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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>165530 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY COMPLETED<br><br>07/11/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Glen Haven Village |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>133 Indian Hills Drive<br>Glenwood, IA 51534 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673</b></p> <p>Based on observations, resident interviews, and staff interviews the facility failed to provide privacy during personal care to 1 of 3 residents reviewed (Resident #15). The facility also failed to respect each resident's dignity to 4 of 10 residents reviewed (Resident #1, #3, #13 and #44) throughout all care and services provided. The facility reported a census of 65 residents.</p> <p>Finding include:</p> <p>1. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #15 entered the facility on 5/9/16. The MDS also documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment.</p> <p>On 7/10/24 at 2:42 PM Resident #15 stated she would have liked the window shut, especially with another resident outside that could see in the window. Resident #15 stated she did not feel abused in the situation but did feel like it was undignified to leave the window open. Resident #15 stated leaving the window open bothered her.</p> <p>On 7/10/24 at 1:00 PM an observation revealed Staff K, Certified Nursing Assistant (CNA) and Staff L, Licensed Practical Nurse (LPN) during a change of wound vacuum dressing on Resident #15. During the wound vacuum change the curtain at the foot of Resident #15's bed was not drawn. Observed the resident seated in a chair with the ability to see the window from the chair.</p> <p>On 7/10/24 at 2:51 PM Staff L stated normally she would shut the window when providing cares to Resident #15. Staff L stated the expectation was privacy is given to the resident during all cares. Staff L acknowledged the window was open when providing care to Resident #15.</p> <p>On 7/10/24 at 3:19 PM the DON stated the facility's expectation was for the staff to close the doors or curtains to provide dignity and privacy for the resident.</p> <p>On 7/10/24 at 7:30 AM the Administrator stated the facility taught dignity based on the residents rights - the facility did not have a separate policy regarding dignity specifically.</p> <p>44420</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>2. The MDS assessment dated [DATE] documented Resident #1 entered the facility on 8/25/23. The MDS also documented a BIMS score of 15 which indicated no cognitive impairment.</p> <p>The facility's investigation regarding Staff A, CNA dated 3/15/24 at 3:45 PM showed the facility asked the following questions and Resident #1's reply:</p> <p>a. Do you have any concerns with the staff of the cottage? Resident #1 replied, Yes Staff A.</p> <p>The investigation recorded the following statements:</p> <p>i. Don' t like her.</p> <p>ii. She is mean.</p> <p>iii. Does not talk to me when I talk to her.</p> <p>3. The MDS assessment dated [DATE] documented Resident #3 reentered the facility on 1/7/19. The MDS also documented a BIMS score of 15 which indicated no cognitive impairment.</p> <p>The facility's investigation regarding Staff A, CNA dated 3/15/24 at 3:45 PM showed the facility asked the following questions and Resident #3's reply:</p> <p>a. Are you being treated badly or disrespectfully by any of the staff that work in this cottage? Resident #3 replied, Yes.</p> <p>The investigation recorded the following statements:</p> <p>i. She treated me bad, and others bad.</p> <p>ii. She was rough.</p> <p>iii. Then she left for the day. I was happy.</p> <p>4. The MDS assessment dated [DATE] documented Resident #13 entered the facility on 12/15/23. The MDS also documented a BIMS score of 10 which indicated moderately impaired cognition.</p> <p>The facility's investigation regarding Staff A, CNA dated 3/15/24 at 3:45 PM showed the facility asked the following questions and Resident #13's reply:</p> <p>a. Are you being treated badly or disrespectfully by any of the staff that work in this cottage? Resident #13 replied, Yes Staff A.</p> <p>The investigation recorded the following statements:</p> <p>i. Refuses to provide ice water in the room.</p> <p>ii. Called me a whiner.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>iii. Does not respond when I talk to her.</p> <p>5. The MDS assessment dated [DATE] documented Resident #44 entered the facility on 2/17/24. The MDS also documented a BIMS score of 12 which indicated moderately impaired cognition.</p> <p>The facility's investigation regarding Staff A, CNA dated 3/15/24 at 3:45 PM showed the facility asked the following questions and Resident #44's reply:</p> <p>a. Are you being treated badly or disrespectfully by any of the staff that work in this cottage? Resident #44 replied, Part of the time.