What she needs is her chair. That's what she is looking for. At 9:42 AM, V10 CNA (Certified Nursing Assistant) walked up to the nurses station with maintenance and R52's wheelchair. R52 had a wheelchair with a thick pad on it and anti-tip bars. V10 told R52 this was her chair and had her sit in the wheelchair.</p> <p>On 11/12/24 at 9:48 AM, V10 CNA stated R52 was not supposed to be up walking. V10 stated she put R52 in a brown chair in her room and left the room to help another resident. V10 stated after she left R52, the resident ended up down here (at nurse's desk). V10 stated R52 is impulsive so they try to keep her out in the common area in front of the nurse's station. V10 stated she did not know why R52 has a wheelchair. V10 stated R52 can walk but not on her own safely and is a 1 person assist for walking.</p> <p>On 11/12/24 at 3:28 PM, R52 was walking in front of the elevator in the common area. V11 CNA (Certified Nursing Assistant) was facing in front of R52, holding the resident's hands and walking with her. R52 did not have a gait belt on. R52's wheelchair was across the room next to a table. R52's pants were wet. V11 stated she was off the clock, was coming back up to grab something, and saw R52 walking so she had to grab her. V11 looked at V9 LPN (Licensed Practical Nurse) and asked her to bring R52's wheelchair over to her. V9 stated to just walk R52 to her room. V11 stated she did not have her gait belt on.</p> <p>On 11/13/24 at 2:13 PM, V2 DON (Director of Nursing) stated after a resident falls the care plan has to be updated and a fall risk assessment completed.</p> <p>On 11/13/24 at 2:24 PM, V2 DON reviewed R52's care plan and stated the care plan was not updated after R52's fall on 9/27/24. V2 stated R52 should not be ambulating by herself and should be assisted by staff. A gait belt and walker should be used. R52 should have increased rounding, low bed, call light in reach, educated on the use of the call light and mats next to the bed can be used. V2 stated if staff walk past R52's room and she is trying to get up they will put her out in the common area or an activity. V2 was notified of R52 ambulating from her room to the nurse's station on 11/12/24 at 9:37 AM and stated R52 needed more supervision.</p> <p>The Face Sheet dated 11/14/24 for R52 showed diagnoses including dementia, venous insufficiency, varicose veins, hypertension, morbid, hypothyroidism, delusional disorders, primary osteoarthritis, and acquired left clubfoot.</p> <p>The Progress Note dated 11/11/24 for R52 showed, R52 is alert, disoriented, but can follow simple instructions; able to make needs known. R52 needs extensive assist x 1 for transfers, eating with tray set up help only with supervision, dressing/hygiene with total assist, is occasionally incontinent of urine, and is occasionally incontinent of bowel.</p> <p>R52's Nurse Notes showed on 10/3/24 at 7:58 AM, R52 was found sitting on her buttocks on the window side of her bed facing the foot of the bed. On 9/27/24 at 6:40 AM, R52 was found on the floor between the bedside table and chair. R52 had a 5 cm x 1 cm skin laceration to her left lower extremity.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The Care Plan dated 11/12/24 for R52 showed, R52 is at risk for falls related to dementia, history of falls. Bed in low position while resident is resting in bed - Date Initiated: 10/04/2024. R52's Care plan was not updated after her fall on 9/27/24.</p> <p>The Restorative assessment dated [DATE] for R52 showed, substantial assist of 2; can hardly walk without assistance.</p> <p>The Fall Risk Review for R52 dated 10/11/24 showed a score of 10 - high risk for falls.</p> <p>The MDS (Minimum Data Set) dated 8/7/24 for R52 showed moderate cognitive impairment; walk 10 feet - not attempted due to medical condition or safety concerns; uses wheelchair; substantial/maximal assist for transfers.</p> <p>The facility's Fall Reduction Policy (1/1/24) showed, Prevention and Treatment Guidelines: 1. Any fall risk factors identified by the Fall Risk Assessment, MDS (Minimum Data Set), or other assessment should be reviewed and addressed as determined appropriate through the RAI process, including the resident's care plan. These risk factors include, but are not limited to: a. mental status; b. history of falls in the last 3 months; c. ambulation and elimination status; .e. gait patterns, balance and ambulation ability 12. The care plan should be reviewed after every fall and updated with a new intervention, when applicable.</p> <p>The facility's Fall Prevention Policy (12/2023) showed, Program contents: 10. Care plan incorporates: a. identification of all risk/issue; b. interventions are changed with each fall, as appropriate; and c. preventative measures. Standards: 3. Safety interventions will be implemented for each resident identified at risk. Standard Fall/Safety Precautions for all Residents: 1. All staff will be oriented and trained in Fall Prevention.</p> | | |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>20042</p> <p>Based on observation, interview, and record review the facility failed to provide catheter care daily, change suprapubic catheter dressing change daily and ensure catheter tubing secure device was in place for 1 of 4 residents (R38) reviewed for catheters in the sample of 20.</p> <p>The findings include:</p> <p>On 11/12/24 at 10:21 AM, R38 was sitting in bed, on top of his blankets, with his head of the bed elevated while watching TV. R38 had a thin 4 x 4 with a ragged cut in it that was placed around his suprapubic catheter. The dressing was sticking up and not secured with tape. R38 stated his dressing around the suprapubic catheter was just changed by the nurse before the surveyor entered the room. R38 stated the nurse changes the dressing once a week. R38 pointed to a white paper back next to his bed and stated there are dressings in there for him to put around the catheter himself. R38 stated his catheter tubing gets cleaned once a week. The catheter tubing secure device was sitting in it's package on the table next to his bed. R38 stated he didn't think they put the catheter secure device on because it didn't fit but he didn't know for sure. R38 stated he is okay with having a catheter secure device put on.