

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2024
NAME OF PROVIDER OR SUPPLIER  Timbercreek Rehab & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2220 State Street Pekin, IL 61554	

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>33975</p> <p>Based on interview and record review the facility failed to issue a written Notification of Hospital Transfer upon Discharge for four (R38, R41, R51 and R61) of four Residents reviewed for hospitalization in the sample of 37.</p> <p>Findings include:</p> <p>1.R51's Census List, dated 8/6/24, documents R51's Hospital Unpaid Leave dates of 4/13/24, 5/14/24, 5/18/24, 5/29/24 and 6/8/24.</p> <p>30678</p> <p>2. The local hospital record for R38, document R38 was admitted to the local hospital on 6/4/24 through 6/8/24.</p> <p>The Dietary Progress Note for R38, dated 6/8/24, documents R38 returned to the facility after hospitalization .</p> <p>On 8/7/24 at 12:20 pm, V3 ADON (Assistant Director of Nursing) confirmed R38 had a hospital stay, however, there are no Nursing Progress Notes documenting R38 had a hospitalization .</p> <p>3. On 8/5/24 at 8:25 am, R41 stated he has been in and out of the hospital since his admission to the facility, always comes back, and does not have any complaints.</p> <p>The medical record for R41, documents R41 was sent to the local hospital on 1/8/24, 1/12/24, 3/13/24, 3/30/24, 6/11/24, and 7/30/24. R41 came back and does not have any complaints.</p> <p>33973</p> <p>4. R61's Hospital After Visit Summary, dated 7/23/24, documents R61 returned from a hospital stay in which, A paper copy of the discharge instructions/after visit summary/information was given to the patient (R61) or caregiver.</p> <p>On 8/05/24, at 11:03am, V11 Social Services Worker confirmed that V11 does not give any written notice for reason resident is going out to the hospital to residents' representative.</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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/5/24 at 12:35 pm, V1 (Administrator in Training/AIT) stated, I cannot find a specific policy for handwritten hospital discharge notifications. Also, I cannot locate any written confirmation, for any of the hospitalization transfer/discharge for the last six months for any of our resident's. We just do not have any.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>33973</p> <p>Based on observation, interview and record review, the facility failed to ensure resident Minimum Data Set/MDS Resident Assessments were completed correctly for two (R16 and R17) of two residents in a sample of 37.</p> <p>Findings include:</p> <p>The facility's Comprehensive Care Planning policy, revised 7/20/22, documents, It is the policy of (named facility) to comprehensively assess and periodically reassess each Resident admitted to this facility. The results of this Resident assessment shall serve as the basis for determining each Resident's strengths, needs, goals, life history and preferences to develop a person centered comprehensive plan of care for each Resident that will describe the services that are to be furnished to attain or maintaining the Resident's highest practicable physical, mental, and psychosocial well-being. The Resident Assessment (RAI) shall be the guide utilized for all comprehensive assessments, care area assessments and care planning.</p> <p>1. On 8/4/24, at 10:40am, R17 was in her room with oxygen infusing per nasal cannula.</p> <p>R17's Minimum Data Set/MDS assessments, dated 3/6/24 and 6/6/24, do not indicate R17 uses oxygen.</p> <p>On 8/07/24, 1:22pm V24 MDS Coordinator stated R17 should have oxygen marked on her MDS if she was on it continuously or on it during the past 7 days prior to MDS. V24 confirmed that R17's 3/6/24 and 6/6/24 MDSs do not have oxygen marked. V24 was unable to produce any documentation proving R17 was not using oxygen during the MDS assessment periods.</p> <p>30678</p> <p>2. On 8/4/24 R16's bedroom door held a Contact Isolation sign, PPE (Personal Protective Equipment) bin next to entrance of door, and two barrels in the bathroom marked for linens and garbage. On 8/7/24 V15 LPN (Licensed Practical Nurse) performed wound care to R16's left hip and right buttock wounds.</p> <p>The final laboratory culture for R16, documents a wound culture was obtained from R16's left lateral hip and sent to the facility laboratory on 3/12/24 with final results received on 3/17/24 and positive for Heavy Growth of MRSA (Methicillin-resistant Staphylococcus aureus), Klebsiella Pneumonias, Proteus Mirabilia, Lactose Fermenter, and Bacillus Species.</p> <p>The Physician Orders for R16, document R16 started the antibiotic Doxycycline for MRSA infection of wound on 3/20/24.</p> <p>The 3/19/24 Admission MDS (Minimum Data Set) assessment and the 6/19/24 Quarterly MDS for R16 do not document R16's wound infection.</p> <p>(continued on next page)</p>

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F 0641  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	On 8/5/24 at 8:50 am, R16 stated his wounds were checked when he first came to the facility and showed he had MRSA and has been in contact isolation since the day he came to the facility. R16 stated no one has re-tested his wound so he doesn't know if he still has the infection or not.		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33973</b></p> <p>Based on interview and record review, the facility failed to ensure a PASRR (Preadmission Screening and Resident Review) Level II screening for mental disorder was completed for one (R66) of one resident reviewed for PASRRs in a sample of 37.</p> <p>Findings include:</p> <p>R66's current Face sheet documents an admitted [DATE].</p> <p>R66's Physician Order Sheet/POS, dated 5/8/23, documents diagnoses (including but not limited to) schizoaffective disorder.</p> <p>R66's Notice of PASRR (Preadmission Screening and Resident Review) Level I Screen Outcome, dated 5/1/23, documents PASRR Level I Determination: No Level II Required - Situational Symptoms and Your Level I screen shows low-level behavioral health symptoms which appear to be situational. The nursing facility will watch your symptoms/behaviors to see if they improve or resolve within 30-60 days of this screen. If they do not, a nursing facility staff member must submit another Level I screen to maximus. This is called a status change. The status change will decide if you need a PASRR Level II evaluation for serious mental illness. This screening also documents Mental Health Diagnoses - Check any or all of the following mental health conditions that are diagnosed or suspected for this individual now or in the past: No mental health diagnosis is known or suspected.</p> <p>The facility was unable to produce a PASRR policy.</p> <p>On 8/07/24, at 2:50pm, V12 BOM/Business Office Manager stated V12 is the one who gets the PASRR screenings but does not review them. V12 confirmed that R66 transferred to this facility with her Level I screening, which states that R66 does not have a mental disorder and does not need a Level II. V12 also confirmed that R66 admitted with a diagnosis of schizoaffective disorder and should have had a Level II completed.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>33973</p> <p>Based on observation, interview, and record review the facility failed to ensure resident Baseline Care plan includes oxygen for one (R28) of 19 residents reviewed for Care plans in a sample of 37.</p> <p>Findings include:</p> <p>The facility's Care Plan policy, revised 1/11/23, documents, Purpose: To provide guidance to the facility in developing, implementation and communicating the individualized plan of care of residents.'