</p> <p>The investigation recorded the following statements:</p> <p>i. Does not respect my choices.</p> <p>ii. Sometimes is sassy.</p> <p>iii. Tells me it is time to go to dinner even if I ask to wait.</p> <p>iv. Will only give me thin pads</p> <p>In an interview on 7/8/24 at 12:52 PM, Staff B, Licensed Practical Nurses (LPN), Care Coordinator revealed residents in the cottage reported Staff A, Certified Nursing Assistant performed care in a rough manner. Staff B stated, resident didn't feel it was intentional. Staff B stated, Staff A did not return to the cottage after that and residents felt safer after Staff A left.</p> <p>In an interview on 7/9/24 at 3:10 PM, Staff P, CNA reported she observed an incident in the kitchen, when Staff A, CNA told a female resident that she didn ' t need to use the call light so much, and the resident needed to hold it. Staff P explained the resident called out to use the bathroom multiple times and Staff A told her to hold it. Staff P couldn't recall which resident.</p> <p>In an interview on 7/9/24 at 7:50 PM, Staff E, CNA stated, she never saw Staff A, CNA talk rudely to residents.</p> <p>In an interview on 7/10/24 at 11:16 AM, Staff N, LPN stated, Staff A could be a bit snappy. We would have to get on her sometimes.</p> <p>In an interview on 7/10/24 at 11:21 AM, Staff O, Hostess, stated Staff A was rude when it came to the residents watching TV.</p> <p>In an interview on 7/11/24 at 8:43 AM, the Administrator reported she expected staff to treat residents with dignity in their home. The Administrator stated, We investigated immediately, completed interviews and terminated when the residents confirmed a pattern of behavior that was not respectful.</p> |   |  |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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> 47673</p> <p>Based on electronic record review (EHR), staff interviews, and policy review the facility failed to develop a comprehensive care plan that included problems, goals, or approaches for use of anticoagulant therapy and diuretic therapy for 2 of 5 residents reviewed (Resident #38 and #43). The facility reported a census of 65 residents.</p> <p>Finding include:</p> <p>1. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #43 entered the facility on 2/17/21. The MDS also documented a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. The MDS revealed diagnoses of essential (primary) hypertension and localized edema.</p> <p>Review of Resident #43's Care Plan revealed no problems, goals or approaches to use of a diuretic.</p> <p>Review of Resident #43's MDS dated [DATE] revealed use of diuretic.</p> <p>Review of Resident #43's Physician Orders in EHR revealed furosemide 40 mg by mouth daily at 10:00 AM started 6/3/24.</p> <p>On 7/9/24 at 1:53 PM Staff F, LPN stated Resident #43's diuretic was discontinued when she was in the hospital and then the diuretic was restarted about a month ago. Staff F stated the facility's expectation was the use of a diuretic would have been in Resident #43's Care Plan.</p> <p>On 7/9/24 at 2:46 PM the Director of Nursing (DON) stated the facility's expectation was that Care Plans would have included use of an anticoagulant for Resident #38 and use of diuretic for Resident #43.</p> <p>Review of a document provided by the DON revised 9/13 and titled, Glen Haven Village Care Planning - Interdisciplinary Team documented the facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team.</p> <p>48004</p> <p>2. The MDS assessment dated [DATE] for Resident #38 revealed diagnoses of coronary artery disease, hypertension, and transient ischemic attack.</p> <p>Review of Resident #38's Physician Orders revealed an order for Xarelto (an anticoagulant) 20 mg 1 tablet by mouth every day with a start date of 2/1/24.</p> <p>Review of Resident #38's Care Plan revealed no comprehensive care plan for the use of an anticoagulant.</p> <p>(continued on next page)</p> |   |  |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few                            | During an interview 7/09/24 at 2:35 PM with Staff F Licensed Practical Nurse (LPN) revealed she was the person who completes the Care Plans for Resident #38's unit. Staff F then revealed her expectation would be for anticoagulants to be on Care Plans. |   |  |

