| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146086 | A. Building<br>B. Wing | 10/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Tuscola Health Care Center | 1203 Egyptian Trail<br>Tuscola, IL 61953 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642<br><br>Based on observation, interview, and record review the facility failed to provide a dependent resident with dressing assistance of compression stocking for one of four residents (R1) reviewed for wounds/activities of daily living assistance on the sample list of four.<br><br>Findings include:<br><br>R1's Physician Order Summary sheet (POS) dated 10/1/24 - 10/31/24 documents the following: Diabetes Mellitus Type II, Other Sequela Of Cerebral Infarction With Diabetic Neuropathy, Unspecified, Morbid (Severe) Obesity Due to Excess Calories. R1's same POS documents the following treatment orders: Elevate Legs after each meals, (name brand) Compression hose, On in am off at HS (bedtime).<br><br>R1's Wound Assessment and Plan dated 10/24/24 documents the following:<br><br>Diabetic Wound, Dorsal Aspect of Left Foot.<br><br>Wound Onset: 08/17/24<br><br>Healing Status: Healing.<br><br>Depth of Tissue Involvement: Full Thickness: with Fat Layer Exposed Wound Measurement: 4cm (centimeters). Length x 5.6cm. Width x <0.1 cm. Depth Wound Bed Tissue Composition at Beginning of Visit: 90% Epithelial / 10% Granulation<br><br>Periwound: Within Normal Limits Signs and Symptoms of Infection: None<br><br>Exudate: Minimal<br><br>R1's Minimum Data Set (MDS) dated [DATE] documents R1 had a Brief Interview of Mental Status score of 15 out of a possible 15, indicating no cognitive impairment.<br><br>R1's (Formal Name) skin assessment dated [DATE] for predicting pressure ulcers documents R1 is chairfast and requires moderate to maximum assistance with moving. The same assessment documents R1 is at high risk for developing pressure ulcers. The same assessment documents R1 has unresolved diabetic foot ulcers.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R1's ADL (Activities of Daily Living) Flow Sheet (Formal Name - Certified Nursing Assistants Care Plan Guidance) dated October 2024 documents R1 is dependant on two person physical assistance with dressing.<br><br>On 10/29/24 at 1:45 pm R1 seated in a bedside recliner with R1's bilateral feet elevated. Bilateral lower legs visibly swollen. V6, Licensed Practical Nurse (LPN) removed R1's ankle high cotton sock from R1's left foot to complete R1's wound treatment. R1 stated, I am supposed to have on my hose. V6, LPN confirmed R1 does not have on R1's compression hose. V6, LPN stated, I signed (initialed the treatment sheet) the (name brand compression) off. I thought that they were already on. I signed the treatment sheet because I thought the CNA's (Certified Nursing Assistants) put them on this morning. They usually do. I should have checked before I documented they were on. You can see the swelling in her (R1's) legs. The (name brand compression socks) are supposed to be on all day, and taken off in the evening. R1 stated, The compression socky (sock-like) things have not been on for two days. They went to laundry. I have mentioned it both days. The CNA's, I thought were still waiting for them to come back from laundry. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642<br><br>Based on observation, interview and record review the facility failed to prevent cross contamination between wounds, during wound treatment for one of four residents (R3) reviewed for wounds on the sample list of four.<br><br>Findings include:<br><br>R3's Physician Order Sheet (POS) dated 10/01/24-10/31/24 documents the following: Site; Right Buttock Cleanse with NSS (Normal Saline) and apply a thin layer of Hydrogel and Zinc Cream every shift and prn (as needed). The same POS documents: R (right) Breast, clean w (with) wound cleanser and cover w (with) bordered gauze (dressing), daily and prn.<br><br>R3's Wound Assessment and Plan signed by V9, Wound Nurse Practitioner documents the following: Visit Date: October 24, 2024<br><br>Discussed care and course of treatment and obtained general consent to evaluate and treat.<br><br>Wound Visit Type: Active/Initial Phase of Treatment<br><br>Wound Location: right breast Wound Type: Other abscess<br><br>Depth of Tissue Involvement: Part Thk (thickness): Limited To Exposed Epidermis/Dermis Wound Measurement: 0.5cm. Length x 0.5cm. Width x <0.1 cm. Depth<br><br>Wound Bed Tissue Composition at Beginning of Visit: 100% Epithelial.<br><br>COMMENTS: PCP (Primary Care Physician) reviewed wound culture results with MRSA (Methicillin-resistant staphylococcus aureus) (bacterial infection that is contagious and difficult to treat) indicated and patient now on Clindamycin and Bactrim (antibiotic medication).<br><br>R3's Minimum Data Set, dated dated dated [DATE] documents Brief Interview of Mental Status score of 15 out of a possible 15, indicating no cognitive impairment.