</p> <p>On 8/4/24, at 6:25 am, R28 was in her room with oxygen infusing per nasal cannula.</p> <p>R28's Nurse's Note, dated 6/26/24, documents R28 arrived at the facility for admission with nasal oxygen via concentrator.</p> <p>R28's current Baseline Care plan does not document oxygen or any cares for oxygen.</p> <p>On 8/07/24, at 1:30pm, V23 Care Plan Coordinator confirmed that R28's Baseline care plan does not have oxygen on it. V23 stated, There is no place to mark it on the sheet. It should have been written in. V23 confirmed at this time that R28 was admitted to the facility with oxygen.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50962</p> <p>Based on observation, interview and record review the facility failed to develop a comprehensive person-centered care plan for eight of 19 residents (R16, R17, R21, R28, R33, R41, R43, R63) reviewed for care plans in the sample of 36.</p> <p>Findings include:</p> <p>The facility's Comprehensive Care Planning policy, revised 7/20/22, documents, It is the policy of (Name of Facility Organization) to comprehensively assess and periodically reassess each Resident admitted to this facility. The results of this Resident assessment shall serve as the basis for determining each Resident's strengths, needs, goals, life history and preferences to develop a person centered comprehensive plan of care for each Resident that will describe the services that are to be furnished to attain or maintaining the Resident's highest practicable physical, mental, and psychosocial well-being .The following procedures shall be utilized in the development and maintenance of care plans: 3.) Components of the CPC (Comprehensive Plan of Care) may include: e.) Care Plan- Plan of care describing a need/problem and indicating approaches/interventions to be instituted to assist the Resident in maintaining/receiving care in relation to the need/problem. A care Plan may or may not specify a goal for the Resident.</p> <p>On 8/6/24 at 11:45 am, V24 MDS (Minimum Data Set) Coordinator stated the paper Care Plans in the resident's chart is the working Care Plan and the most current. Each Department Head and the Nurses are encouraged to update the Care Plans with any new information as it changes and notify V23 CPC (Care Plan Coordinator) if something is new.</p> <p>On 8/6/24 at 12:10 pm, V23 CPC confirmed the paper Care Plans in the Resident charts are the most current Care Plans and stated the Staff are supposed to update them if something comes up or changes and should notify V23 CPC if something is new so that V23 CPC can develop a new Care Plan.</p> <p>1. R63's current physician's orders documents R63 admitted to facility on 7/15/22 and R63 has a diagnosis of Post-Traumatic Stress Disorder (PTSD).</p> <p>R63's Minimum Data Set/MDS assessment dated [DATE] documents that R63 is cognitively intact and documents R63 of an Active Diagnosis of PTSD.</p> <p>On 08/06/24 at 12:01 PM, R63 stated she has PTSD due to being abused by R63's father as a child and loud noises make her anxious and fearful. R63 stated she stays in her room and limits her socialization to Bingo twice a week and smoking as needed. R63 stated she is seen by V10 (Social Service Director) weekly for one to one and sometimes twice weekly and feels it is very helpful. R63 stated that she continues to go to psychiatrist every three months.</p> <p>On 08/07/24 at 01:40 PM, V23 (Licensed Practical Nurse, Care Plan Coordinator) stated V23 is responsible for Care Plans but shares responsibility with each entity such as Social Services, Dietary and Activities. V23 stated if a specific section on the Care Plan is not completed after 14 days that V23 will utilize notes or ask questions to ensure Care Plan are fully completed.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>As of 08/06/24 at 12:43 PM, R63's Care Plan did not contain any documentation related to R63's PTSD diagnosis or triggers.</p> <p>2. R21's current Physician Order dated August 2024 documents R21 with a diagnosis of Heart Failure.</p> <p>R21's Physician Order dated 4/14/24 documents an order for Oxygen 2-4 Liters to keep oxygen saturations greater than 90% (percent).</p> <p>On 08/04/24 at 10:00 AM, R21's room contained an Oxygen concentrator with a nasal cannula attached.</p> <p>As of 8/5/24 at 3:00 PM, R21's current Care Plan did not contain any documentation regarding R21's oxygen use.</p> <p>33973</p> <p>3. On 8/4/24, at 10:40am, R17 was in her room with oxygen infusing per nasal cannula.</p> <p>R17's current Care Plan does not include the use of or cares for oxygen.</p> <p>On 8/07/24, at 1:33pm, V23 Care Plan Coordinator confirmed that R17's Comprehensive care plan should include oxygen.</p> <p>4. The facility's Care Plan policy, revised 1/11/23, documents, Policy Interpretation and Implementation: 1. A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS - Minimum Data Set).</p> <p>On 8/4/24, at 6:25 am, R28 was in her room with oxygen infusing per nasal cannula.</p> <p>R28's medical chart does not include a Comprehensive Care plan.</p> <p>R28's Admission MDS assessment was completed on 7/2/24.</p> <p>On 8/07/24, at 1:26pm, V23 Care Plan Coordinator confirmed R28 should have a completed Comprehensive Care plan. V23 stated, (R28) only has a Baseline Care plan at this time. I try to keep on the MDS (Minimum Data Set) schedule, but our admissions have been heavy, so I am behind.</p> <p>30678</p> <p>5. On 8/4/24 a Contact Precautions sign was posted to R16's bedroom door, PPE (Personal Protective Equipment) at entrance to room, and garbage and linen barrels in R16's room.</p> <p>The facility Laboratory Results for R16 documents a left hip wound culture was obtained on 3/12/24 and final result reported to the facility on [DATE] with Heavy Growth of Klebsiella Pneumonias, Proteus Mirabilis, MRSA, Lactose Fermenter, and Bacillus Species.</p> <p>The current Care Plan for R16, does not document an Infection Care Plan was developed for R16's left hip pressure ulcer wound infection and does not include infection precaution status.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. The Face Sheet for R41, documents R41 with diagnoses: End Stage Renal Disease, Anemia in Chronic Kidney Disease, Acute Kidney Failure and Moderate Protein-Calorie Malnutrition.</p> <p>The current facility Matrix, dated 8/4/24, documents R41 is receiving dialysis services.</p> <p>The current Care Plan for R41 does not include a Dialysis care plan was developed for R41.</p> <p>7. The current Physician Orders Sheet for R33 documents R33 is receiving hospice services from a local Hospice organization.</p> <p>The current facility Matrix, dated 8/4/24, documents R33 is receiving hospice services.</p> <p>The current Care Plan for R33 does not include a Hospice care plan was developed for R33.</p> <p>8. The Weekly Wound Report for R43, dated 7/10/24, documents R43 has an unstageable pressure ulcer to her left buttocks and a stage two pressure ulcer to her right buttock.</p> <p>The current Care Plan for R43 does not include a Pressure Ulcer care plan was developed for R43.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>30678</p> <p>Based on observation, interview, and record review the facility failed to revise resident Care Plans to reflect resident condition for three (R38, R41, and R43) of 19 residents reviewed for Care Planning in the sample of 37.