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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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47673</p> <p>Based on electronic health record review, policy review, resident interview, and staff interviews the facility failed to provide an opportunity for a comprehensive care plan to be reviewed and revised by an interdisciplinary team composed of each resident and resident representative to allow developing the care plan and making decisions about his or her care for 1 of 3 residents reviewed (Resident #34). The facility reported a census of 65 residents.</p> <p>Finding include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #34 entered the facility on 4/1/21. The MDS also documented a Brief Interview for Mental Status (BIMS) score of 14 indicating no cognitive impairment.</p> <p>On 7/8/24 at 12:55 PM Resident #34 stated her family does not come and are not invited to care plan conferences. Resident #34 stated that she did not get invited to care plan conferences either.</p> <p>On 7/10/24 at 12:47 PM Staff I, Recreation Coordinator stated the last care conference for Resident #34 was completed January of 2024. Staff I stated Staff J, Resident Services Director was the person that schedules the care conferences. Staff I stated that the care conferences should have been completed every 3 months. Staff I stated that the care conferences for Resident #34 were not completed every 3 months.</p> <p>On 7/10/24 at 2:15 PM Staff J, Resident Services Director stated she was unable to find any documentation that care conferences were held every three months for Resident #34. Staff J stated she was unable to find any more care conferences than was available on the EHR titled, Care Conference for Resident #34. Staff J stated care conferences should be completed quarterly within 2 weeks of MDS completion. Staff J stated the facility now had a new system in place since this concern was brought to her attention by the survey team.</p> <p>On 7/10/24 at 3:15 PM the Director of Nursing (DON) stated care plan conferences were expected to be completed quarterly with the MDS schedule. The DON acknowledged that Staff J stated she was unable to find any documentation that care conferences were held every 3 months for Resident #34.</p> <p>Review of policy, titled Glen Haven Village Care Planning - Interdisciplinary Team documented The resident, the resident's family and/or the resident's legal representative guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family.</p> |   |  |

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| <p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420</b></p> <p>Based on clinical record review, staff interviews, camera footage review and facility policy review the facility failed to assure residents were free from significant medication errors for 1 of 7 resident reviewed (Resident #24). The facility reported a census of 65 residents.</p> <p>Findings Include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] for Resident #24 documented diagnoses of high blood pressure, Diabetes Mellitus (DM) and hemiplegia. The MDS showed a Brief Interview for Mental Status (BIMS) score of 5 which indicated severe cognitive impairment.</p> <p>The Care Plan for Resident #24 dated 12/1/23 showed the following:</p> <ul style="list-style-type: none"> <li>- I have the potential for hypoglycemia and hyperglycemia episodes secondary to the diagnosis of DM.</li> <li>- I have the potential for complications related to antiplatelet therapy.</li> <li>- I may have difficulty verbally expressing my needs due to my diagnosis of vascular dementia and recent stroke which affected my vocal cords.</li> </ul> <p>The June 2024 Medication Reconciliation Form showed the following medications were administered by Staff D on 6/9/2024 for the 7 PM medication pass:</p> <p>Ferrous Sulfate 325 milligrams (mg) for iron deficiency</p> <p>Metformin 500 mg for diabetes</p> <p>Metoprolol 25 mg for rheumatoid arthritis</p> <p>The MDS assessment dated [DATE] for Resident #13 documented diagnoses of high blood pressure, Parkinson's Disease, seizure disorder and depression. The MDS showed a BIMS score of 10 which indicated a moderately severe cognitive impairment.</p> <p>The Care Plan for Resident #13 dated 6/13/24 showed the following:</p> <ul style="list-style-type: none"> <li>- I am at risk for complications related to antiplatelet therapy.</li> <li>- I am at risk for adverse consequences related to receiving psychotropic medications for the treatment of depression and bipolar disorder.</li> <li>- My team will administer my anti-seizure medication</li> </ul> <p>The June 2024 Medication Reconciliation Form showed the following medications were administered on 6/9/2024 for the 7 PM medication pass:</p> <p>(continued on next page)</p> |

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| <p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>Aspirin 81 mg to prevent blood clotting</p> <p>Cephalexin 250 mg for infection</p> <p>Divalproex DR 500 mg for convulsions/seizures</p> <p>Lamotrigine 100 mg for convulsions/seizures</p> <p>Latanoprost 0.005% eye drops for dry eyes</p> <p>Primidone 50 mg for convulsions/seizures</p> <p>Risperidone 1 mg for bipolar depression</p> <p>Trazadone 100 mg for depression and to treat thought processes and behavioral disorders in people with perceptual disorders.