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/29/24 at 2:40 pm V10 and V11 Certified Nursing Assistants (CNA's) assisted R3 with a full-body mechanical lift transfer and incontinence care at which time the dressing on R3's right buttocks came off on its own. V10 and V11, CNA positioned R3 in a side lying position. V6, Licensed Practical Nurse entered R3's room, while V10 and V11, CNA's assisted R3 to maintain a side lying position. V6 entered R3 room with gloves and a gown already on. V6 carried wound treatment supplies in her right gloved hand and opened R3's bedroom door with her left gloved hand. V6 pulled back the privacy curtain back with the same gloved she had contaminated when V6 touched the door as she opened it. V6 moved personal items on R3's bedside table and set her normal saline wound cleanser and Hydrogel gel and zinc on R3's bedside dresser. V6 continued with the same soiled gloves. R3 had a dime sized open are on her right buttocks and an dime size, open red-raw area on R3's right posterior upper thigh. The right upper thigh area appeared to be an open blister with loose white skin at the superior aspect. R3 stated the right upper thigh wound was new, V6, LPN agreed. R3 stated she noticed the new area on the right posterior thigh when she got up today, because it was it was 'stinging'. V6 continued with the same soiled gloves. V6 used one four by four piece of gauze saturated in normal saline wound cleanser and washed R3's right posterior upper thigh, new open area. V6 wore the same gloves contaminated by the door, curtain, and bedside dresser items. V6 did not change her gloves or perform hand hygiene. V6, LPN continued with the same soiled four by four wet gauze used to wash R3's right upper thigh wound. V6 continued the right buttocks treatment, with the same soiled gloves and soiled four by four inch wet gauze. V6 washed R3's right buttocks wound. V6 disposed of the soiled four by four gauze. V6 applied Hydrogel and zinc with the fingers area of the same soiled gloves. V6 disposed of the soiled gloves, and gown and used hand sanitizer for the first time during wound treatments. V6 stated she will call the Nurse Practitioner for orders to treat the new area on R3's right posterior upper thigh. R3's right upper posterior thigh left opened to air after being assessed and cleansed. V10 and V11 pulled R3's sweat pants up and over the open right upper thigh wound, further contaminating the new open are with sweat pants.<br><br>On 10/29/24 at 3:00 pm V6, LPN confirmed that she failed to wash her hands or use hand sanitizer during R3's dressing change, failed to change her gloves when they were soiled, failed to wash each wound separately to prevent cross contamination and used the same soiled gloves to apply treatment cream/gel. V6, LPN stated, I guess I was just nervous being watched by you (surveyor).<br><br>The facility policy Aseptic Wound and Skin Treatment Procedure dated 3/16/23 documents the following:<br><br>Purpose:<br><br>To prevent contamination of the wound, protect wound from mechanical injury, to stimulate, restore, and promote circulation and healing, prevent further deterioration of skin tissue, prevent necrosis of deeper body structures, and to promote resident comfort.<br><br>Responsibility: Licensed Personnel<br><br>The same policy documents: Procedure:<br><br>7. Wash your hands.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 8. Establish your clean and dirty fields. Remember the dirty field should be the farthest away from your clean field. (Place the plastic bag at the end or foot of the bed to receive soiled dressings).<br><br>9. Put on gloves and removed soiled dressings and place in plastic bag at the end of the bed.<br><br>10. Observe area for any signs and symptoms of infection and healing process.<br><br>11. Remove gloves and place in plastic bag.<br><br>12. Wash your hands.<br><br>13. Put on clean gloves.<br><br>14. Clean the wound as ordered. Clean from center outward, never going back over area, which has been cleaned. (If two (2) wounds, treat each wound as separate wounds).<br><br>15. Place soiled sponges used for cleaning wound in the plastic bag.<br><br>16. Remove gloves and place in plastic bag.<br><br>17. Wash your hands.<br><br>18. Put on clean gloves.<br><br>19. Apply clean dressing as ordered, using gloves or no-touch technique.<br><br>20. Remove gloves and discard in plastic bag.<br><br>21. Initial and date the dressing.<br><br>22. Close plastic bag securely with a knot and place in trash can on treatment cart or in dirty utility room in trash labeled biohazard.<br><br>23. Position resident comfortably and leave call light within reach.<br><br>24. Wash your hands.<br><br>25. Document procedure on treatment sheet. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642<br><br>Based on observation, interview, and record review the facility failed post infection control/contact isolation precaution sign to alert staff and visitors to wear personal protective equipment, and failed to wear personal protective gowns during high risk personal care care These failures affected one of four (R3) residents reviewed for wound/infection control on the sample list of four.<br><br>Findings include:<br><br>R3's Physician Order Sheet (POS) dated 10/01/24-10/31/24 documents the following: Site; Right Buttock Cleanse with NSS (Normal Saline) and apply a thin layer of Hydrogel and Zinc Cream every shift and prn (as needed). The same POS documents: R (right) Breast, clean w (with) wound cleanser and cover w (with) bordered gauze (dressing), daily and prn.