</p> <p>Findings include:</p> <p>The facility's Comprehensive Care Planning policy and procedure, revised 7/20/22, documents It is the policy of (the facility) to comprehensively assess and periodically reassess each Resident admitted to this facility. The CCP (Comprehensive Care Plan) shall be reviewed after each Annual, Significant Change and Quarterly MDS (Minimum Data Set) and revised as necessary to reflect the resident's current medical, nursing, and mental and psychosocial needs as identified by the IDT (Interdisciplinary Team). The Care Plan shall be revised as necessary when the needs/problems and care and services specified in the plan of care no longer reflect those of the Resident.</p> <p>The facility's Resident Weight Monitoring policy and procedure, revised 3/19, documents Significant changes in weights are documented in the care plan with goals and approaches/interventions listed.</p> <p>On 8/6/24 at 11:45 am, V24 MDS (Minimum Data Set) Coordinator stated the paper Care Plans in the resident's chart is the working Care Plan and the most current. Each Department Head and the Nurses are encouraged to update the Care Plans with any new information as it changes.</p> <p>On 8/6/24 at 12:10 pm, V23 CPC (Care Plan Coordinator) confirmed the paper Care Plans in the Resident charts are the most current Care Plans and stated Staff are supposed to update them if something comes up or changes and should notify V23 CPC.</p> <p>1. The current Physician Orders for R38 documents an order dated 7/23/24 to decrease R38's gastrostomy feedings to 60 ml (milliliters) every eight hours three times daily.</p> <p>The Dietary Manager Note, dated 6/8/24, documents R38 returned from the hospital with gastrostomy tube still in place and with a diet order of puree with nectar thick liquids for pleasure feedings.</p> <p>The RD (Registered Dietician) Note, dated 6/25/24, documents R38 receives puree with honey thick liquids for comfort, otherwise nutrition from gastrostomy tube feeding.</p> <p>On 8/04/24 at 10:07 am, R38 was lying in bed with a gastrostomy feeding tube to abdomen.</p> <p>The facility Weight Log, documents: On 06/01/2024, R38 weighed 105.0 lbs. On 08/01/2024, R38 weighed 81.0 pounds which is a -22.86 % Loss.</p> <p>The current Care Plan for R38 was not revised to include R38's pleasure feedings, decrease in gastrostomy feeding or significant weight loss.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>30678</p> <p>Based on observation, interview, and record review the facility failed to assess and monitor pressure ulcers weekly and failed to perform hand hygiene in between glove changes for one (R16) of four residents reviewed for pressure ulcers in the sample of 37.</p> <p>Findings include:</p> <p>The facility's Decubitus Care/Pressure Areas policy and procedure, revised 1/18, documents, It is the policy of this facility to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer. Documentation of the pressure area must occur upon identification and at least once each week on the TAR (treatment administration record) or Wound Documentation Form.</p> <p>The facility's Hand Hygiene policy and procedure, updated 8/14/23, documents, All staff will comply with current CDC (Centers for Disease Control and Prevention) hand hygiene guidelines to reduce the incidence of healthcare associated infections. This policy documents hand washing should occur when hands are visibly soiled or contaminated with blood or other body fluids. After contact with body fluids, excretions, mucous membranes, non-intact skin and wound dressings. Before and after direct resident care. When moving from contaminated body site to clean body site during resident care. After contact with intact skin. After removing gloves. The Indications for Alcohol Based Hand (ABH) Rub include: When hands are not visibly soiled, before and after having direct contact with residents, after contact with a resident's intact skin, after contact with inanimate objects, and after removing gloves.</p> <p>The Cumulative Diagnosis Log for R16, includes diagnoses: Spinal Bifida, Mild Mental Retardation, Chronic Osteomyelitis, Paraplegia, Depression, Neurogenic Bowel, Chronic Obstructive Poly-nephritis, Constipation, Acute Kidney Injury, Obesity, Gastroesophageal Reflux Disease, Obstructive Sleep Apnea, History of Sepsis and UTI (urinary tract infection).</p> <p>The facility Laboratory Results for R16 documents left hip wound culture was obtained on 3/12/24 and final result reported on 3/17/24 with Heavy Growth of Klebsiella Pneumonias, Proteus Mirabilis, MRSA, Lactose Fermenter, and Bacillus Species. This Laboratory form, documents lab was obtained from prior facility and reported to current facility after admission to this facility on 3/17/24. There are no other laboratory reports in R16's medical record indicating R16's wound was recultured or that R16's hip wound does not have any infections.</p> <p>The current Physician Orders for R16, document the following physician orders as: 6/25/24 Weekly Skin Documentation on back of TAR on Wednesday; 8/16/24 Silver CA (calcium) Alginate 4x4 (four by four size) dressing, apply topically to left lateral hip and ABD (abdominal padded dressing), change once daily and as needed; and 8/16/24 Silver CA Alginate 4x4 dressing, apply topically to right buttocks and ABD, change once daily. The date of 8/16/24 is what is documented in the orders, which is a future date.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Timbercreek Rehab & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2220 State Street Pekin, IL 61554	

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The backside of July and August TAR's for R16, do not include wound documentation. The most current Weekly Wound Tracking for R16, dated 7/23/24, documents R16 has a Stage two pressure ulcer to his left lateral hip and a Stage three pressure ulcer to his right buttock with onset date of 6/26/24 for both wounds. The Weekly Wound Tracking for R16, dated June through August, does not include any assessments or measurements of R16's wounds for the week of 7/17/24 or 7/31/24.</p> <p>On 8/4/24 at 7:00 am, 8/5/24 at 8:50 am, and 8/6/24 at 8:15 am, A Contact Isolation Precautions sign was posted to R16's door that documents instructions for those entering R16's room. The Sign read 1. Mask (required) 2. Gloves (Required) Change after contact with infective material. Remove before leaving the room. 3. Gown when entering room. (If at risk for splashing or sprays of body fluids, secretions, or blood or excretions) remove before leaving room. 4. Eye Protection (If involved in procedure or activity that is likely to generate splashes or sprays of blood, body fluids, secretions or excretions.) 5. Equipment (Dedicate the use of non-critical Resident Care equipment to a single resident.) An empty PPE (personal protective equipment) bin was at the entrance of R16's room with a box of gloves on top of the bin. In R16's bathroom there were two barrels; one marked linens and one marked garbage. Neither of the barrels contained soiled gowns, gloves or masks.</p> <p>On 8/5/24 at 8:50 am, R16 stated he came to the facility with pressure ulcers to his right buttock and left lateral hip and the dressings are supposed to be changed every day on day shift but does not always get done when it is supposed to be. R16 stated he tested positive for MRSA (methicillin-resistant staph aureus) in his left lateral hip wound when he first came to the facility and is unsure if he still has an infection because the facility has not retested it. R16 stated he does not think his wounds have been measured weekly.</p> <p>On 8/6/24 at 8:15 am, R16 stated V17 LPN did not do his pressure ulcer dressing changes yesterday and he told V2 DON about it again this morning. R16 stated V17 LPN told him she had one more thing to do and would be in to do the dressing changes but never came back. Instead, the third shift night nurse had to come and wake me up at three something this morning to do the treatment. R16 stated, I am so tired this morning. I don't know why she (V17 LPN) won't do the treatment.