</p> <p>Vitamin D3 25 mcg</p> <p>In an interview on 7/9/24 at 12:32 PM, Staff B, Licensed Practical Nurse (LPN), Care Coordinator stated, she received a phone call overnight from Staff C. She said, I'm not sure but I think the nurse gave the wrong meds to the wrong resident. Staff C explained, Resident #13, reported the nurse came into her room. Resident #13 observed Staff D, Registered Nurse (RN) open her roommate's medication cabinet door (Resident #24), then left the room. Resident #13 stated, the nurse didn't give her the medications. After the call Staff B then called Staff D and asked the nurse, who's medications she gave in room three? Staff D replied, she just got done giving room [ROOM NUMBER] meds. Staff B stated, Staff D was unsure who exactly she gave meds to, but said that she matched residents with pictures, and matched the medications to the MAR. Staff B stated, she told her to monitor the resident just in case she gave wrong meds. Staff B reported despite sending another nurse over to the cottage, they were unable to determine if a medication error occurred. Staff B stated, she came in the next morning for a cottage meeting, they noticed a change in condition in Resident #24, so they called the primary care provider (PCP). The PCP ordered a Risperdal and Depakote level and they were drawn. The test results showed Resident #24 had both medications in her system. Resident #24 didn't have orders for Risperdal and Depakote but her roommate did. We knew then the medication error occurred. Staff C reported the resident was a little more tired than usual.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>In an interview on 7/9/24 at 3:28 PM, Staff C, Certified Nursing Assistant (CNA) reported Resident #13 and #24 shared a room. Staff C observed Staff D, Registered Nurse (RN) give medications to Resident #24 in the day room. Later as Staff C assisted the roommate, Resident #13, to bed she asked if the resident received medications yet. Resident #13 replied, no. Resident #13 stated she observed the nurse in her medication cabinet and removed the medications from the card containers then left the room. When Staff C told Resident #13 that it was odd the nurse gave her roommate medications and not her. Resident #13 replied, she never saw her go into Resident #24's cabinet. I'm 100% sure. Staff C called Staff B, Licensed Practical Nurse (LPN), Care Coordinator to report Resident #24 may have incorrectly received Resident #13's medications. After the call Staff C found Resident #24 in the day room with her head resting down by her knees and vomit from her knees to the floor. Resident #24 reported her head hurt. Staff C and Staff D then assisted Resident #24 to her room. While in the room Staff C observed Staff D access Resident #24's medication cupboard. Staff C heard Staff D remove medications from each container. Staff C stated, she clearly remembered Staff D attempted to hide the medications with her pointer finger and pinky finger using her left hand. She could not see any pills but the way Staff D held her hands made her think she was hiding them. After that Staff D immediately put her hands down into her pants pockets. Staff C stated, Staff D helped put Resident #24 to bed and left the room. When asked about the Resident's #24 symptoms, Staff C replied, the resident was not throwing up prior to administration that she observed. After that the resident threw up a total of three times after she got meds. The resident also said that her head hurt.</p> <p>In an interview on 7/9/24 at 4:17 PM, the PCP stated, in terms of life threatening, Resident #24 getting Resident #13's medications and psych meds wasn't an imminent danger type of situation but it did throw her for loop for 3 days. The PCP stated he would characterize it as serious but not life threatening.</p> <p>In an interview on 7/10/24 at 12:03 PM, Staff B, LPN, Care Coordinator, reported the day following the medication error Resident #24 requested to stay in bed for meals. Staff B reported, Resident #24 didn't want to get up when staff attempted to get her up for meals. Staff B reported, per documentation, the resident failed to consume meals on 6/9/24, staff assisted the resident to take sips of water.</p> <p>The Progress Note on 6/10/24 at 6:34 AM for Resident #24 showed the following: Called to check on and assess a resident who was reported to have vomited a moderate amount of brown mucus like emesis. Resident observed sitting at the dining table noted with generalized weakness, was awake, lethargic but responsive to tactile stimuli. Resident assisted back to bed and was agitated and combative during transfer and assessment.</p> <p>The Risperidone Lab test collected on 6/10/24 for Resident #24 showed a blood level of 10.9 nanograms/milliliter (ng/ml).</p> <p>Review of the June 2024 MAR for Resident #24 showed Risperidone not ordered.</p> <p>The Depakote lab test collected on 6/10/24 for Resident #24 showed a blood level of 22.1 ng/ml.</p> <p>Review of the June 2024 MAR for Resident #24 showed Depakote not ordered.</p> <p>The Point of Care History for Resident #24 showed the following for the day after the medication error on 6/10/24:</p> <p>(continued on next page)</p> |   |  |