</p> <p>On 11/13/24 at 10:51 AM, V3 LPN (Licensed Practical Nurse) stated, The catheter tubing secure device is supposed to be on R38's leg. V3 stated the purpose of the catheter tubing secure device is to make the catheter tubing secure and not come out; to prevent tension or problems. V3 stated staff should use a drain sponge around the suprapubic catheter and not a 4 x 4 that is cut because pieces can get in there. V3 stated catheter care should be done at least daily.</p> <p>On 11/13/24 at 11:13 AM, V3 LPN went to check R38's suprapubic catheter and there wasn't a dressing in place. V3 observed the catheter tubing secure device sitting in a package on the table next to his bed and stated it wasn't doing the resident any good sitting there.</p> <p>On 11/13/24 at 2:13 PM, V2 DON (Director of Nursing) stated, the dressing change for the suprapubic catheter dressing change should be done daily, marked off on the TAR (Treatment Administration Record), and should be completed as ordered. V2 stated it is important to secure the catheter in place. V2 stated R38 doesn't refuse the secure catheter device.</p> <p>The Face Sheet dated 11/13/24 for R38 showed diagnoses including type 2 diabetes mellitus, moderate protein-calorie malnutrition, iron deficiency anemia, inflammatory disorders of scrotum, and other obstructive and reflux uropathy.</p> <p>The Medication Review Report dated 11/13/24 for R38 showed, apply gauze and tape to skin at suprapubic catheter every day shift related to retention of urine. Catheter care every shift during routine care every shift for catheter care.</p> <p>The Care Plan dated 9/10/24 for R38 showed, risk for infection or complications related to suprapubic catheter use. Render catheter care every shift.</p> <p>(continued on next page)</p> | | |

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| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615</p> <p>Based on observation, interview and record review the facility failed to ensure dietary interventions were implemented for a resident with weight loss for 1 of 1 residents (R3) reviewed for weight loss in the sample of 20.</p> <p>The findings include:</p> <p>R3's admission record shows she was admitted on [DATE] with multiple diagnoses including paranoid schizophrenia, schizoid personality disorder and mood disorder. The November medication review report shows she has a weekly weight for weight monitoring, super cereal with breakfast for supplement, and a general diet with fortified potatoes with lunch daily.</p> <p>The monthly weight report shows a steady decline in R3's weight from 215.8 pounds in January 2024 to 173.6 in November. A 42 pound weight loss over 11 months.</p> <p>The 11/13/24 nutrition weight review notes R3 trigger for a significant weight loss for 6 months and has supplements ordered including fortified potatoes with lunch, ready care twice daily and supercereal. At the nutrition meeting staff reported R3 spends a lot of time in the dining room- drinking coffee and asking for snacks.</p> <p>R13's resident assessment and care screening of 8/2/24 shows she has severe cognitive impairment. The same assessment documents she is able to feed herself with setup.</p> <p>On 11/12/24 at 12:08 PM, R3 was served her lunch tray and included turkey, sweet potato with gravy, and vegetable. No fortified potatoes were on her tray or offered to her during the lunch meal. The meal tray ticket shows at lunch she is to have ready care shake and fortified potatoes. R3 sat up in her chair and fed herself lunch after the aide set up her tray and opened her milk. She ate approximately 75% of her meal.</p> <p>On 11/12/24 at 12:32, V4 Dietary manager said they do not serve fortified potatoes. V4 said he knows he has residents on the potatoes but he does not make them.</p> <p>On 11/13/24 12:10 PM R3 received a lunch tray with spaghetti with meatball, vegetables, watermelon, and bread. She had no fortified potatoes.</p> <p>On 11/13/24 at 11:51 AM, V16 (Registered Dietician) said the kitchen does have recipes for fortified potatoes and the residents with orders should be getting them. The potatoes are supplements for residents with weight loss.</p> <p>On 11/14/24 at 9:33 AM, V2 DON (Director of Nursing) said she would expect the kitchen to be serving the dietary supplements as ordered. The supplements are ordered based on the dietician's assessment and recommendations for weight loss.</p> <p>(continued on next page)</p> | | |

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| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The facility's 1/2024 policy for weight assessment and interventions documents it is to ensure that resident are monitored for undesirable weight loss or gain so appropriate interventions can be put in place in a timely manner.</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042</p> <p>Based on observation, interview, and record review the facility failed to ensure oxygen equipment was clean, filters were intact, bubblers had fluid, oxygen tubing was not too long or kinked, and changed for 2 of 2 residents (R39 & R22) reviewed for oxygen in the sample of 20.</p> <p>The findings include:</p> <p>On 11/12/24 at 9:30 AM, R39 was sitting up on the side of her bed with oxygen on via nasal canula. R39's oxygen tubing was extremely long, tangled up and kinked in several spots. The oxygen tubing was attached to an oxygen concentrator that had an empty humidification bubbler. The oxygen concentrator was covered in a thick layer of dust. The back of the concentrator where there is grate was occluded by a thick layer of gray-white dust.</p> <p>On 11/12/24 at 9:34 AM, V3 LPN (Licensed Practical Nurse) went into R39's room and stated, they should be checking the oxygen concentrator and cleaning it weekly. Obviously it has not been done. V3 stated the humidification bubbler should be full so the nose doesn't dry out. V3 stated R39's oxygen tubing was too long, shouldn't be tangled or kinked because she wouldn't get oxygen through the tubing.</p> <p>On 11/13/24 at 2:13 PM, V2 DON (Director of Nursing) stated oxygen tubing and humidification bubblers should be changed weekly. V2 stated cleaning of the oxygen concentrators should be done at that time. V2 stated there isn't a regular cleaning schedule of the oxygen concentrators that she is aware of.