

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145851	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/02/2024
NAME OF PROVIDER OR SUPPLIER  Eastside Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1400 East Washington Street Pittsfield, IL 62363	

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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33112</p> <p>Based on interview, observation, and record review, the facility failed to provide complete incontinent care to prevent urinary tract infections for 2 of 3 residents (R17, R45) reviewed for incontinent care in the sample of 39.</p> <p>Findings include:</p> <p>1. On 4/30/24 at 11:31 AM, V5, Certified Nurses Aide, (CNA) and V17 CNA, performed incontinent care for R45. V17 removed R45's incontinent brief. The brief was soiled with urine and a small amount of feces. V17 with wet wash cloths and peri-wash cleansed the right and left groin, V17 spread the labia and then with a wash cloth with one finger underneath the cloth wiped the urinary meatus. V17 then dried the areas. R45 was rolled over onto her right side. V17 with 3 wet wash cloths and peri-wash cleansed the rectal area and buttocks. V17 then placed a new incontinent brief and pants on R45. V17 failed to clean the pubic area, thighs, or labia.</p> <p>R45's Admission Information Sheet, undated, documents that R45 was admitted on [DATE].</p> <p>R45's Cumulative Diagnosis Log, undated, documents R45 has diagnoses of Left Side Hemiplegia and Dementia.</p> <p>R45's Minimum Data Set, dated dated [DATE], documents that R45 is severely cognitively impaired, is totally dependent on staff for toileting hygiene, and is always incontinent of bowel and bladder.</p> <p>2. On 04/30/24 at 9:45 AM, V9, CNA and V10, CNA entered R17's room to lay her down and provide incontinent care. R17's pants and incontinent brief was removed. R17's incontinent brief was moderately soiled with urine. V9 with a wet washcloth and peri-wash cleansed the right groin, left groin, and then wiped down the labia and the urinary meatus, flipped the cloth and repeated the process. V9 then wiped again with a wet washcloth. R17 was rolled over onto her right side. V9 wiped the rectal area with a wet washcloth and peri-wash. The washcloth had visible stool on it, with another cloth V9's rectal area was wiped again. The cloth had visible stool on it. R17 was rolled back onto her back. V10 then fastened the incontinent brief. V9 returned to the bedside. V9 and V10 covered R17 and assisted R17 with positioning. V9 failed to cleanse the rectal, buttocks, or the gluteal folds.</p> <p>R17's Profile Sheet, undated, documents that R17 was admitted on [DATE].</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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R17's Cumulative Diagnosis Log, undated, documents that R17 has diagnoses of Dementia and Expressive aphasia.</p> <p>R17's MDS, dated [DATE], documents that R17 is severely cognitively impaired, is totally dependent on staff for toiling hygiene, and is always incontinent of bowel and bladder.</p> <p>On 5/2/24 at 10:35 AM, V9, was questioned why she did not why she did not completely clean R17, V9 stated, I didn't notice any stool on the cloth.</p> <p>On 5/2/24 at 10:47 AM, V2, Director of Nurses, stated, During incontinent care, I expect the groin, pubic area, thighs and labia cleansed with more than just one wipe.</p> <p>The policy Perineal Cleansing, undated, documents, Female Resident. 12. Wash the pubic area including upper inner aspect of both thighs and front portion of perineum. a. Use long strokes from the most anterior down to the base of the labia. b. After each stroke, refold the washcloth to allow use of another area. 13. Follow same procedure for rinsing 14. Dry thoroughly. 15. Instruct or assist resident to turn to their side with top leg slightly bent. 16. Wet the washcloth and soap, other cleansing agent. 17. Wash peri-anal thoroughly with each stroke beginning at the base of the labia and extending up over the buttocks. a. Refold the cloth, as before, to provide clean area. b. Washing should alternate side to side, ending with center anal area. 18. Rinse cloth and entire area in same sequence as above. Dry thoroughly.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>32874</p> <p>Based on record review and interview the facility failed to provide a Registered Nurse (RN) 8 hours a day seven days a week. This has the potential to affect all 50 residents residing at the facility.</p> <p>Findings include:</p> <p>On 04/29/24 at 1:20 PM, the facility daily staffing sheets were reviewed. The staffing sheets documents there was no RN coverage for 8 hours a day in the facility for the following dates: 4/6/24, 4/7/24, 4/20/24 and 4/21/24.</p> <p>On 4/29/2024 at 3:09 PM, V1, Administrator, stated the facility does not have a policy on staffing. V1 stated a RN should be on duty 8 hours a day seven days a week.</p> <p>The CMS 671 Facility Application for Medicare and Medicaid, dated 4/29/2024, documents a census of 50 residents.</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>44967</p> <p>Based on observation, interview and record review, the facility failed to do complete hand hygiene, assist residents with handwashing, maintain a clean field during a wound dressing change, and ensure resident rooms and common resident-use areas are cleaned in a manner that prevents the spread of infection for 9 of 24 residents (R6, R7, R9, R11, R17, R18, R23, R33, R48) reviewed for infection control in the sample of 39.</p> <p>Findings include:</p> <p>R6's Laboratory Result, dated 4/9/24, documents R6 wound to R6's right leg is positive for Methicillin Resistant Staph Aureus (MRSA).