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>How did the resident transfer? Activity did not occur.</p> <p>How did the resident move off the unit? Activity did not occur.</p> <p>The timeline of camera footage for the evening of 6/9/2024 the following was noted:</p> <p>At 6:36 PM Staff D, RN took Resident #24's blood pressure</p> <p>At 6:49 PM Staff D took medication cup into Resident #24's room without the computer. After a few moments the nurse returned to her cart with medications. Staff D placed some of the pills from her hand into a pill crusher sleeve and crushed them, she then opened a capsule pill and emptied the contents into the medication cup along with the crushed pills.</p> <p>At 6:52 PM Staff D walked back toward room [ROOM NUMBER], when she returned she added pudding to the crushed pills in a med cup.</p> <p>At 6:53 PM Staff D approached Resident #24 in the lounge where she sat and administered the medication.</p> <p>By 7:25 PM Resident #24 started to slouch over in her wheelchair in the lounge.</p> <p>At 7:39 Staff C, CNA walked into the lounge and asked Resident #24 what is going on. As Staff C stepped closer to Resident #24 she noticed the vomit.</p> <p>At 7:45 PM Staff D walked out of the hallway where the room is at, the closing of the medication cabinet is audible. Staff D stated, need to give her medications. As Staff D entered the hallway carrying medications, Staff D asked Staff C for assistance with Resident #24. Staff D stated, I can usually get her by herself but she won't sit up. At this time Staff D returned to the room twice, the second time she returned with a drinking cup and what appears to be another med cup.</p> <p>The Medication Administration Policy and Procedure last revised October 2023 identified the following:</p> <ol style="list-style-type: none"> <li>1. Medications are administered only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to administer medications.</li> <li>2. Medications are administered in accordance with written orders of the attending physician or physician extender.</li> <li>3. If a dose seems excessive considering the resident ' s age and condition, or a medication order seems to be unrelated to the resident ' s current diagnoses or conditions, the nurse calls the provider pharmacy for</li> </ol> <p>(continued on next page)</p> |   |  |

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| <p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>clarification prior to the administration of the medication or if necessary contacts the prescriber for clarification. This interaction with the pharmacy and /or prescriber and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate.</p> <p>4. Medications are administered at the time they are prepared. Medications are not pre-poured.</p> <p>5. Medications are administered without unnecessary interruptions.</p> <p>6. The person who prepares the dose for administration is the person who administers the dose.</p> <p>7. Residents are identified before medication is administered. Methods of identification include:</p> <p>a. Checking photograph attached to medical record</p> <p>b. Asking resident to say his/her name</p> <p>c. If necessary, verifying resident identification with other facility personnel</p> <p>8. Hands are washed before and after administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications.</p> <p>9. At least 4 (four) ounces of water or other acceptable liquid are given with oral medications unless fluid restrictions apply.</p> <p>10. Medications are administered within one hour before or one hour after scheduled time, except before or after meal orders, which are administered based on mealtimes. Unless otherwise specified by prescriber, routine medications are administered according to the established medication administration schedule for the facility.</p> <p>11. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications.</p> <p>12. Medications supplied for one resident are never administered to another resident.</p> <p>14. For resident 's not in their rooms or otherwise unavailable to receive medication on the pass, the nurse will not leave medications in the room unattended ever. The nurse will return at a later time to administer medications.</p> <p>15. The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate.</p> <p>16. Identify medication related monitoring and documentation necessary for:</p> <p>(continued on next page)</p> |