</p> <p>On 8/07/24 at 1:40 pm, V15 LPN (Licensed Practical Nurse) and V16 CNA (Certified Nursing Assistant) entered R16's room, applied gloves without performing hand hygiene, and assisted R16 onto his left side. V15 LPN placed the community use wound cleanser and gauze, R16's wound ointments and dressings onto the foot of R16's bed while V16 CNA held R16's position. V15 LPN removed R16's soiled dressing from his right buttock, cleansed R16's right buttock pressure ulcer, changed gloves, applied new treatment and dressing without performing hand hygiene in between glove changes. V15 LPN then removed the soiled dressing from R16's left lateral hip pressure ulcer, changed gloves, cleansed R16's left lateral hip wound, changed gloves, and applied wound treatment and placed dressing over the wound without performing hand hygiene in between glove changes. With same soiled gloved hands V15 LPN proceeded to place community use wound cleanser, remaining gauze and scissors back into the community use treatment cart without cleansing or prior to performing hand hygiene.</p> <p>On 8/7/24 at 1:50 pm, V15 LPN confirmed this is how she generally does dressing changes for the residents.</p> <p>On 8/6/24 at 8:45 am, V2 DON confirmed there are missing wound measurements, and the facility has a new Wound Doctor starting today and V4 Nurse Manager will be doing rounds with him today.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/6/24 at 8:50 am V4 Nurse Manager confirmed R16 has open pressure ulcers and is unsure if all the weekly measurements have been done because she just started as the Nurse Manager on 7/1/24.</p> <p>On 8/7/24 at 2:30 pm, V2 DON confirmed staff should be performing hand hygiene in between glove changes or touching anything soiled.</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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>30678</p> <p>Based on observation, interview, and record review the facility failed to investigate a resident fall and conduct a root cause analysis for one (R48) of two residents reviewed for falls in the sample of 37.</p> <p>Findings include:</p> <p>The facility's Accidents and Incidents policy and procedure, revised 9/6/23, documents, All accidents/incidents involving a resident shall require an incident report. The interdisciplinary team (IDT) will complete an investigation to determine root cause and implement appropriate interventions. It is the responsibility of the DON (Director of Nursing)/Designee to investigate and ensure appropriate completion, notification, and follow-up on all accidents and incidents.</p> <p>The Fall Risk Assessment for R48, dated 6/11/24 and 7/3/24 document R48 with a total score of 21 indicating R48 is a High risk for fall.</p> <p>A Quality Care Reporting Form for R48, dated 7/11/24 at 4:10 am, documents a CNA reported R48 had an alleged fall. This Form does not include any other fall details for R48's alleged fall.</p> <p>The Physician Progress Notes for R48, dated 6/14/24 and 7/30/24 do not document any follow up fall information.</p> <p>On 8/5/24 at 2:00 pm, V2 DON (Director of Nursing) confirmed that this is all the documentation he has for R48's fall.</p> <p>On 8/7/24 at 2:00 pm, V4 Nurse Manager confirmed R48 had a fall on 7/11/24 and was unable to provide any further details or documentation that an investigation was completed for R48's fall.</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>30678</p> <p>Based on observation, interview, and record review the facility failed to ensure Registered Dietician recommendations were communicated to the Physician and failed to document daily weights on the Medication Administration Records for two (R41 and R48) of five residents reviewed for nutrition in the sample of 37.</p> <p>Findings include:</p> <p>The facility's Resident Weight Monitoring policy and procedure, revised 3/19, documents, It is the policy of (the facility) that resident weights are recorded and monitored at least monthly. Monthly weights are obtained by CNA's (Certified Nursing Assistants) or designated staff by the 5th of the month. Monthly weights are entered in the computer in batch by the Dietary Manager, Care Plan Coordinator, or designee. The Food Service Manager and interdisciplinary team review the resident's weights and nutritional status and make recommendations for intervention. The Dietitian shall review and document all significant weight changes along with any recommended nutritional interventions in the dietary progress notes in the medical record monthly. Nursing contacts the physician to convey recommendations from the interdisciplinary team and/or dietitian and obtains any new orders.</p> <p>1. The facility's Monthly Weight Report documents R48 June's weight as 98.0 pounds, does not list a weight for July, and August weight as 80.0 pounds which is an 18.37 percent weight loss for R48.</p> <p>The Dietary Note for R48, dated 6/13/24, by V31 Dietary Manager, documents R48 as new admission to the facility on a regular thin liquid NAS (no added salt) diet. Is 5 feet, 5 inches tall and weighs 98 pounds. R48 is thin upon admission so weight gain is a goal.</p> <p>The RD (Registered Dietician) gave a dietary recommendation for R48, dated 7/23/24 as: Weight is &lt; IBW (below ideal body weight) range at 98# (pounds), NAS diet adequate for needs. Recommend MPS (med pass supplement) for nutrition support and help with weight. Monitor and Refer PRN (as needed). The recommendation is for the MPS 60 ml (milliliters) twice daily. As of 8/7/24, this recommendation has not been signed or dated by V32 (R48's) PCP (Primary Care Physician).</p> <p>The August MAR (Medication Administration Record) does not include a MPS for R48.</p> <p>The Physician Notes for R48, dated 6/14/24 and 7/30/24 do not address R48's diet or weight loss.</p> <p>The POS (Physician Orders Sheet) for R48 for July and August 2024 do not include a Physician Order for R48's NAS diet or a dietary supplement for R48.</p> <p>On 8/7/24 at 2:30 pm, V4 Nurse Manager confirmed R48 has lost 18 pounds since his June admission, the Dietician gave a recommendation in July and the recommendation has not been signed or dated by V32 (R48's) PCP.</p> <p>2. The MAR (Medication Administration Record) for R41, dated 7/1/24 through 7/31/24, documents a Physician Order for R41 as Daily weight d/t (due to) CHF (Congestive Heart Failure). This same MAR does not have daily weights documented for R41.</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 MAR for R41, dated 8/1/24 through 8/31/24, does not document daily weights were obtained for R41.</p> <p>The Monthly Weight log for R41, documents R41's weight range from August 2023 through August 2024 between 135 and 146.</p> <p>On 8/4/24 at 10:18 am, R41 was sitting in recliner with eyes closed. R41 is overly thin and frail in appearance.</p> <p>On 8/5/24 at 8:25 am, R41 stated he eats breakfast before he goes to dialysis, doesn't take any food with him, and eats lunch when he gets back, if he feels like it. R41 stated he only gets weighed at dialysis, on Tuesday, Thursdays, and Saturdays. R41 stated no one at the facility gets his weight, and he is not weighed every day.</p> <p>On 8/7/24 at 10:15 am, V15 LPN (Licensed Practical Nurse) stated if a resident is on a med pass supplement it would be on the MAR (Medication Administration Record), the kitchen brings them to us, and the daily weights are also documented on the MAR. V15 LPN stated there are no residents on the B hall on a daily weight. V15 LPN confirmed R41's MAR documents R41 has an order for daily weights that are not documented on his MAR.