</p> <p>The Face Sheet dated 11/13/24 for R39 showed medical diagnoses including congestive heart failure, asthma, secondary pulmonary arterial hypertension, deep venous thrombosis, chronic peripheral venous insufficiency, chronic respiratory failure with hypoxia, morbid obesity, localized edema, acute cystitis, and dependence on supplemental oxygen.</p> <p>The Physician Orders dated 11/13/24 for R39 showed, oxygen every shift for monitoring at 2 LPM (liters per minute) continuously per nasal cannula.</p> <p>The Care Plan dated 9/18/24 for R39 showed, Resident displays complications with gas exchange due to chronic respiratory failure and congestive heart failure and receives oxygen. Administer oxygen as ordered per medical doctor.</p> <p>The facility's oxygen Administration and Storage policy (1/1/2022) showed, Purpose: to ensure staff follow safety guidelines and regulation for storage and use of oxygen. Concentrator - residents are to be provided with an oxygen concentrator whenever possible for purpose of maximizing mobility and overall consistency in regulation of oxygen administration. Concentrator filters - filters should be removed and cleaned by rinsing with clear, cool water weekly to maximize flow rate of clean air. Tubing - Oxygen tubing should be of length sufficient to provide the resident with adequate oxygen levels while promoting maximum mobility. Procedure: Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through.</p> <p>(continued on next page)</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>36186</p> <p>2. The facility face sheet for R22 shows he has diagnoses to include chronic respiratory failure, dementia and hypertension. The facility assessment dated [DATE] for R22 shows him to be cognitively intact and is short of breath with all activities and wears oxygen.</p> <p>On 11/12/2024 at 9:46 AM, R22's oxygen tubing was dated 10/4/24 and the concentrator filter was observed on the floor. Later that same morning, the maintenance director was observed vacuuming debris from the oxygen concentrator.</p> <p>On 11/13/24 at 9:20 AM, V13 Maintenance Director said he was replacing the filter to R22's oxygen because it was found on the floor by the staff. V13 said he is told by the staff when a new filter is needed for the oxygen concentrator, and he does not regularly check the concentrators. V13 said he vacuumed the concentrator due to the amount of debris found.</p> <p>On 11/13/2024 at 3:20 PM, V2 Director of Nursing (DON) said the tubing should be changed every week and the filters should be checked every week.</p> <p>The Medication Administration Record (MAR) for November 2024 shows the staff signed out the tubing as being changed on 11/12/24.</p> <p>The Physician Order Sheet (POS) dated November 2024 for R22 shows an order to change the oxygen tubing every Tuesday.</p> <p>The care plan for R22 dated 1/15/19 for oxygen therapy shows oxygen via nasal cannula at 2 liters continuously.</p> <p>The facility policy dated 1/1/2022 for oxygen administration and storage shows the oxygen tubing should be changed weekly. Filters should be removed and cleaned by rinsing with clear, cool water weekly to maximize flow rate of clean air.</p> | | |

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| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615</p> <p>Based on observation, interview and record review the facility failed to have policy and procedures in place for the care of a dialysis resident for 1 of 2 residents (R13) reviewed for dialysis in the sample of 20.</p> <p>The findings include:</p> <p>R13's admission record shows she was admitted on [DATE] with multiple diagnoses including dependence on renal dialysis and end stage renal disease. The 10/11/24 admission assessment of R13 shows she is cognitively intact.</p> <p>The November medication review report shows her dialysis days to be Tuesday, Thursday, and Saturday at a local dialysis center. The orders show she has an access site located in her right arm and the site is to be checked daily for a bruit and thrill (potency). The November MAR (Medication Administration Record) was reviewed and showed no order for the access site assessment for bruit or thrill. R13 did not have a TAR (Treatment Administration Record).</p> <p>R13's diet slip was observed to show an order for a low concentrated sweet diet and no added salt. The slip shows she is to have a lunch bag on her dialysis days. She is to have no tomatoes, does not like potatoes or processed meats. No oranges, orange juice or lemons. No regular milk.</p> <p>On 11/12/24 at 2:49 PM R13 said she should be following a renal diet due to being on dialysis but they still put food on her tray she is not supposed to have such as potatoes and regular milk. She said there is no lactose free milk available or given to her so she just has to go without. R13 said she began dialysis in September of this year, so not very long. When she goes to dialysis they listen to her graft site to make sure it is working right, but the staff in the facility do not listen to it. She said as far as she knew there was no emergency kit or equipment available if she should begin to bleed from her dialysis shunt.</p> <p>On 11/13/24 at 11:17 AM, V7 LPN (Licensed Practical Nurse) said R13 goes out three times a week for dialysis, and the facility does not send any information with her and there is no communication with dialysis. She said sometimes the dialysis center will send a note with R13's vital signs and might have her weight listed. V7 said upon return to the facility R13's site is checked for bleeding and ensure her bandage is intact. V8 RN (Registered Nurse) said there was no communication book or information from R13's dialysis. None had been scanned in or documented in her record. She said no emergency kit was in R13's room for a hemorrhage event. V8 said the nurses should be checking the dialysis shunt at least daily, probably twice daily, for a bruit or thrill to ensure it is patent. She said it would just be good nursing practice. V8 checked the MAR/TAR and said it was not listed as an order and unsure if or when any assessments were being completed for the access site. V8 said labs are done at dialysis and if the facility wanted copies, they could call for them.</p> <p>On 11/13/24 at 11:51 AM, V16 (Registered Dietician) said for renal/dialysis patients it should be noted on the diet slip what items to limit such as bananas, oranges, tomatoes, and potatoes. She should not be served these items and for the regular milk supplement she should be getting lactose free milk. After checking with the kitchen, V16 said the kitchen had no lactose free milk.</p> <p>(continued on next page)</p> | | |