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| <p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>Adverse Consequences/Events related to medication use</p> <p>Efficacy</p> <p>Side-Effects</p> <p>In an interview on 7/11/24 at 9:10 AM, the Administrator reported the facility terminated Staff D, RN for not following proper medication administration procedures and because she was not honest about the medication error. The Administrator reported there were many steps in the medication administration process Staff D failed to follow that placed residents at risk.</p> |   |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48004</b></p> <p>Based on observations, staff interviews, policy review and the Center for Disease Control guideline review the facility failed to use universal infection control measures (hand hygiene) and Enhanced Barrier Precautions (EBP) during catheter cares for 2 of 3 residents reviewed for infection control (Resident #34, and #47). The facility reported a census of 65 residents.</p> <p>Findings include:</p> <p>1. On 7/10/24 at 9:03 AM observed Staff G Certified Nursing Assistant (CNA) and Staff H Medication Aide complete hand hygiene and don gloves prior to catheter care for Resident #47. Staff G placed a barrier on the floor and placed a urine graduate on the barrier. Staff G then went to drain the urinary collection bag which spilled urine onto the floor and into the urine graduate. The urinary drainage port was then cleaned with an alcohol swab and returned. Staff G and Staff H then doffed gloves and completed hand hygiene. During the procedure Staff G and Staff H failed to wear a gown as required per Enhanced Barrier Precautions (EBP).</p> <p>In an interview on 7/10/24 at 9:10 AM Staff G revealed she forgot to put on a gown when a gown should have been worn for draining Resident #47's catheter.</p> <p>In an interview on 7/10/24 at 9:31 AM Staff B Licensed Practical Nurse (LPN) revealed her expectation would be for gowns and PPE to be worn at appropriate times for EBP.</p> <p>In an interview on 7/10/24 at 9:37 AM with the Director of Nursing (DON) revealed his expectations would be for the correct PPE to be worn while providing catheter cares on Enhanced Barrier Precautions.</p> <p>Review of the facility provided policy titled, Enhanced Barrier Precautions dated 4/1/24 documented:</p> <p>a. When any staff member is performing high-contact resident cares, the use of an isolation gown will be implemented for any resident on EBP (in addition to already used gloves as part of standard precautions).</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 - Few</p>                     | <p>Centers for Disease Control and Prevention website titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), visited 7/11/24 and updated 7/12/22 revealed recent changes included, additional rationale for the use of Enhanced Barrier Precautions (EBP) in nursing homes, including the high prevalence of multidrug-resistant organism (MDRO) colonization among residents in this setting. Expanded residents for whom EBP applies to include any resident with an indwelling medical device or wound (regardless of MDRO colonization or infection status). Expanded MDROs for which EBP applies. Clarified that, in the majority of situations, EBP are to be continued for the duration of a resident's admission. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status and Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care.</p> <p>47673</p> <p>2. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #34 entered the facility on 4/1/21. The MDS also documented a Brief Interview for Mental Status (BIMS) score of 14 indicating no cognitive impairment.</p> <p>On 7/10/24 at 12:14 PM an observation of Staff M, Certified Nursing Assistant (CNA) completed of catheter cares on Resident #34. Staff M completed hand hygiene, applied a gown, and applied gloves. Staff M removed Resident #34 briefs and pants. Staff M then cleansed the peri area, removed gloves, pulled the chair forward away from the wall, did not complete hand hygiene, and applied new gloves. Staff M completed peri cares, applied briefs, and pants were pulled up. Staff M then applied a barrier on the ground, applied gloves, unscrewed catheter tip, emptied 100 mL of urine from the catheter, tightened catheter tip, and removed gloves. Staff M failed to perform hand hygiene then applied gloves, stood Resident #34 up and transferred Resident #34 to another recliner. Staff M emptied the graduate into the toilet. Staff M removed gloves, removed gown, emptied trash, and put shoes on Resident #34. Staff M left Resident 34's room, went down the hall to obtain a chair pad from the closet, returned to Resident #34's room, and applied the bed pad to the recliner. Staff M left the room, threw trash away in hallway, returned to another resident's room, and failed to complete hand hygiene.</p> <p>On 7/10/24 at 3:29 PM the DON stated the facility expected hand hygiene to be completed with all glove changes, before and after all resident care.</p> <p>Review of document dated 1/14/22 titled, Hand Hygiene Policy and Procedure documented the staff are to wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Gloves are not a substitute for hand hygiene. If the task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves.</p> |   |  |