</p> <p>On 4/30/24 at 9:13 AM, V13, Housekeeper, was seen cleaning R6's room. R6 was on contact isolation for MRSA. V13 stated that she uses this same cart to clean all rooms. V13 pulled a washcloth out of a bucket of water on the cart and took it into R6's room, began wiping things down, then placed the washcloth into a plastic bag. V13 used the toilet brush off her cart and cleaned R6's toilet and replaced it back on the cart. V13 used the broom off the cart, swept the floor, then put the broom back on the cart. V13 then used the mop sitting in the mop bucket and mopped R6's floor, then placed the mop back into the mop bucket of water. V13 finished R6's room and took the cleaning cart down the hall and began cleaning the West-Hall restroom/shower room with the same contaminated broom, mop, and mop water that was used in R6's isolation (MRSA) room.</p> <p>On 5/2/24 at 9:03 AM, V13, Housekeeper, stated that she changes her mop water whenever it looks dirty. V13 stated that on isolation rooms, she tries to change the water after every room, but sometimes she gets confused and forgets. V13 stated that the other day when she was cleaning (R6's) room, she did go into the shower room on the west-hall to clean that room after cleaning R6's.</p> <p>On 5/2/24 at 9:08 AM, V21, Housekeeper, stated that she starts out her shift with a clean mop bucket of water, she will clean and mop the non-isolation rooms first, then change the mop water, and then do the isolation rooms. When she is done with the isolation rooms, she will change the mop water and mop head.</p> <p>V1, Administrator, provided a list of residents who received a shower in the West-Hall shower room on 4/30/24. This was after V13 used contaminated mop water to clean the shower room. There were six residents R9, R11, R18, R23, R33, and R48 who received a shower in that shower room that day.</p> <p>On 5/2/24 at 9:28 AM, V20, Regional Nurse, stated the Routine and Terminal Cleaning of Isolation Rooms Policy, does not address mopping the floor, or when to change the mop water or mop head. V20 stated that she would expect the housekeeper to clean the broom and change the mop water and mop head after cleaning an isolation room.</p> <p>The Facility's Routine and Terminal Cleaning of Isolation Rooms, dated 5/30/14, documents To ensure all resident isolation rooms are clean and to prevent the spread of microorganisms.</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>2. On 5/1/24 at 9:42 AM, V16, Licensed Practical Nurse (LPN) was performing wound care on R6. V16 donned PPE (personal protective equipment) and removed the old dressing from R6's right leg. V16 donned new gloves with no Hand Hygiene done in between glove changes. V16 went into the restroom and got a paper towel from the wall dispenser, wet it from the restroom sink, then walked back to R6 and began wiping his wound on his right leg with the wet paper towel. V16 then used a dry paper towel from the restroom dispenser and dried off the wound. V16 doffed PPE and walked out of room and gathered supplies from the wound cart. V16 took out the Calcium Alginate from the original package and placed it on the top of the cart, without wiping the cart down or having a clean barrier. V16 then picked up the dry dressing, dated it, obtained Kling wrap, and tape, and again placed all supplies on top of the cart while donning PPE again. V16 then entered the room with supplies, and applied the Calcium Alginate to the wound, wrapped R6's leg with Kling, and secured with tape.</p> <p>R6's Laboratory Result, dated 4/9/24, documents R6 wound to his right leg has MRSA.</p> <p>R6's Wound Center Physician Order, dated 4/30/24, documents Cleanse the wound with mild soap and water, gently pat dry prior to applying clean dressing. Apply primary dressing to wound: Begin Calcium Alginate with Silver then dry gauze and roll gauze and tape. Change dressing every day.</p> <p>On 5/2/24 at 10:00 AM, V22, LPN, stated that she will clean R6's wound with wound cleaner or water and 4X4's, will pat dry, then apply the Calcium Alginate and cover with a non-stick pad and tape or wrap to his leg.</p> <p>On 5/2/24 at 10:13 AM, V2, Director of Nursing (DON), stated that she would expect the nurses to maintain a clean and/or sterile field while performing wound care, and to follow physician orders for appropriate wound care and cleaning.</p> <p>The Facility's Dressing Change Policy, dated 7/2007, documents To avoid introducing organisms into a wound. Procedure: 7. Set up clean area for supplies. 13. Wash your hands. 17. Cleanse wound per physician's order or use gauze and forceps or cotton applicators. 19. Apply dressing without touching wound or side of dressing.</p> <p>33112</p> <p>3. On 04/29/24 at 01:38 PM, V2 entered R7's room to hang / run an IV (Intravenous) of Piperacillin and Tazobactam 3.375 grams in 100 ML (milliliters) of Normal Saline (NS). V2 performed and hygiene, donned gloves, spiked the IV bag, primed a new IV line, cleansed IV catheter hub with alcohol, flushed with 10 ML of NS and attached the line. V2 set the IV pump to run at 100 ml/hr (hour). V2 removed her gloves and exited the room. V2 failed to perform hand hygiene.</p> <p>On 5/2/24 at 10:20 AM, V2, stated, I was talking to (R7) and just forgot. I was trying to keep him happy.</p> <p>On 5/1/24 at 3:30 PM, V20 stated that all staff should wash hands before putting on gloves and after removing them.</p> <p>The policy Hand Hygiene, dated 8/14/23, documents, Hand washing can also be used routinely in the following clinical situations: 6. Removing gloves.</p> <p>(continued on next page)</p>		

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