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| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 11/14/24 at 9:20 AM, V2 DON (Director of Nursing) said the nursing staff should be checking R13's dialysis access port at least daily to ensure it is patent. The order should be on the MAR or TAR. She said labs should be exchanged along with the pre and post treatment weights. That information should be in the record for the dietician and physician to review during their visit. She said there is no consistency with the exchange of information with dialysis. V2 said some of the nurses have had training regarding the care and treatment of the dialysis patients, but not all of the nurses are aware of what needs to be done, especially in cases of emergency. V2 said there is no emergency kit in R13's room. She said in case of hemorrhage or bleeding the nurse would have to hold pressure and call for help.</p> <p>On 11/14/24 at 10:04 AM V1 (Interim Administrator) said there is no facility policy and procedures for dialysis.</p> | | |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615</p> <p>Based on observation, interview and record review the facility failed to ensure medications were taken by residents at the time of administration for 2 of 2 residents (R18, R13) reviewed for medications in the sample of 20.</p> <p>The findings include:</p> <p>1. R18's admission record shows she was admitted on [DATE] with multiple diagnoses including osteomyelitis, diabetes, congestive hear failure, pressure ulcers, and gastroparesis. The facility's 8/13/24 resident assessment and care screening for R18 shows she has moderate cognitive impairment with behaviors including rejection of care and verbal behaviors towards others.</p> <p>On 11/12/24 at 9:30 AM, R18 was observed lying on her right side in bed. On the bedside table next to the bed was a medication cup about half full of multiple pills. R18 was alert and was able to speak clearly. She said the nurse had delivered her medications to her this morning, but she was nauseous at the time, so the nurse just left them on the bedside table. R18 said the pills were from 8:00 AM, and could not list any of the medications in the cup.</p> <p>On 11/12/24 at 9:35 AM, V8 RN (Registered Nurse) was given the cup of pills, and she said there was 11 pills present. She said no pills should be left at the bedside, we have to watch the residents take the pills to ensure they have taken all the medication.</p> <p>The November 2024 MAR (Medication Administration Record) for R18 shows multiple morning medications scheduled, including two antibiotics for urinary tract infection, and blood pressure medications.</p> <p>On 11/14/24 at 9:16 AM, V2 DON (Director of Nursing) said the nurse should be making sure R18 takes her medication, and watch her. The staff have found cups of medication in her room before, she is known for keeping them and not taking the pills as ordered.</p> <p>2. On 11/12/24 at 10:39 AM, R13 was not in her room. The bedside table was observed to have a glucometer, a blood pressure cuff and monitor. On the table was a cup with an insulin pen and multiple medication cups stacked inside. Upon looking at the medication cups, 2 long white pills were inside the bottom cup. V7 (Licensed Practical Nurse) said R13 was not a resident who self medicates and did not know where the insulin pen came from. V7 said she did not know what the 2 pills were inside of the cup, but those should not be by the bedside. V7 compared the 2 white pills to R13's prescribed pills and stated they were both Norco (controlled opioid pain medication) tablets.</p> <p>On 11/12/24 at 10:39 AM V8 said R13 was alert and oriented and currently at dialysis. She said R13 should absolutely not have those pills on her bedside table. V8 said R13 must have brought in the insulin pen, the staff did not give one to her, because they only had vials of insulin and not pens. She said the pen did not have any name on it, and did not show a date of when it was initially opened, and it would have to be discarded. V8 said R13 should not have any of those items such as pills and insulin by her bedside.</p> <p>(continued on next page)</p> | | |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 11/12/24 at 2:49 PM R13 said the insulin pen was from home and did not recall when she had opened it. She said she had saved the Norco for when she returned from dialysis.</p> <p>The facility's 3/2024 policy for administering medications documents the purpose is to ensue safe and effective administration of medication in accordance with physician orders and state/federal regulations. 13. Should a medication be withheld or refused. Documentation identifying the explanation of withholding or reason for refusal will be documented in the medical record. Physician will be notified as needed.</p> | | |

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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>41639</p> <p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to administer medications at ordered times. There were 32 opportunities with 2 errors resulting in a 28.5% medication error rate. This applies to 1 of 3 residents (R16) observed in the medication pass.</p> <p>The findings include:</p> <p>R16's physician's orders for November 2024 showed R16 is to receive apixaban 5mg (milligrams) at 9am and 5pm and baclofen 10mg at 9am, 1pm, and 5pm.</p> <p>On 11/12/24 at 10:20AM, V7 (Licensed Practical Nurse) administered R16's apixaban 5mg and baclofen 10mg. (1 hour and 20minutes past the scheduled administration time). V7 stated she is a new nurse and is trying her best to keep up with learning all the residents. V8 (Registered Nurse) was training beside V7 and stated she should have stepped in to help V7, but she was trying to get her to learn her own routine. V7 and V8 both stated medications are to be given within 1 hour before or 1 hour after the scheduled administration time.</p> <p>On 11/14/24 at 10:52AM, V2 (Director of Nursing) stated, All medications should be given within 1 hour before or after the scheduled administration time. We usually do the patient center medication pass times but if they are scheduled then that's how they should be given.</p> <p>The facility's policy titled, Administering Medications dated 3/2024 showed, 6. Medications should be administered within one (1) hour of the prescribed times or according to liberalized medication pass.</p> | | |