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>30678</p> <p>Based on observation, interview, and record review the facility failed to provide gastrostomy feeding per order and provide gastrostomy tube care for one (R43) of two residents reviewed for enteral feedings in the sample of 37.</p> <p>Findings include:</p> <p>The facility's Enteral Feeding policy and procedure, revised 2/08, documents, It is the policy of (the facility) to provide nutrition via Nasogastric or Gastrostomy tubes when ordered by physician. The resident may receive nutrition and hydration either by intermittent, continuous, or bolus feeding into the stomach by means of a tube when the oral route cannot be used.</p> <p>On 8/4/24 at 1:57 pm, An enteral feeding pump was resting in front of R43's bathroom door without a bottle hanging and not running. When writer asked R43 if she had a gastrostomy feeding tube, R43 raised her shirt to reveal a gastrostomy tube in her abdomen. The dressing covering R43's gastrostomy tube was undated and soiled a light tan at the split of the dressing. On this same date and time R43 stated she cannot remember when the dressing was changed last and stated the feeding pump is no longer used. R43 stated she can eat food now.</p> <p>On 8/7/24 at 1:29 pm, V19 LPN (Licensed Practical Nurse) performed gastrostomy tube care for R43. V19 LPN removed R43's soiled dressing, dated 8/5/24 and stated, I didn't get her dressing changed yesterday and I should have. V19 LPN stated R43's G-tube dressing is to be changed daily. V19 LPN also stated R43 has not been getting any feeding or flushes since she (R43) started eating a week or so ago and We are still waiting for the physician to give us clarification as to what to do with R43's g-tube.</p> <p>The RD (Registered Dietician) Progress Note for R43, dated 7/23/24, documents R43 is on TF (tube feeding) for nutritional needs. Receives Jevity 1.5 at 45 ml (milliliters) x (times) 23 hours providing 1035 ml, 1550 calories, 66 grams of protein, and 731 ml of free fluids. R43 does get ahold of food and has Speech therapy evaluation on July 30th. Recommend changing diet to 55 ml x 22 hours for 1210 ml, 1800 calories, 77 grams of protein, and 854 ml of free fluids. 230 ml of water flush four times daily, monitor tolerance of changes. Changes to help support weight/nutritional needs. Refer PRN (as needed).</p> <p>The Dining RD (Registered Dietician) Request for Diet Change for R43, dated 7/23/24, documents recommendation to change Summary: Rec (recommend) change TF (tube feeding) to Jevity 1.5 55 ml (milliliters) x (times) 22 hours, flush 160 ml 4 x/day. Provides 1800 calories, 77 grams of Protein, and 854 ml of free fluids. Monitor tolerance of changes. Refer PRN (as needed). Please change diet to: Jevity 1.5 to 55 ml x 22 hours, flush 160 ml 4x day. This recommendation is signed by V30 (R43's) PCP (Primary Care Physician) on 7/26/24.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The July POS for R43 documents: 7/30/24 Diet upgrade to mechanical soft diet with thin liquids and 6/27/24 Jevity 1.5 cal (calories) at 45 ml (milliliters) continuous via G-tube (gastrostomy tube). This POS does not include a physician order for gastrostomy tube water flushes or to discontinue to R43's gastrostomy feedings.</p> <p>The July MAR (Medication Administration Record) for R43, documents R43's gastrostomy feeding tube order as Jevity 1.5 calories via G-tube continuous at 45 ml per hour between July 1 through July 31. There are 62 entries available for documentation with 35 entries left blank, indicating R43 did not receive the scheduled feeding as ordered. The last documented gastrostomy tube feeding R43 received is signed out on 7/27/24. This MAR box has three lines through it and documents D/C (discontinued). There is not date indicating when this order was discontinued and was not previously documented as 55 ml per hour x 22 hours. There is no documented gastrostomy tube water flush on this July MAR.</p> <p>The July TAR (Treatment Administration Record) for R43, dated 7/1/24 through 7/31/24 documents gastrostomy tube cares to be done every shift, to cleanse and apply a splint sponge after cleansing. This TAR has 39 blank entries of the 62 available entries, indicating that R43 did not receive gastrostomy feeding tube cares.</p> <p>The August POS (Physician Order Sheet) for R43, does not include any gastrostomy tube feedings, flushes, or cares and no Physician Orders to discontinue R43's gastrostomy tube.</p> <p>The QA (Quality Assurance) Note for R43, dated 7/29/24 documents: Team reviewed R43's G-tube related to broken jaw. R43 currently receiving Jevity 1.2 kcal @ 55ml/hr. x 22 hours daily. R43 has no complaints of pain or discomfort and no signs or symptoms of infection. R43 caloric needs are being met as evidenced by weight maintenance and healing wounds. Awaiting swallow study to discontinue G-tube. Will continue to monitor and provide cares per orders.</p> <p>The Physician Telephone Order for R43, dated 7/7/24, documents Speech therapy to evaluate and treat to upgrade diet.</p> <p>The Dietary Note for R43, dated 7/30/23 at 8:45 am documented by V31 Dietary Manager documents: Resident (R43) upgraded to mechanical soft, thin liquids. D/C G-tube per Speech (therapist). Will continue to monitor.</p> <p>The Progress Notes for R43, dated 7/30/24, documents, Diet upgrade to mechanical soft with thin liquids with doctor office contacted in regards to G-tube clarifications and awaiting return phone call.</p> <p>On 8/6/24 at 8:52 am, V4 Nurse Manager confirmed there is no Physician Order for R43's gastrostomy tube feedings to be discontinued.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>33973</p> <p>Based on observation, interview, and record review the facility failed to ensure physician orders were obtained, oxygen tubing and humidifier bottles were changed routinely and dated, oxygen signs were posted, and oxygen cylinders were stored safely for seven (R17, R28, R33, R38, R41, R48, R51) of seven residents reviewed for oxygen in a sample of 37.</p> <p>Findings include:</p> <p>The facility's Oxygen Storage and Assembly policy, revised 01/02, documents, Policy: To properly store and assemble oxygen tanks and accessories in a safe and correct manner. This policy also states Safety and Storage of Oxygen Tanks: 1. Store tanks in a cool place away from a source of heat. 2. A chain, on a care or on a stand must secure tanks .5. Post oxygen safety warning sign outside the room where oxygen is stored or is in use.</p> <p>The facility's Oxygen Therapy policy, revised 8/03, documents, Note: Oxygen therapy may be used provided there is a written order by the physician. The order must state liter flow per minute, mask or cannula, time frame. On an emergency basis, oxygen may be administered until the physician is notified. Procedure: 1. Verify physician's order .12. Place oxygen sign on door to resident's room .13. Change oxygen tubing/mask/cannula/and/or tracheostomy mask on a weekly basis .Date tubing changes and document on the treatment sheet. 14. If humidification is indicated, date prefilled bottles when changed.</p> <p>On 8/6/24, at 11:22am, V2 Director of Nursing/DON stated, Oxygen tanks are kept in an outdoor storage shed outside in the parking lot if not in a resident room. They are only to be in a resident's room if they are in the oxygen tank holder on the back of their wheelchair and they go out of their room a lot. It (oxygen cylinder) should not be free standing alone on the floor of a resident's room. I don't want it to be free standing anywhere. It should be treated like a medication and behind a locked door.