STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Point Christian Village	6685 East 117th Avenue Crown Point, IN 46307

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 20580 Based on observation, record review, and interview, the facility failed to notify a resident's physician and responsible party in a timely manner, related to a gastrostomy (g-tube, feeding tube) mechanical malfunction requiring hospital intervention, which resulted in medications and flushes not being given as ordered for 1 of 3 residents reviewed for physician and family notifications. (Resident B) See F693 for additional information on Resident B. Finding includes: During an observation on 8/13/24 at 5:24 a.m., the resident was lying in bed with the head of the bed elevated. A liquid tube feeding of Osmolyte 1.5 was infusing at 72 cc (cubic centimeters) per hour. During an observation on 8/13/24 at 11:45 a.m., the resident's tube feeding was turned off. Resident B's record was reviewed on 8/13/24 at 10:31 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, gastrostomy, and iron deficiency anemia. An Annual Minimum Data Set (MDS) assessment, dated 5/15/24, indicated a feeding tube was present, the resident received 51% or more calories from the feeding tube and 501 cc's (cubic centimeters) or more of fluids from the feeding tube. A Care Plan, dated 5/15/24, indicated a feeding tube was required for nutrition and fluids. The interventions included, the the tube feeding would be administered as ordered by the Physician. During an observation on 8/13/24 at 1:33 p.m., LPN 3 indicated she was unable to administer the morning medications and the water flush to the resident. She was unable to separate the g-tube from the feeding tube line. The feeding tube line was inserted into the g-tube with a male connector. LPN 3 was unable to remove the feeding tube line. She indicated she had administration nurses and other nurses attempt to get the tube apart and they were also unable to get it apart. LPN 3 indicated she needed to find a syringe so she could see if the second port on the g-tube could be used and left the room. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross reference F693. LPN 3 reentered the room on 8/13/24 at 1:50 p.m. with the ADON (Assistant Director of Nursing) and informed the ADON the resident needed to be sent out to the hospital. She indicated she had attempted to administer the morning medications between 9 a.m. and 9:30 a.m. and was unable to get the remove the feeding line from the g-tube. She then attempted to the use flush the second port and the second port on the g-tube was blocked. During an interview on 8/13/24 at 2:00 p.m., LPN 3 indicated she was going to notify the physician and get an order to transfer the resident to the hospital for the tubing removal. During an interview on 8/13/24 at 2:11 p.m., the ADON and the Unit Manager/Infection Control Nurse indicated they had not been notified that the nurse could not remove the feeding line from the g-tube so the medications and flushes could be administered. During an interview on 8/13/24 at 2:53 p.m., LPN 3 indicated she had just paged the physician and was awaiting a return call. She indicated the Wound Nurse, the ADON, and the Unit Manager/Infection Control Nurse also tried to get the feeding line and g-tube separated, and they were unable to do so. The ADON again indicated she had not been notified about the feeding line and g-tube malfunction. The Medication Administration Record (MAR), dated 8/2024, indicated the flush was scheduled for 2:00 a.m., 8:00 p.m., 2:00 p.m., and 8:00 p.m. The 325 cc's of water was not administered at 8 a.m. or at 2 p.m. The morning medications, scheduled for 8:00 a.m. and 9:00 a.m., were marked not given on the MAR on 8/13/24. The Progress Note, written by LPN 3, dated 8/13/24 at 10:52 p.m., indicated the resident's morning medications and water flush were not administered because she was unable to unhook the feeding line from the g-tube. The Wound Nurse, the Unit Manager/Infection Control Nurse and the ADON were unable to separate the line. The Nurse Practitioner was notified and she was waiting on a return call. The resident's family was in the building and made aware of the situation and did not want the resident sent to the hospital and she could get the feeding line apart from the g-tube. The Progress Note from 8/13/24 at 10:52 p.m., when investigated further, indicated it had been created at 3:16 p.m. The Physician had not been notified until after 2:30 p.m. and the family member had not been notified until she arrived at the facility after 2:53 p.m. During an interview on 8/14/24 at 8:20 a.m., the ADON and Unit Manager/Infection Control Nurse acknowledged the Nurse Practitioner/Physician had not been notified until after 2:30 p.m. and the family had not been notified until they came in to the facility. The ADON indicated the resident was sent to the hospital for the g-tube to be changed and had returned to the facility. A facility physician and family notification policy, received from the Administrator on 8/14/24 at 10:44 a.m. as current, indicated the physician and responsible party would be notified with a change in status and the need to significantly alter the resident's treatment. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation relates to Complaint IN00434830. 3.1-5(a)(3) 3.1-5(a)(4)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 20580 Based on record review and interview, the facility failed to ensure residents who were dependent on staff for activities of daily living (ADL's) received bathing/showers at least twice a week for 2 of 3 dependent residents who were reviewed for ADL's. (Residents B and H) Findings include: 1. Resident B's record was reviewed on 8/13/24 at 10:31 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, gastrostomy tube, and iron deficiency anemia. An Annual Minimum Data Set (MDS) assessment, dated 5/15/24, indicated and short and long term memory problem, had no behaviors, and was dependent for ADL's. Shower and bathing status was marked as not assessed. A Care Plan, dated 5/10/23, indicated a self-care performance deficit and all ADL needs would be met. The Shower Schedule, located in the Shower Sheets Binder, indicated the resident was to be bathed/showered on Mondays and Thursdays. The Shower Sheets in the binder indicated bathing had occurred on 7/22/24 and 7/29/24. During an interview on 8/13/24 1:33 p.m., CNA 2 indicated the bathing was documented either on the Shower Sheets or in the computer. The computer documentation for bathing was received on 8/14/24 at 10:44 a.m. from the Administrator, and indicated a shower and bed bath had not been received twice a week. The bathing had not occurred on 6/13/24 - the form was left blank, 6/17/24 - the form was documented as non-applicable, 6/24/24 - the form was left blank, 2024, 7/25/24 - the form was left blank, and on 8/1/24 - the form was marked non-applicable. No additional Shower Sheets were received from the facility. 2. Resident H's record was reviewed on 8/14/24 at 2:02 p.m. The diagnoses included, but were not vascular dementia. A Quarterly MDS assessment, dated 6/5/24, indicated an intact cognitive status, no behaviors, and was dependent on staff for bathing. A Care Plan, dated 6/18/24, indicated assistance was required with ADL's and the resident was totally dependent for bathing. The computer documentation for bathing was received on 8/14/24 at 10:44 a.m. from the Administrator, and indicated the showers were scheduled on Wednesday and Saturdays. Bathing had not been received on 7/24/24 - the form was marked with non-applicable and on 8/3/24 - the form was left blank. No additional Shower Sheets were received from the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/24 at 3:05 p.m., the Unit Manager/Infection Control Nurse indicated the residents were to receive bathing twice a week and as needed. This citation relates to Complaint IN00434830. 3.1-38(a)(3) 3.1-38(b)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 20580 Based on observation, record review, and interview, the facility failed to ensure a resident received the necessary care and services related to medications not administered as ordered by the Physician, for 2 of 15 residents reviewed for quality of care. (Residents B and D) Finding includes: 1. Resident B's record was reviewed on 8/13/24 at 10:31 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, gastrostomy, and iron deficiency anemia. A Care Plan, dated 6/9/23, indicated a diagnosis of anemia. The interventions included the medications would be administered as ordered and laboratory testing would be completed as ordered. The complete blood count laboratory results on 5/10/24 indicated red blood cells (RBC) level was 3.88 (normal 4.7-6.10) and hemoglobin (HGB) was 11.4 (normal 14-18). On 7/15/24, the RBC was 3.46 and HGB 10.5. On 7/31/24, the RBC was 3.24 and HGB 9.7, and on 8/5/24, the RBC was 3.14 and HGB 9.3. The Physician's Orders, dated 6/13/23, indicated five cc's (cubic centimeters) of a liquid multi-vitamin was to be administered daily and seven cc's of ferrous sulfate (iron) liquid 220 milligrams per five cc's was to bed administered through the gastrostomy tube (g-tube) twice a day. The Medication Administration Records (MARs), dated 6/2024 and 7/2024, indicated by initials the multi-vitamin and ferrous sulfate had been administered as ordered. The MAR, dated 8/2024, indicated the multi-vitamin and ferrous sulfate had been administered as ordered on 8/1/24 through 8/12/24. During an observation on 8/13/24 at 2:00 p.m., LPN 3 indicated there were two bottles of ferrous sulfate for the resident in the medication cart. The labels indicated one bottle was delivered on 6/20/24 and the second bottle was delivered on 8/9/24. The bottle that was delivered on 6/20/24, came with 473 cc's of medication in the bottle and the bottle was 3/4 full of the medication. LPN 3 acknowledged the amount of the medication. The bottle delivered on 8/9/24 was full. The Physician's Orders for the ferrous sulfate, was to administer seven cc's twice a day. Each bottle of the ferrous sulfate would have approximately 33 doses of the medication. The bottle delivered 6/20/24 still had 3/4 of the medication remaining. LPN 3 indicated she was unsure why there was a large amount of ferrous sulfate left in the bottle delivered on 6/20/24. During an interview on 8/13/24 at 2:11 p.m. the Unit Manage/Infection Control Nurse indicated the Nurse Practitioner had spoken with her about the resident's laboratory results and had asked about the ferrous sulfate and if it had been given. She indicated on 8/8/24, she observed the cart and saw there was a bottle of ferrous sulfate that was delivered on 6/1/24 that was almost gone and a full bottle that was delivered on 6/20/24. The 6/1/24 bottle was destroyed and the bottle delivered on 6/20/24 should have been all used or at least almost emptied. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Pharmacy Fill History form, received from the Assistant Director of Nursing (ADON) on 8/13/24 at 3:00 p.m. , indicated a 30 day supply of ferrous sulfate, 473 cc's, was delivered on 3/21/24, 5/24/24, 6/20/24, and 8/9/24. She acknowledged a bottle of the ferrous sulfate should last approximately 33 days, with the dosage of seven cc's twice a day. During an observation on 8/13/24 at 2:53 p.m., The ADON indicated the bottle of multi-vitamin liquid in the medication cart was delivered on 3/30/24. There was 236 cc's of medication in a full bottle and there was approximately 1/4 of medication remaining in the multi-vitamin bottle that was delivered on 3/30/24. The resident was to receive five cc's of the medication daily. There was 47 doses in each bottle. A Pharmacy Fill History form, received from the ADON on 8/13/24 at 3:38 p.m., indicated the multi-vitamin liquid medication was delivered on 3/3/24 and 3/30/24. There had been no deliveries of the vitamin after 3/30/24. The form indicated each bottle was a 30 day supply. The ADON indicated the multi-vitamin could not have been administered as ordered. 32788 2. The record for Resident D was reviewed on 8/13/24 at 9:11 a.m. Diagnoses included, but were not limited to, dementia, general anxiety disorder, and malignant neoplasm of the colon. The Quarterly Minimum Data Set (MDS) assessment, dated 8/3/24, indicated the resident was cognitively impaired and received anti-anxiety medication. A Care Plan, dated 1/4/24, indicated the resident had periods of restlessness and increased anxiety. The interventions included, administer medications as ordered . The Physician's Order Summary, dated 8/2024, indicated an order for Xanax (alprazolam, an anti-anxiety medication) 0.5 milligrams (mg) 1 tab every afternoon. The Medication Administration Record (MAR), dated 8/2024, indicated the Xanax medication was not signed off as given on 8/3/24 and 8/10/24. The Medication Administration Record (MAR), dated 7/2024, indicated the Xanax medication was not signed off as given on 7/11/24. During an interview on 8/14/24 at 10:39 a.m., the Administrator was made aware of the blanks on the MARs. No further information was provided. This citation relates to Complaints IN00434830. 3.1-48(a)(6)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 20580 Based on observation, record review, and interview, the facility failed to provide proper feeding tube (gastrostomy tube) (g-tube) care as per professional standards, related to water flushes not completed as ordered, verification of the g-tube placement not completed prior to medication administration, failure to flush the g-tube after each medication was administered, a liquid feeding bag not labeled, dated or timed, and a piston syringe (used for water flushing and other care for the g-tube) not changed daily, for 2 of 3 residents reviewed for feeding tube care. (Residents B and J) See F580 for additional information on Resident B Findings include: 1. Resident B's record was reviewed on 8/13/24 at 10:31 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, gastrostomy, and iron deficiency anemia. An Annual Minimum Data Set (MDS) assessment, dated 5/15/24, indicated feeding tube was present, he received 51% or more calories from the feeding tube and 501 cc's (cubic centimeters) or more of fluids from the feeding tube. A Care Plan, dated 5/15/24, indicated a feeding tube was required for nutrition and fluids. The interventions included, the placement of the feeding tube would be checked for gastric contents/residual volume and the tube feeding would be administered as ordered by the Physician. During an observation on 8/13/24 at 1:33 p.m., LPN 3 indicated the morning medications and water flush had not been administered because she was unable to separate the g-tube from the feeding tube line. The feeding tube line was inserted into the g-tube with a male connector. LPN 3 was unable to remove the feeding tube from the g-tube. Cross reference F580. A Physician's Order, dated 4/26/24, indicated the g-tube was to flushed with 325 cc's of water every six hours. The Medication Administration Record (MAR), dated 8/2024, indicated the flush was scheduled for 2:00 a.m., 8:00 p.m., 2:00 p.m., and 8:00 p.m. The 325 cc's of water was not administered at 8:00 a.m. or at 2:00 p.m. on 8/13/24. The morning medications of ascorbic acid (vitamin C) 250 mg (milligrams), one tablet, cholecalciferol (vitamin D3) 1000 units, one tablet, cyanocobalamin (vitamin B12) 2500 micrograms, one tablet, escitalopram (anti-anxiety/anti-depressant) 5 mg, one tab, ferrous sulfate 220 mg/5 cc's, give 7 cc's, twice a day, lorazepam (anti-anxiety) 0.5 mg twice a day, Miralax (laxative) 17 grams daily, memantine (Alzheimer's medication) 10 mg, one tablet daily, multivitamin 5 cc's, and omeprazole (stomach medication) 20 mg, one tablet were marked not given on the MAR on 8/13/24. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/14/24 at 8:35 a.m., LPN 4 was starting to prepare the morning medications for Resident B, which consisted of the above listed medications. She placed each medication in a separate plastic medication cup. She crushed the tablets of medication and placed the powder back into the individual cups. LPN 4 filled three cups with 120 cc's of water each and mixed each medication with 30 cc's of water. The feeding pump was then turned off, and the feeding line was removed from the g-tube. The g-tube was flushed with 30 cc's of water that was pushed in with a syringe. The g-tube placement was not verified prior to administration of the medications. The syringe was used to administer the first medication dissolved in 30 cc's of water and pushed into the stomach through the g-tube. LPN 4 continued to use this pushing technique with the next medication and then indicated she had forgotten to verify placement of the g-tube, and pulled back on the syringe to check for gastric contents, then the gastric contents were pushed back into the g-tube. Two more medications were dissolved in 30 cc's of water and were pushed separately into the feeding tube, then 30 cc's of water was pushed into the g-tube. The g-tube was not flushed with water until after the fourth medication was administered. After the 30 cc flush, the rest of the medications were pushed into the stomach through the g-tube with the syringe piston. After the last medication was pushed, the g-tube was flushed by pushing 30 cc's of water into the tube. The liquid feeding was then resumed. During an interview on 8/14/24 at 9:47 a.m., LPN 4 indicated there was no order for the amount of water with which to flush the feeding tube or to mix the medications. The policy stated the flush was to be 30 cc's of water and the g-tube should have been flushed with 30 cc's of water after each medication. She indicated she had to push the medications in to the stomach because they would not flow in by gravity. If she attempted to administer the medications by gravity, they would not go in and the feeding would flow out of the stomach. The medications were always pushed into the stomach through the feeding tube. A Professional Resource, titled, Medication Aide Training Curriculum, dated 1/2/24, indicated if more than one medication was being administered, they were to be given separately with a minimum of 10 cc's of warm water or according to facility policy or provider's order before and after each medication. Tube placement was to be verified prior to medication administration. Medications and fluids were not to be forced into the tube. The medications were to be administered by gravity and if necessary, gentle pressure could be applied. The delivery of the medication was to be slow and steady. The fluid was not to be administered too quickly. The g-tube was to be flushed after checking for placement. A facility policy, dated 9/1/2023 and received from the Administrator as current, indicated the medication was to be dissolved in 5-10 cc's of warm water or the prescribed amount. The g-tube was to be verified for placement. The g-tube was to be flushed with 15-30 cc's of water, the preferred amount of flush was 30 cc's, using gravity flow. The medications were to be given and allowed to flow in by gravity and were to be flushed with 15 cc's of water between medications. 45666 2. On 8/14/24 at 9:07 a.m., Resident J was observed lying in his bed with the head of bed elevated. He had a feeding tube connected to a feeding tube bag containing formula. The pump was set to 90 milliliters per hour. The feeding tube bag had no label observed and the formula inside was unidentified. The enteral feeding syringe was placed in a plastic bag hanging on the tube feeding pole and was dated 8/12/24. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/24 at 9:17 a.m., LPN 1 indicated the enteral feeding syringe was not available in the stock room on the unit, but it was supposed to be replaced each day. The tube feeding bag should have been labeled when it was started at 9:00 a.m. that morning. Resident J's record was reviewed on 8/13/24 at 3:26 p.m. The diagnoses included, but were not limited to, dementia, gastrostomy status, and heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 5/14/24, indicated the resident was moderately impaired for daily decision making. The resident was dependent for all activities of daily living including, but not limited to, oral hygiene, toileting hygiene, personal hygiene, and transfers. The resident received 51% or more of total calories and 501 cc per day or more of fluid intake through a tube feeding. The August 2024 Physician Order Summary indicated the resident received a 150 cc water flush every 6 hours, a pump feeding of Fibersource through a PEG (feeding tube) at 90 milliliters per hour, on at 9:00 a.m. and off at 5:00 a.m., change the feeding syringe and storage bag/canister every night shift, and label the feeding container with the resident's name, formula, date, time hung, and rate every day. During an interview on 8/14/24 at 10:39 a.m., the Assistant Director of Nursing indicated she had no further information to provide. During an interview on 8/14/24 at 10:50 a.m., the Administrator indicated she had no further information to provide. A policy titled, Enteral Feedings, noted as current, indicated, Procedures . 2 . A new catheter tip syringe and feeding administration set will be utilized and dated daily .7. Label the feeding or ready to hang container with the resident's name, formula ordered, and date. If a feeding bag is used, each time a feeding is administered into the bag, the amount of formula hung and the time it was hung must be noted on the feeding bag 11 . If using a feeding bag, once a formula is put into a feeding bag, it must be administered within eight hours. If the formula is in the bag beyond 8 hours, it must be discarded This citation relates to Complaint IN00434830. 3.1-44(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 20580 Based on observation, record review, and interview, the facility failed to ensure a resident who required nebulizer breathing treatments was assessed prior to, during, and/or after the treatment for effectiveness of the treatment, lung sounds, pulse, oxygen status, and blood pressure status for 1 of 1 resident reviewed for oxygen therapy. (Resident B) Finding includes; Resident B's record was reviewed on 8/13/24 at 10:31 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, gastrostomy, and iron deficiency anemia. An Annual Minimum Data Set (MDS) assessment, dated 5/15/24, indicated a short and long term memory problem, had no behaviors, was dependent for activities of daily living and oxygen was administered. A Care Plan, dated 5/13/24, indicated the resident required oxygen therapy. The interventions included, the medications would be administered as ordered. A Physician's Order, dated 7/5/24, indicated a nebulizer treatment of ipratropium-albuterol (breathing medication) inhalation solution 0.5-2.5 mg (milligrams) per 3 cc's (cubic centimeters) was to be given every six hours due to wheezing. During an observation on 8/14/24 at 8:35 a.m., LPN 4 prepared the resident's morning medication, which included 3 cc's of the ipratropium-albuterol to be administered by a nebulizer. She entered the room and obtained an oximeter reading (oxygen level) of 94 with a pulse of 79. LPN 4 placed the liquid medication in the nebulizer reservoir and placed the mask over the resident's mouth and nose. She then proceeded to administer the other morning medications through the gastrostomy tube. At 9:40 a.m., LPN 4 had finished the administration of the morning medications and then obtained another oximeter reading of 95% with a pulse of 83. She then turned the nebulizer off, removed the mask with the reservoir from the resident and placed it in a plastic bag in the top drawer of the bedside dresser. She did not rinse the reservoir or the mask with water after the treatment. LPN 4 had not assessed lung sounds or monitored the blood pressure before, during or after the treatment. The oxygen saturation level and pulse had not been monitored during the treatment. A facility nebulizer policy, dated 6/2/2009 and received from the Administrator as current, indicated lung sounds were to be auscultated, the respiratory rate/effort and pulse was to be assessed. The mask and reservoir was to be rinsed with water and allowed to dry after each treatment. During an interview on 8/14/24 at 1:48 p.m., the Assistant Director of Nursing indicated the policy had not been followed for the nebulizer medication administration. This citation relates to Complaint IN00434830. 3.1- 47(a)(6)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Point Christian Village	6685 East 117th Avenue Crown Point, IN 46307

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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20580 Based on observation, record review, and interview, the facility failed to provide a safe and sanitary environment to help prevent the potential of transmission of communicable diseases and infections, related to glucometers (blood sugar monitor) used for multiple residents not sanitized before and after each resident use (RN 8) and failed to sanitize an oximeter (oxygen saturation monitor) used for multiple residents after it was used on a resident. (Resident B, LPN 4) This had the potential to affect the 26 residents in the facility who receive glucometer testing and the 25 residents who reside on [NAME] C Hall. The facility also failed to ensure staff were educated on Enhanced