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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>41639</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe storage of narcotic medications, failed to ensure medications were stored in their original packaging, and failed to monitor the temperature of a medication refrigerator. This applies to 1 of 2 medication rooms and 1 of 2 medication carts reviewed for medication storage.</p> <p>The findings include:</p> <p>On 11/13/24 at 1:41PM, The facility's medication refrigerator had a temperature log dated April 2024 located on the outside of it. The refrigerator had a lock on it that was not locked and was hanging open. Upon review of the refrigerator, 2 bottles of liquid lorazepam were located inside. V9 (Licensed Practical Nurse) stated, We don't usually have the medication fridge unlocked but we have 2 nurses' up here today and we don't have 2 sets of keys. We are supposed to be checking the medication and resident refrigerator temperature, but it looks like we haven't had it done since April according to the sheet on both refrigerators.</p> <p>On 11/13/24 at 1:52PM, One of the facility's medication carts were reviewed and showed 36 unidentified pills spilled throughout the cart under resident medication cards and bottles. V7 (Licensed Practical Nurse) stated, I'm not sure what all of those pills are but they must have been dropped over time during medication passes or popped out of the medication cards when we were putting them back. We should be checking the cart routinely and disposing of these medications because there are a lot of them.</p> <p>On 11/13/24 at 2:07PM, V1 (Interim Administrator) stated, The medication room and refrigerator should both be locked so that narcotics are double locked to prevent diversion. The nurses should be checking the temperature of the refrigerators every day to ensure the medications are stored under the proper temperatures. If the temperature is out of range, then we need to correct it immediately or we may have to dispose of medications. If a nurse drops a pill during medication administration, I expect them to try to find it but if they are not able to then they can look for it after their medication pass is complete. 36 pills are far too many pills to be floating around the medication cart.</p> <p>The facility's policy titled, Medication Storage dated 11/2023 showed, Purpose: To ensure that medications are stored safely, securely, and properly .5. Medications requiring refrigeration must be stored in the refrigerator located in the drug room at the nurses' station .Proper temperature in the refrigerator must be maintained in accordance with manufacturer specification and national guidelines .9. Medication cart/compartments must always be kept clean.</p> | | |

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| <p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>41639</p> <p>Based on observation, interview, and record review the facility failed to serve the correct menu items for residents receiving a mechanical soft and pureed diet, and failed to provide the correct portion size of food for all residents. These failures have the potential to affect 63 of the 64 residents residing in the facility.</p> <p>The findings include:</p> <p>The facility's resident roster provided on 11/12/24 showed 64 residents residing in the building with 1 resident receiving tube feedings.</p> <p>On 11/12/24 at 9:04AM, V4 (Dietary Manager) stated, For lunch today we are serving oven herb roasted turkey with gravy, baked sweet potato, capri mixed vegetables, and frosted white cake.</p> <p>The facility's daily spreadsheet printed 5/14/24 showed, Oven herb roasted turkey General diet: 2oz Mechanical Soft: #16 scoop Pureed: 2, #24 scoops. Baked sweet potato Mechanical soft: baked sweet potato no skin Pureed #8 scoop pureed baked sweet potato no skin.</p> <p>On 11/12/24 at 11:07 AM, V4 removed the cooked turkey from the oven and began slicing it in random portions. V4 stated they will serve the residents an equal amount of turkey. V4 stated he is unsure of what the portion sizes need to be for the residents.</p> <p>On 11/12/24 at 11:54AM, V6 (Cook) prepared the pureed meals. V6 measured the amount of food prior to pureeing it; however, V6 did not obtain measurements when plating the food prior to meal service. V6 stated she just looks at how much food there is and splits it between the 2 residents that receive pureed food. V6 prepared instant mashed potatoes instead of mashed sweet potatoes for both residents and stated that it was due to time restraints as she did not have time to peel 2 sweet potatoes.</p> <p>On 11/12/24 at 12:16PM, V6 began serving residents their noon meal. V6 used a 3oz scoop for the capri vegetables (recipe shows #8 scoop, 1/2 cup), tongs to serve the random turkey portions, no mechanical soft diets, and the unmeasured pureed diets. All residents on the mechanical soft diet (R4, R12, R19, R22, R23, R24, R28, R40, R41, R45) received mashed potatoes instead of skinned sweet potatoes.</p> <p>On 11/12/24 at 3:06PM, V4 stated, We didn't serve the sweet potatoes for the pureed and mechanical soft because of time constraints. We should have peeled them and served them to them like that, but we didn't want to serve late because state is here. I didn't weigh any of the turkey when I sliced it. I guess I should have so that the residents all got the same amount of food. V6 stated, I just eyeballed the portions for the turkey and the pureed and did not think of the fact that the residents might not be getting the right amount of nutrition.</p> <p>The facility was unable to provide a policy regarding residents receiving the food that is displayed on the menu and portion sizes.</p> | | |