</p> <p>On 8/07/24, at 1:42pm, V2 DON/Director of Nursing stated that they should be changing out oxygen tubing and humidifiers every Sunday and date them. If a resident is on routine oxygen (prn or continuous) then they need a physician order.</p> <p>1. On 8/4/24, at 10:40 am, R17 sat in a wheelchair in her room with oxygen infusing per nasal cannula via oxygen concentrator. R17's oxygen tubing and humidifier bottle are dated 7/14/24. A free standing oxygen cylinder tank is on the floor behind R17's wheelchair.</p> <p>On 8/5/24 at 7:52am and 8/6/24 at 10:50am, R17 sat in a wheelchair in her room with oxygen infusing per nasal cannula via oxygen concentrator. A free standing oxygen tank is on the floor behind R17 against a back wall.</p> <p>R17's July and August Physician Order Sheets do not document any physician orders for oxygen use.</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 - Some</p>	<p>2. On 8/4/24 at 6:25 am, 8/5/24 at 7:50am, and 8/6/24, at 11:20am, R28 was in her room with oxygen infusing per nasal cannula. R28's door does not have any oxygen in use signage. R28's oxygen tubing and humidifier bottle are not dated.</p> <p>R28's current POS/Physician Order Sheet does not document an order for oxygen.</p> <p>30678</p> <p>3. On 8/4/24 at 7:00 am, R41's room contained an oxygen cylinder tank, free standing on the floor, that was not secured in a cart or holder. R41's oxygen concentrator was running at the rate of 2 liters and the humidifier bottle and oxygen tubing were dated 7/22/24.</p> <p>On 8/5/24 at 8:25 am, R41 sat in a recliner chair with an oxygen cylinder tank free standing next to the wall, not secured in a cart or holder.</p> <p>The August Physician Orders for R41, do not include a Physician order for the administration of oxygen.</p> <p>4. On 8/4/24 at 7:25 am, R33 was lying in bed with oxygen concentrator infusing at 3.5 liters via nasal canula. The humidifier bottle was empty, and the bottle and oxygen tubing were undated.</p> <p>On 8/5/24 at 8:35 am, an oxygen cylinder tank was free standing on the floor in R33's room and not secured in a cart or holder.</p> <p>The August Physician Orders for R33 do not include a Physician Order for the administration of Oxygen.</p> <p>5. On 8/4/24 at 10:04 am, R48 was sitting in recliner chair with oxygen concentrator infusing at 4 liters per nasal canula. The humidifier bottle was empty, and the bottle and tubing were dated 7/21/24.</p> <p>The August POS for R48 does not include a Physician order for administration of Oxygen.</p> <p>6. On 8/4/24 at 10:07 am, R38 was lying in bed with oxygen concentrator next to his bed. The oxygen bottle and tubing were dated 7/21/24.</p> <p>On 8/5/24 at 9:14 am, R38 was lying in bed and oxygen bottle and tubing remained dated 7/21/24.</p> <p>The August Physician Orders do not include an order for the administration of oxygen.</p> <p>33975</p> <p>7. On 8/4/24 at 9:40 am and 8/5/24 at 8:23 am, R51 was lying in bed with oxygen tubing attached to R51's nares and oxygen concentrator setting on 2.5 liters. The oxygen tubing was not dated, was laying on the floor and a humidification bottle was not attached to the oxygen concentrator.</p> <p>R51's current Care Plan documents that R51 has an order for oxygen therapy related to Chronic Obstructive Pulmonary Disease, Shortness of Breath and Hypoxemia.</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 - Some</p>	<p>R51's Physician Order Sheet, 8/2024, does not document R51's Oxygen Therapy orders or cares.</p> <p>On 8/5/24 at 11:10 am, V2 (Director of Nursing/DON) stated, 'The staff should be dating the oxygen tubing when they are changing the tubing.'</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>33973</p> <p>Based on interview and record review, the facility failed to ensure medications were not left at residents' bedside for one (R17) of 19 residents reviewed for medication storage in a sample of 37.</p> <p>Findings include:</p> <p>The facility's Medication Administration policy, revised 11/18/17, documents, 14. Observe the resident consume the medication to insure resident swallows medication. Never leave prepared medications unattended. No medications should be left at bedside unless specifically ordered by the physician and then only in limited amounts as described by the physician.</p> <p>On 8/4/24, at 10:40 am, R17 was lying in bed with R17's pharmacy labeled Stiolto Inhaler and Ipratropium Nasal 0.06% spray resting on overbed table. At this time R17 stated, I can do my own inhalers. They just leave them here for me.</p> <p>R17's August 2024 POS/Physician Order Sheet documents orders for Ipratropium 0.06% Nasal for Atrovent Nasal Spray and Stiolto 2.5-2.5mcg/act (micrograms/activation) inhaler.</p> <p>R17's August 2024 POS/Physician Order Sheet does not include any order that allows R17 to keep any medications at the bedside.</p> <p>On 8/06/24, at 2:43pm, V25 Licensed Practical Nurse/LPN stated, (R17) is allowed to keep nasal spray and her inhaler at her bedside since she's always used them on her own. It started a couple of weeks ago when I was told in report. There should be a doctor order for it. At this time V25 looked in R17's clinical chart and did not find an order for R17's medications to be left at the bedside.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>30722</p> <p>Based on observation, record review and interview the facility failed to ensure enhanced barrier precautions and/or contact precautions were in place for six (R5, R8, R13, R16, R38, R43) of six residents reviewed for Infection Control) in the sample of 37. This failure has the potential to affect all 90 residents who currently reside in the facility.</p> <p>Findings include:</p> <p>Facility Contact Precaution policy reviewed on 04/03/23 documents, In addition to Standard Precautions, use Contact Precautions or the equivalent for specified residents known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the resident (hand or skin to skin contact that occurs when performing resident care activities that require touching the residents dry skin) or indirect contact (touching with environmental surfaces or resident care items in the residents environment). This policy also documents gowns and gloves should be used when entering resident rooms.</p> <p>Enhanced Barrier Precautions policy dated 07/13/23 documents, Purpose: To reduce transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) should be used when contact precautions do not apply, for residents with any of the following: Open wounds that require a dressing change, indwelling medical devices, infection or colonized with MDRO (Multi drug resistant organism). The EBP Policy continues, Enhance Barrier Precautions require use of a gown and gloves during high-contact resident care activities that provide opportunities for the transfer of MDRO's to staff hands and clothing. EBP is primarily intended to use for care that occurs within a resident room, when high-contact resident care activities are bundled together. High contact care activities are listed as: dressing, bathing or showering, transfers (when bundled with other high-contact resident care activities), hygiene changing linens, changing briefs or toileting, caring for medical devices (central lines, urinary catheters, feeding tubes, tracheotomies, drainage tubes, ports), wound care (pressure ulcers, diabetic ulcers, unhealed surgical wounds, chronic venous stasis wounds, skilled therapies.</p> <p>The Centers for Disease Control and Prevention Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007) documents multi-drug-resistant organisms, infection or colonization, (including ESBL (Extended Spectrum Beta-Lactamase) require contact and standard precautions.