<br><br>R3's Wound Assessment and Plan signed by V9, Wound Nurse Practitioner documents the following: Visit Date: October 24, 2024<br><br>Discussed care and course of treatment and obtained general consent to evaluate and treat.<br><br>Wound Visit Type: Active/Initial Phase of Treatment<br><br>Wound Location: right breast Wound Type: Other abscess<br><br>Depth of Tissue Involvement: Part Thk (thickness): Limited To Exposed Epidermis/Dermis Wound Measurement: 0.5cm. Length x 0.5cm. Width x <0.1 cm. Depth<br><br>Wound Bed Tissue Composition at Beginning of Visit: 100% Epithelial.<br><br>COMMENTS: PCP (Primary Care Physician) reviewed wound culture results with MRSA (Methicillin-resistant staphylococcus aureus) (bacterial infection that is contagious and difficult to treat) indicated and patient now on Clindamycin and Bactrim (antibiotic medication).<br><br>R3's Minimum Data Set, dated dated dated [DATE] documents R3 is always incontinent of bowel and bladder.<br><br>R3's ADL (Activities of Daily Living) care plan flow sheet dated October 2024 documents R3 is on Contact Isolation Precautions<br><br>On 10/29/24 at 2:40 pm R3's bedroom had an infection control dresser, set-up with gowns an and gloves, outside R3's room. There was no sign to indicate R3 was on any type of infection control isolation or enhanced barrier precautions. V6, Licensed Practical Nurse (LPN) asked V10 and V11 Certified Nursing Assistants (CNA's) to transfer R3 to bed in order for V6, LPN could complete R3's wound dressing treatment on R3's buttocks.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | V10 and V11 entered R3's room without a gown on. V10 and V11 CNA's transferred R3 from her wheelchair to bed with a full-body mechanical lift. V10 and V11, CNA's used hand sanitizer and donned gloves, but did not don gowns. V10 and V11 provided R3 incontinence care and repositioning. R3 was incontinent of an extra large bowel movement and a large amount of urine that continued to be excreted as residents incontinence brief was being removed. R3's linen savor sheet on the bed was totally saturated with urine. R3's soiled linen and incontinence brief was removed by V10 and V11, CNA.<br><br>V10 and V11 repeatedly used hand sanitizer and donned new gloves, but did not don gowns during incontinence and linen change. V10 and V11 maintained R3's side lying position while V6 provided wound care to R3's right buttock and right upper posterior thigh dime size open area. R3's right upper posterior thigh wound remain open to air. V10 and V11 pulled R3's sweat pants up and over the open right upper thigh wound. V10 and V11, CNA's never wore gowns throughout transferring resident , incontinence care, linen change , assisting with wound care and re-dressing R3.<br><br>On 10/29/24 at 3:00 pm V6 stated, The CNA's (V10 and V11) should have had on gowns when providing incontinence care. I should have said something to them when they prepped (R3) for the wound care and provided incontinence care. Any resident with open wounds is on enhanced barrier precautions. With (R3) she is on contact isolation precautions for MRSA in her breast wound. I had already changed that, but they still should have had on gowns.<br><br>On 10/30/24 at 9:10 am V2, Director of Nursing/ Infection Control Preventionist stated enhance barrier precautions are required for all resident with wounds. Isolation and enhanced barrier precautions signs are to be posted. V2 also stated (R3) is most definitely on Contact Isolation (precautions) for MRSA in her breast wound. The CNA's (V10 and V11) should have gowned when providing personal care, transferring (R3) as well as positioning (R3) during her wound treatments.<br><br>The facility Enhanced Barrier Precautions (EBP) policy dated 7/13/23 documents the following: Purpose: To reduce transmission of multidrug-resistant organisms.<br><br>Enhance 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, and Infection with a colonized MDRO (Multidrug-Resistant Organism).<br><br>The same policy documents Examples of MDRO's: includes MRSA (Methicillin-resistant staphylococcus aureus).<br><br>The same policy documents EBP require use of a gown and gloves (Personal Protective Equipment) 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's room, when high-contact resident care activities are bundled together.<br><br>High-contact care activities include: Dressing, Transfers, Changing briefs or toileting, and Wound care (pressure ulcers, diabetic ulcers, unhealed surgical wounds, chronic venous stasis wounds).<br><br>The same policy directs staff as follows:<br><br>1. Educate staff on EBP.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Identify residents with an infection or colonized with a MDRO, residents with medical devices or chronic wounds that do not require contact precautions.<br><br>3. Review Contact precautions to ensure that Enhanced Barrier Precautions are appropriate.<br><br>3. Post approved EBP signage that indicates high-contact activities.<br><br>4. Ensure that disposable or washable isolation gowns and gloves are available to HCP (Health Care Providers), where high-contact resident care activities may be required.<br><br>5. Keep a container or hamper inside resident's room for HCP to dispose of PPE. |