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| <p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>41639</p> <p>Based on observation, interview, and record review, the facility failed to prepare and serve residents a mechanical soft diet. This applies to 3 residents in the sample of 20 (R22, R23, R45) and 7 residents (R4, R12, R19, R24, R28, R40, R41) outside of the sample reviewed for mechanical soft diets.</p> <p>The findings include:</p> <p>The facility's document titled, Diet Type Report printed on 11/12/24 showed R4, R12, R19, R22, R23, R24, R28, R40, R41, and R45 receive mechanical soft diets.</p> <p>The facility's document titled, Recipe preparation: Ground herb roasted turkey with gravy showed, Place portion of prepared turkey in food processor and grind to appropriate consistency. Serve 2oz ground protein portion with #16 scoop. Top with 1oz hot gravy to keep moist.</p> <p>On 11/12/24 at 11:54AM, V6 (cook) stated, I didn't prepare any mechanical soft food because they are getting mashed potatoes and the turkey I will just shred with my hands. The turkey is basically mechanical soft already, it's just not ground up.</p> <p>On 11/12/24 at 12:16PM, V6 served all residents their noon meal. All 10 residents on a mechanical soft diet received turkey chunks with gravy. (V1-Interim Administrator) was notified of residents receiving the incorrect diet and stated the residents could choke if they are given the incorrect diet.</p> <p>On 11/12/24 at 3:04PM, V4 (dietary manager) stated, The residents that receive a mechanical soft diet got turkey that we just shredded by hand because that's easier than having to grind it up and it saved time. I'm not sure how much it would affect the resident if they don't get the right diet. I'm not in the nursing department. Sometimes the residents complain if we give them the ground diet because they don't like it, so we try to give them what they want. I don't know the reason for the ground diets.</p> <p>The facility's undated policy titled, Explanation of Diets: Mechanical soft showed, This consistency modified diet is for individuals with limited or difficulty in chewing regular textured foods .foods should be moist and fork tender. Meat is ground or chopped.</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41639</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper dishwasher sanitizer levels, failed to maintain overall kitchen cleanliness, failed to ensure foods were stored in a manner to prevent pests and rodents, and failed to store bulk dry foods in a manner to prevent cross contamination. These failures have the potential to affect 63 of the 64 residents residing in the building.</p> <p>The findings include:</p> <p>The facility roster printed on 11/12/24 showed 64 total residents in the building with 1 resident receiving tube feedings.</p> <p>On 11/12/24 at 9:04AM, the initial tour of the kitchen showed the following: a bulk sized bag of sugar split open, beef base and chicken base containers with dried substance crusted on top of both lids and sides of containers, scoops located inside of the beef and chicken base, floors underneath the dry storage filled with crumbs and cereal, a bulk bag of pinto beans ripped open, bulk bread crumbs opened, and an opened bag of cheese puffs with a large hole in it. All 3 exposed cooler doors had dried, crusted substances on them. The walk-in freezer had small puddles of dried, melted ice cream.</p> <p>On 11/12/24 at 9:32AM, The dishwasher had a screwdriver, random parts, dust, and crumbs layered across the top. The dish machine operational requirements showed wash and rinse temperature minimum 120 degrees, 50ppm (parts per million) chlorine sanitizer.</p> <p>On 11/12/24 at 9:42AM, Surveyor asked V5 (dietary aide) to check the sanitizer level in the dishwasher while it was running. V5 stated, I don't know what levels you're talking about or how to do that. V5 confirmed her initials were located on the dish machine log check off sheet showing she had checked the sanitizer levels earlier that morning and they were 50ppm. Surveyor then requested V4 (dietary manager) to check the levels and they were below 50ppm. V4 stated he is unsure how V5 could be documenting the correct sanitizer levels if she does not know how to obtain them.</p> <p>An additional tour of the kitchen at 10:30AM showed a container of food thickener opened on the shelf with no lid and sticky on all sides with a scoop inside, a box of ground cinnamon opened with the scoop inside on top of the spice rack and a container of sugar located on the bottom shelf in the meal preparation area opened with a scoop inside.</p> <p>A review of the drawers in the meal preparation area showed all 3 drawers with meal service scoops and ladles laying different directions, upside down and food debris on the scoops and ladles.</p> <p>On 11/12/24 at 3:06PM, V4 accompanied surveyor on a tour of the kitchen. V4 agreed the kitchen was not as clean as it could be and doesn't currently have a set cleaning schedule. Surveyor showed V4 the scoops inside the bulk items as well as many open bags and containers and V4 stated that he doesn't know what the issue is with these items being like this, but open bags does give an opportunity for pests to enter the food.</p> <p>(continued on next page)</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>The facility's policy titled, Food Storage dated 6/24 showed, Purpose: To protect food from contamination, to ensure wholesomeness, and to prevent the spread of infections and communicable disease .2. All food being stored shall be protected against contamination from dust, rodents, and other vemin; unclean utensils and wood surfaces; unnecessary handling, human excretions, flooding, drainage, overhead leakage, and other sources of contamination .5. All stored food products will be covered, identified, and dated .8. Food storage areas will be cleaned in accordance with the cleaning schedule .</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36186</p> <p>Based on observation, interview and record review the facility failed to follow contact isolation precautions as ordered (R214), failed to follow enhanced barrier precautions (R57) and failed to implement enhanced barrier precautions (R38, R52 and R17). This applies to five (R214, R57, R38, R52, and R17) of six residents reviewed for infection control in the sample of 20.</p> <p>The findings include:</p> <p>1. The facility face sheet for R214 shows he was admitted to the facility with a diagnosis of enterocolitis due to clostridium difficile (C-diff) (inflammation of the colon caused by the bacteria C-diff). The Physician Order Sheet (POS) shows an order dated 10/16/2024 to maintain contact precautions for C-diff.</p> <p>On 11/12/2024 at 8:47 AM, at the entrance conference, V2 Director of Nursing (DON) said R214 is on isolation for C-diff.