</p> <p>1. R13's urine culture dated 7/17/24 documents a culture result of ESBL.</p> <p>R13's Nurses Note dated 7/24/24 documents, Cath (indwelling catheter) is patent and draining dark yellow urine. Resident in ISO (isolation) d/t (due to) ESBL.</p> <p>On 08/24/24 at 9:39 am R13's room was observed to have a small bin in the hallway outside of R13's door which held disposable gowns. There was no sign posted on R13's door. R13 had two large barrels inside of the room, one with a red bag containing trash and one with a clear bag containing soiled laundry. There were no disposable gowns noted in the trash barrel.</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 - Many</p>	<p>On 08/04/24 at 10:11 am V21 CNA (Certified Nursing Assistant) and V22 CNA were observed providing R13's catheter care. V21 and V22 donned only gloves, no gowns were donned. V21 was asked why the two barrels are in R13's room. V21 stated, because of her urine. V21 and V22 were asked if either typically wore gowns while giving catheter care to R13 or anyone who has a catheter. Both V21 and V22 stated, No. V21 and V22 both reported they were not told to and there is no sign on the door indicating R13 is in isolation or to use precautions. V21 stated she just recently returned to this hallway as she is assigned throughout the facility depending on needs.</p> <p>On 8/7/24 at 12:15 pm, V2 DON (Director of Nursing) confirmed that anyone with EBSL should be on contact precautions. V1 stated he noted R13 did not have a contact isolation precaution sign during walk through this morning.</p> <p>2. R8's Physician Order Sheet signed on 07/29/24 documents a handwritten entry, 07/30/24 coccyx (wound) - cleanse, apply oil emulsion and border gauze dressing every 6 days.</p> <p>R8's Wound Assessment and Plan dated 08/06/24 documents R6 has a 3 centimeter (length) by 1.2 (width) centimeter by 0.2 centimeter (depth) stage 3 (full thickness, depth to subcutaneous tissue) pressure ulcer. The date of wound onset is 06/26/24.</p> <p>On 08/04/24 at 9:33 am, R8's room was observed. R8 had a private room with no personal protective equipment (PPE) was noted inside or outside of R8's room with the exception of disposable gloves. There was no PPE noted in R8's trash cans.</p> <p>On 08/05/24 at 1:18 pm, V21 and V22 CNA's assisted R8 from her wheelchair to bed using a mechanical lift. V21 and V22 placed R8 on a bedpan donning only gloves. V21 and V22 did not wear gowns.</p> <p>On 08/05/24 at 1:25 pm, V4 Nurse Manager/Infection Preventionist assisted R8 in rolling over, pulling back incontinence brief and observe R8's wound. V4 donned only gloves but did not don a gown.</p> <p>33975</p> <p>3. On 8/4/24 at 10:50 am and 8/5/24 at 6:55 am, R5 was lying in bed, with an indwelling urinary catheter bag draining clear yellow urine.</p> <p>R5's current Care Plan documents that R5 has an Indwelling Urinary Catheter to be changed monthly/as needed and provide catheter care/flush every shift.</p> <p>R5's Physician Order Sheet, 8/2024, does not document R5's Indwelling Urinary Catheter orders or cares.</p> <p>R5's entrance door did not have a sign for Enhanced Barrier Precautions.</p> <p>30678</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 - Many</p>	<p>4. On 8/4/24 at 7:00 am a Contact Precautions sign hung on R16's door that documents instructions for those entering R16's room. The Sign read 1. Mask (required) 2. Gloves (Required) Change after contact with infective material. Remove before leaving the room. 3. Gown when entering room. (If at risk for splashing or sprays of body fluids, secretions, or blood or excretions) remove before leaving room. 4. Eye Protection (If involved in procedure or activity that is likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.) 5. Equipment (Dedicate the use of non-critical Resident Care equipment to a single resident.) An empty Isolation PPE bin sat at the entrance of R16's room with a box of gloves on the top of it. The hand sanitizer dispenser in the hallway, near R16's room was empty.</p> <p>The Cumulative Diagnosis Log for R16 includes the following diagnoses: Spinal Bifida, Mild Mental Retardation, Chronic Osteomyelitis, Paraplegia, Depression, Neurogenic Bowel, Chronic Obstructive pyelonephritis, Constipation, Acute Kidney Injury, Obesity, Gastroesophageal Reflex Disease, Obstructive Sleep Apnea, History of Sepsis and Urinary Tract Infection.</p> <p>The current Physician Order Sheet for R16 does not include Physician Orders for Contact Precautions or Enhanced Barrier Precautions (EBP).</p> <p>The current Treatment Administration Record, and current Care Plan for R16, document R16 receives: Pressure ulcer treatments to his left lateral hip and right buttock; Suprapubic Catheter care; and Colostomy care. There is no Physician order for R16 to be in Contact Isolation or Enhanced Barrier Precautions.</p> <p>The Laboratory sheet for R16, documents a left hip wound culture was obtained on 3/12/24 with final results reported on 3/17/24 as: Heavy Growth of Klebsiella Pneumoniae, Proteus Mirabilis, MRSA (Methicillin Resistant Staphylococcus Aureus), Lactose Fermenter, and Bacillus Species. This same laboratory sheet has a had written physician order on the bottom for Doxycycline 100 mg (milligrams) BID (twice daily) for 12 days. There are no other culture or laboratory test results in R16's medical record indicating that R16 no longer has MRSA or other infections in his left hip wound.</p> <p>On 8/5/24 at 8:50 am, an empty Isolation bin sat at the entrance of R16's room with a box of gloves on top of it. R16's bathroom contained two isolation barrels; One marked for garbage and the other for linens. During these same dates and times there were no isolation gowns, masks, or gloves inside the isolation barrels. There were a few blue gloves in the small garbage can in R16's room. R16's bathroom soap dispenser was lying broken on R16's bathroom floor and there were no other soap products or hand sanitizer in R16's bathroom or in his bedroom. The hand sanitizer dispenser in the hallway was empty.</p> <p>On 8/5/24 at 8:50 am, R16 stated he has a supra pubic urinary catheter, a colostomy, and pressure ulcers on his buttock. R16 stated his wounds were checked when he first came to the facility, and he had MRSA in them. R16 stated I don't know if I still have it. They have not tested them since. R16 stated the Isolation sign has been on his door since the day he came to the facility. R16 stated a wound culture was done when he first came to the facility and showed he had MRSA, and he has been in isolation ever since. R16 stated no one has ever recultured his wound so he doesn't know if he still has MRSA or not. R16 stated the staff have not and do not wear any of that (PPE) other than gloves when they do his pressure ulcer treatment, or when they provide cares for his suprapubic urinary catheter or colostomy.</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 - Many</p>	<p>On 8/6/24 at 8:15 am, the Contact Precautions sign remained on R16's bedroom door with isolation bin at the entrance. V33 CNA (Certified Nursing Assistant) and V2 DON were in R16's room without gowns, gloves, or masks on as per Contact Precaution signage. V33 CNA exited R16's room without performing hand hygiene. V2 DON then exited R16's room without performing hand hygiene. The isolation barrels in R16's bathroom did not contain isolation gowns, masks or gloves. R16 stated the staff do not wear that (PPE-gowns, gloves or mask) in here. The broken soap dispenser was no longer on the bathroom floor and there was no soap or paper towels in R16's bathroom.