Barrier Precautions (EBP), ensure staff were aware of which residents were on EBP, and correct Personal Protective Equipment (PPE) was used by staff members (CNA 5, CNA 6, CNA 7). This had the potential to affect the 96 residents who reside in the facility. Findings include: 1. During an observation of the Gracepoint Unit on 8/13/24 at 5:32 p.m., RN 9 was in Resident S's room administering a glucometer test. During an observation on 8/13/24 at 5:37 a.m., RN 9 exited Resident S's room and walked down the hallway. RN 9 held a small basket that contained lancets (fingerstick needles) and a glucometer in her hand. RN 9 indicated she was doing the morning blood sugar tests. No sanitizing wipes were observed. She indicated the glucometer was sanitized prior to starting the blood sugar testing and the glucometer was not sanitized after each resident, only before starting the tests and again after everyone was tested . RN 9 indicated bleach wipes were to be used to sanitize the glucometer and was unaware that the glucometers needed to be sanitized after each use. RN 9 indicated she worked on both Gracepoint Unit and [NAME] Unit. A facility blood glucose monitoring policy, dated 3/26/20 and received as current from the Administrator, indicated the glucometer was to be cleaned after each use. 2. During observations on 8/13/24 at 8:24 a.m., Resident J was observed with a feeding tube, Resident H had a urinary catheter, Resident F had a urinary catheter, Resident T had a feeding tube, and Resident B had a feeding tube. There were no signs on the doors or inside the room that indicated the residents were on EBP. Resident H's room was the only room with gowns in a storage container in the room. CNA 5 was interviewed and indicated she was unsure what EBP was. She looked on the care card in her pocket and indicated there was no information on the care card about EBP. During an interview on 8/13/24 at 8:28 a.m., CNA 7 indicated if the the resident required EBP, there would be a sign on the door and a cart with PPE outside of the door. During an interview on 8/13/24 at 8:39 a.m., LPN 8 indicated she had not received education about EBP and was unsure when EBP was. She indicated gloves were always worn while providing care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/13/24 at 9:30 a.m., the Unit Manager/Infection Control Nurse indicated there had not been education on EBP since she started employment in July. The Assistant Director of Nursing indicated the facility had not had training for EBP. They were unable to fully explain what the EBP requirements were. During an observation on 8/13/24 at 10:23 a.m., Resident H was lying in bed and CNA 5 was providing care. The resident had a urinary catheter and colostomy. CNA 5 wore gloves and had no gown on to cover her uniform. CNA 5 was observed emptying the urinary catheter drainage bag. A gown was put on after being made aware of the EPB sign on the wall inside by the room entry door. During on observation on 8/13/24 at 1:33 a.m., CNA 6 and CNA 7 were in Resident B's room and indicated they had just finished his daily care. CNA 6 and CNA 7 had gloves on and no gowns were on. CNA 6 indicated she forgot to put a gown on. There was now a sign on the entry door that indicated EBP required to be used when in the room. A facility infection control policy, dated 7/9/24 and received from the Administrator as current, indicated EBP was to be implemented for residents with wounds, indwelling medical devices or targeted multi-drug resistant organisms. High-contact care activities included dressing, bathing, hygiene, changing linens, changing briefs, device care or use, and wound care. PPE was to be stored in an isolation cart immediately outside of the resident's room. 3. During an observation on 8/14/24 at 8:35 a.m., LPN 4 applied an oximeter probe to Resident B's finger and the oxygen saturation level was obtained. The oximeter probe was removed from the finger and placed in the basket attached to the blood pressure/oximeter machine on a rolling pole, on top of the blood pressure cuffs stored in the basket. Resident B's nebulizer treatment was administered. The blood pressure/oximeter machine remained in the room during the nebulizer treatment. During an observation on 8/14/24 at 9:40 a.m., the nebulizer treatment was completed and LPN 4 removed the mask. LPN 4 reapplied the oximeter probe to the resident's finger and obtained the oxygen saturation level. The probe was removed from the resident's finger and placed in the basket attached to the blood pressure/oximeter machines, on top of the blood pressure cuffs stored in the basket. LPN 4 then removed the machine from the room and placed it in the hallway. The oximeter probe, blood pressure cuffs, rolling pole and the machines were not sanitized after it was removed from the room. The rolling pole, machines, and oximeter probe was not used from 9:40 a.m. until 10:55 a.m. During an interview on 8/14/24 at 10:55 a.m., the Wound Nurse indicated the pole, machines, blood pressure cuffs and oximeter probe should have been sanitized after it was used. 3.1-18(b)