</p> <p>On 11/12/2024 at 10:54 AM, the door leading into R214's room had a sign stating R214 was on enhanced barrier precaution and to see the nurse before entering. The bin for PPE (personal protective equipment) did not have any gowns in it.</p> <p>On 11/12/2024 at 12:45 PM, V20 Restorative CNA (Certified Nurses Assistant) was observed entering and exiting R214's room without any PPE on.</p> <p>On 11/13/2024 at 9:06 AM, V14 and V15 CNA's were observed taking the bedside chair scale into R214's room and were not wearing any PPE. V14 and V15 said R214 is on enhanced barrier precautions only and they do not need to wear PPE if they are not providing any care. V14 said she was told R214 did not have C-diff, that he was fine now.</p> <p>On 11/13/2024 at 1:10 PM, therapy staff were observed entering R214's room and no PPE was put on. The door to R214's room continues to show enhanced barrier precautions and to see the nurse before entering.</p> <p>Throughout the survey numerous staff (nurses, CNA's, therapy staff) were observed entering R214's room and were not applying any PPE. The signage on the door continued to show R214 was on enhanced barrier precautions until the last day of the survey (11/14/2024) when a sign was placed on the door showing contact isolation.</p> <p>On 11/13/2024 at 2:14 PM, V7 LPN (Licensed Practical Nurse) said she was the nurse caring for R214 that day and he was not on contact isolation and to her knowledge he did not have C-diff.</p> <p>The November MAR (medication administration record) shows the facility nurses signing off on the order to maintain contact precautions for C-diff.</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>On 11/13/2024 at 2:05 PM, V1 Administrator said, Yes R214 should be on contact isolation for C-diff. V1 said there was no definitive testing from the hospital to show R214 had C-diff, so the providers at the facility instructed them to continue with contact isolation for C-diff. V1 said the staff should be wearing PPE whenever entering R214's room and there should be signs on the door showing he is on contact isolation.</p> <p>On 11/13/2024 at 3:20 PM, V2 DON said R214 is on contact isolation for C-diff and PPE (gowns and gloves) should be worn by all staff to prevent the spread of C-diff. V2 said when R214 came from the hospital his records did not give a definitive answer to whether he was still positive, so the facility decided to monitor his symptoms and continue the contact isolation. V2 said R214 still has occasional loose stools and is still being treated with antibiotics.</p> <p>The November 2024 POS shows an order for R214 for vancomycin (antibiotic) 500 milligrams every other day until 12/8/2024 for C-diff.</p> <p>The hospital discharge records dated 10/16/2024 shows R214's current active diagnoses to include fecal incontinence and C-diff diarrhea.</p> <p>The facility policy for transmission based precautions with a revision date of 12/2023 shows the purpose is to establish transmission-based precautions for residents who are suspected or confirmed to have communicable infections that can be transmitted to others. For contact precautions it shows prior to entering the isolation room, the staff should apply a gown and gloves. The policy shows to discontinue contact isolation for C-diff when the treatment is completed and when diarrhea has ceased for 72 consecutive hours/stools are formed.</p> <p>2. The facility face sheet for R57 shows he was admitted to the facility with diagnoses to include fracture of the right leg, congestive heart failure and atrial fibrillation. The facility assessment dated [DATE] shows R57 to be cognitively intact and is dependent on staff for his personal care. The same assessment shows R57 to have a urinary drainage catheter.</p> <p>On 11/12/2024 at 10:15 AM, the door into R57's room showed he was on enhanced barrier precautions. V14 and V15 CNA's were observed entering R57's room to empty his urinary drainage bag. V14 emptied the bag and was not wearing a gown.</p> <p>On 11/13/2024 at 9:24 AM, V14 said when providing direct resident care to a resident on enhanced barrier precautions, a gown and gloves should be worn.</p> <p>On 11/13/2024 at 3:20 PM, V2 DON said when a resident is on enhanced barrier precautions, she expects the staff to wear a gown and gloves when proving direct resident care including while emptying a urinary drainage bag.</p> <p>The POS dated November 2024 for R57 shows orders for the care of a urinary drainage catheter.</p> <p>The facility policy for enhanced barrier precautions with a revision date of 8/15/2024 shows the use of gown and gloves during high contact resident care activities including device care or use of an indwelling medical device such as a urinary catheter .</p> <p>20042</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>3. On 11/12/24 at 10:21 AM, R38 was sitting in bed, on top of his blankets, with his head of the bed elevated while watching TV. R38 had a thin 4 x 4 with a ragged cut in it that was placed around his suprapubic catheter. The dressing was sticking up and not secured with tape. R38 stated his dressing around the suprapubic catheter was just changed by the nurse before the surveyor entered the room. R38 stated the nurse changes the dressing once a week. R38 pointed to a white paper back next to his bed and stated there are dressings in there for him to put around the catheter himself. R38 stated his catheter tubing gets cleaned once a week. R38 did not have an enhanced barrier precaution sign on his door or container with PPE (personal protective equipment).</p> <p>On 11/12/24 at 12:30 PM, V11 CNA (Certified Nursing Assistant) stated she did not know what enhanced barrier precautions (EBP) were. After enhanced barrier precautions were explained, V11 stated they did not have any residents with EBP. V11 stated there wasn't any residents on the second floor with any isolation or that needed to have gown and gloves used when providing care.</p> <p>On 11/13/24 at 10:51 AM, V3 LPN (Licensed Practical Nurse/Infection Control Nurse) stated she guessed EBP would be for anyone with wounds, that is compromised, or has a catheter. They would need to have an isolation bin but not full PPE because it is a precautionary thing. Staff would have to wear gloves. V3 stated she was not aware of staff needing to wear a gown. V3 stated staff should wear a gown if they come in contact with anything that is soiled. V3 stated PPE should be worn with catheter care and wound care.