</p> <p>On 8/6/24 at 8:45 am, V2 DON (Director of Nursing) confirmed R16 had a Contact Precaution sign to his door with an empty bin of PPE. V2 stated anyone that has MRSA should be in contact isolation precautions and stated he does not know why the Contact Precaution sign was on R16's door. V2 DON stated V4 Nurse Manager does all the wound and infection tracking and all of the staff education for the facility.</p> <p>On 8/6/24 at 8:50 am, V4 Nurse Manager stated R16 had MRSA when he first came and was treated with antibiotics so R16 will not need to be re-tested for MRSA and does not need to be in isolation. V4 Nurse Manager confirmed R16 has open pressure ulcers, a suprapubic urinary catheter and colostomy. V4 also stated she does not know if R16 needs to be in EBP because she does not know what the policy says and will have to check.</p> <p>On 8/7/24 at 1:40 pm, there is no longer a Contact Precautions sign and no Enhanced Barrier Precaution sign on R16's bedroom door. The PPE bin remains outside at the entrance to R16's room with gowns, gloves, and masks in it at this time. There remains two barrels in R16's bathroom, marked linens and garbage and there are no isolation gowns, masks, or gloves inside the barrels. There are a few pairs of blue gloves in the small garbage can in R16's room. During this same time V15 LPN (Licensed Practical Nurse) and V16 CNA entered R16's room to do wound care without performing hand hygiene or applying gown, mask, or gloves. V15 LPN rolled the community use treatment cart into R16's room, opened the drawer and pulled out the community use wound cleanser and gauze pads and placed them on R16's bed. During wound care V15 LPN did not perform hand hygiene in between glove changes, and with soiled gloves picked up community use wound cleanser and unused gauze and placed them back into the treatment cart. V15 LPN then entered R16's bathroom, turned on the water, looked around for soap, unable to locate ran her hands under the sink faucet, rinsing with water. V15 LPN then exited R16's bathroom and asked V16 CNA to go find paper towels for her. V15 LPN then dried her hands. When writer asked her if there was soap in the bathroom, V15 LPN stated No, just water. V15 LPN then asked V16 CNA to go find soap for her. V15 LPN re-entered the bathroom and washed her hands with soap. V15 LPN confirmed she usually does the treatments this way.</p> <p>On 8/7/24 at 2:00 pm, V16 CNA provided supra pubic urinary catheter care for R16, changed gloves when going from soiled to clean but did not perform hand hygiene in between glove changes. V16 CNA confirmed she does not wear gowns or masks during the resident cares unless she is told to.</p> <p>5. On 8/4/24 at 1:57 pm, an enteral feeding pump was in R43's room, was shut off and not infusing. No Contact or Enhanced Barrier Precaution signage was in place on or near R43's door. When writer asked R43 if she had a gastrostomy feeding tube, R43 raised her shirt revealing a gastrostomy tube in her abdomen. R43 stated the Nurses change her dressing and wear gloves, but has not seen anyone in her room wearing a gown or mask.</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 - Many</p>	<p>The current Physician Order Sheet for R43, documents R43 to receive feeding at 45 ml (milliliters) an hour continuously via gastrostomy tube. As of 8/7/24 at 10:00 am, there is currently no Physician order to discontinue the feeding. There is no Physician Order for Enhanced Barrier Precautions.</p> <p>The current Treatment Administration Record for R43, documents a Physician order for G-tube (gastrostomy tube) cares every shift, apply new split sponge after cleansing.</p> <p>On 8/7/24 at 1:29 pm, V19 LPN entered R43's bedroom. V19 performed gastrostomy tube dressing change for R43 with gloves only and without a gown or mask on. V19 LPN confirmed R43 was not in any type of precautionary room and no isolation.</p> <p>6. On 8/4/24 at 10:07 am, R38 was lying in bed with urinary catheter in place and a gastrostomy tube. There are no Enhanced Barrier Precautions in place and no signage for R38's room.</p> <p>The current Physician Order Sheet for R38 document R38 receiving routine gastrostomy feedings every eight hours and a water flush every four hours.</p> <p>On 8/7/24 at 12:15 pm V2 DON confirmed he has not seen a policy on enhanced barriers from the new ownership company; however, according to the policy for the previous company, V2 confirmed anyone with a wounds, gastrostomy tube, or indwelling medical device should be on enhanced barrier precautions. V2 confirmed that at the start of the survey on 8/04/24 and through today (8/7/24), there are no enhanced barrier precautions in place for anyone in the facility.</p> <p>The Long Term Care Facility Application for Medicare and Medicaid, CMS (Central Management Services) Form 671, signed and dated on 8/4/24 by V1 AIT (Administrator in Training), documents there are currently 90 residents residing in the facility.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Implement a program that monitors antibiotic use.</p> <p>30722</p> <p>Based on record review and interview the facility failed to monitor active infections in the facility and failed to implement their Antibiotic Stewardship Program. These failures have the potential to affect all 90 residents who currently reside in the facility.</p> <p>Findings include:</p> <p>Facility Antibiotic Stewardship Program dated 11/1/17 documents, Purpose: To improve the use of antibiotics in healthcare to protect residents and reduce the threat of antibiotic resistance through a set of commitments and actions designed to optimize the treatment of infections while reducing adverse events associated with antibiotic use.</p> <p>Infection Control Surveillance and Monitoring policy last reviewed by the facility on 12/7/18 documents, It is the policy of the facility to do routine surveillance and monitoring of the facility to determine if compliance with work practices and care of protective clothing and equipment is maintained. Procedure: Monitoring the effectiveness of the facility work practices and protective equipment will be conducted by the Administrator, ICP (Intervention Control Preventionist) and DON (Director of Nurses). This includes but is not necessarily limited to: a. Surveillance of the facility to ensure that required work practices are observed and that protective clothing and equipment are provided and properly used; b. Investigation of known or suspected parenteral exposure to blood/body fluids to establish the conditions surrounding the exposures; and c. Improvement in training, work practices or protective equipment to prevent recurrence; d. Maintain a procedure of notification to physicians, and IDPH/ Illinois Department of Public Health as required by regulation, of any infection cases. e. Review all policies, procedures, and programs relating to infection control including environmental controls on a yearly basis. 2. Monitoring of the day to day operation of the Infection Control Program will be conducted by the DON.</p> <p>On 08/06/24 at 3:08pm V2 DON stated, I cannot provide antibiotic stewardship logs, I will look for an infection control log.</p> <p>On 08/07/24 at 10:13am V1 AIT (Administrator in Training) stated regarding infection control/antibiotic stewardship tracking, We have a new DON. The other DON is not here for a reason.</p> <p>On 08/07/24 at 1:13pm V2 DON confirmed he could not provide infection control logs for the past 6 months.</p> <p>The Long Term Care Facility Application for Medicare and Medicaid, CMS (Central Management Services) Form 671, signed and dated on 8/4/24 by V1 AIT, documents there are 90 residents currently residing in the facility.</p>		