</p> <p>The Face Sheet dated 11/13/24 for R38 showed diagnoses including type 2 diabetes mellitus, moderate protein-calorie malnutrition, iron deficiency anemia, inflammatory disorders of scrotum, and other obstructive and reflux uropathy.</p> <p>The Medication Review Report dated 11/13/24 for R38 showed, apply gauze and tape to skin at suprapubic catheter every day shift related to retention of urine. Catheter care every shift during routine care every shift for catheter care.</p> <p>The Care Plan dated 9/10/24 for R38 showed, risk for infection or complications related to suprapubic catheter use. Render catheter care every shift.</p> <p>The facility's Enhanced Barrier Precautions policy (8/15/24) showed, Purpose: Reduce the transmission of novel or targeted multi-drug-resistant organisms (MDRO). Procedure: 1. enhanced Barrier Precautions (EBP) require the use of gown and glove during high contact resident care activities. High- contact resident care activities include: dressing, bathing/showering, transferring, providing hygiene (e.g., brushing teeth, combing hair, shaving), changing linens, changing briefs or assisting with toileting, device care or use of an indwelling medical device, such as: urinary catheter, feeding tube, central line, tracheostomy, or ventilator. Wound care: any skin opening requiring a dressing (focusing on wound at high risk of acquiring an MDRO, such as: pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic wounds such as chronic venous stasis ulcers).</p> <p>4. On 11/12/24 at 12:30 PM, V11 CNA (Certified Nursing Assistant) stated she did not know what enhanced barrier precautions (EBP) were. After enhanced barrier precautions were explained, V11 stated they did not have any residents with EBP. V11 stated there wasn't any residents on the second floor with any isolation or that needed to have gown and gloves used when providing care.</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>On 11/12/24 at 3:30 PM, V11 CNA took R52 to her room after finding the resident ambulating by herself near an elevator in the common area. R52's pants were wet. V11 wore gloves and provided incontinence care for the resident and changed the resident's pants. R52 had a dressing on her right ankle. V11 did not have a gown on with care. R52 did not have an EBP sign on her door or container with PPE outside of her room.</p> <p>On 11/13/24 at 10:37 AM, R52 was on her back in a low bed in her room. R52 had a dressing to her right ankle. There were no EBP signs on her door or container with PPE outside of her door.</p> <p>On 11/13/24 at 10:51 AM, V3 LPN (Licensed Practical Nurse/Infection Control Nurse) stated she guessed EBP would be for anyone with wounds, that is compromised, or has a catheter. They wound need to have an isolation bin but not full PPE because it is a precautionary thing. Staff would have to wear gloves. V3 stated she was not aware of staff needing to wear a gown. V3 stated staff should wear a gown if they come in contact with anything that is soiled. V3 stated PPE should be worn with catheter care and wound care.</p> <p>The Wound Care Physician's Note dated 11/11/24 for R52 showed, arterial wound of the right, medial ankle - full thickness. Wound size (Length x Width x Diameter): 1.9 x 1.0 x 0.3 cm. Dressing treatment plan: Primary Dressing - apply santyl once daily for 30 days. Secondary dressing - gauze roll (kerlix) 3.4 apply once daily for 16 days. Tubigrip apply once daily for 16 days: low pressure. Periwound treatment - skin prep apply once daily for 16 days.</p> <p>The Face Sheet dated 11/14/24 for R52 showed diagnoses including dementia, venous insufficiency, varicose veins, hypertension, morbid, hypothyroidism, delusional disorders, primary osteoarthritis, and acquired left clubfoot.</p> <p>The facility's Enhanced Barrier Precautions policy (8/15/24) showed, Purpose: Reduce the transmission of novel or targeted multi-drug-resistant organisms (MDRO). Procedure: 1. enhanced Barrier Precautions (EBP) require the use of gown and glove during high contact resident care activities. High- contact resident care activities include: dressing, bathing/showering, transferring, providing hygiene (e.g., brushing teeth, combing hair, shaving), changing linens, changing briefs or assisting with toileting, device care or use of an indwelling medical device, such as: urinary catheter, feeding tube, central line, tracheostomy, or ventilator. Wound care: any skin opening requiring a dressing (focusing on wound at high risk of acquiring an MDRO, such as: pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic wounds such as chronic venous stasis ulcers).</p> <p>31615</p> <p>5. R17's November 2024 Medication review report shows she had a gastrostomy tube (feeding tube) and had orders for enhanced barrier precautions.</p> <p>On 11/12/24 and 11/13/24, R17's room was observed to have no signage to indicate EBP were required, and no PPE was available in the hallway. R17 was observed to by lying in bed with a feeding tube infusing from a pump.</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>On 11/13/24 at 1:42 PM, V17 CNA said none of the residents on her floor were on enhanced barrier, and she did not know of enhanced barrier and did not know what she would wear for PPE into a room with EBP. At 1:44 PM, V17 LPN said any resident with wounds, indwelling catheters and feeding tubes should be on EBP status, including R17. She said R17 should have a sign on her door to indicate staff should wear a gown, and gloves when doing care.</p> <p>On 11/14/24 at 9:30 AM, V2 said she was now aware EBP was not in place as ordered for R17, and there should be PPE available and signs for staff to don gowns, gloves and masks before providing care for R17. V2 said anyone with open wounds, ostomies, catheters and feeding tubes should be on EBP. The purpose of the precautions is to protect both staff and residents for infection control purposes.</p> <p>The facility's 11/28/22 policy for enhanced barrier precautions documents the purpose is to reduce the transmission of novel or targeted multi-drug resistant organisms (MDRO). 1. EBP require the use of gown and glove during high contact resident care activities.</p> | | |