

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165607	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER The Cottages		STREET ADDRESS, CITY, STATE, ZIP CODE 1742 Main Street Pella, IA 50219	

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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817</p> <p>Based on clinical record review, staff interview, and policy review the facility failed to document an accurate code status for one of four residents sampled for advanced directives (Resident #147). The facility reported a census of 92 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #147 had diagnoses that included multiple sclerosis, thyroid disorder, and a left fibula (a bone in the lower leg) fracture.</p> <p>The Care Plan revised 9/17/24 revealed the advance directives was manifested by the resident and family's specifications. The staff directives included to refer to the IPOST (Iowa Physician's Orders for Scope of Treatment) form on file and review the advanced directives routinely at the care conferences and PRN (as needed).</p> <p>The electronic health record (EHR) (screenshot) revealed Resident #147's code status as a Full Code. The MDS Coordinator entered and confirmed the order on 9/16/24.</p> <p>The EHR Order Details revealed a full code listed under the advanced directives ordered on 9/16/24 at 11:27 AM.</p> <p>The Order Summary Report revealed a prescriber's written active order for a full code ordered on 9/16/24.</p> <p>The IPOST signed by the physician on 9/18/24 revealed a DNR/do not attempt resuscitation.</p> <p>The EHR Resident Detail report printed 9/24/24 at 4:25 PM revealed a DNR entered into the Code Status section.</p> <p>The Order Details revealed on 9/25/24 at 7:53 AM, the MDS Coordinator entered the advanced directives as a DNR order.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview 9/24/24 at 3:15 PM, Staff A, Licensed Practical Nurse (LPN) reported the Social Worker (SW) obtained the resident's or resident representative's signature, indicated the choice for a full code or DNR status, then the physician signed the IPOST. The IPOST got scanned into the resident's EHR and placed into a binder located at each household. The SW updated the code status in the computer to reflect if the resident was DNR or full code status. At the time, Staff A confirmed Resident #147's code status was listed as a full code in the EHR.</p> <p>During an interview 9/24/24 at 3:24 PM, the MDS Coordinator reported the SW updated the code status in the EHR after they received the signed IPOST.</p> <p>During an interview 9/24/24 at 4:19 PM, Staff B, SW, reported she presented the IPOST to the resident/representative whenever a resident admitted to the facility. Staff B reported a hard (paper) copy of the IPOST placed in the binder at the nurse's station. She scanned the IPOST into the EHR after the physician signed the IPOST. She also updated the code status in the EHR.</p> <p>During an interview 9/25/24 at 3:03 PM, Staff C, Registered Nurse (RN), reported she looked in the EHR for the resident's code status. Staff C reported the SW updated the code status in the EHR whenever the resident's code status changed.</p> <p>During an interview 9/25/24 at 3:15 PM, Staff D, RN, reported she looked at the EHR to check a resident's code status. Staff D reported they also had a red folder at the nurse's station with all of the residents who had a full code status. Staff D confirmed three residents in the Gelderland Household currently had a full code status. Resident #147's code status information was not contained in the folder.</p> <p>During an interview 9/26/24 at 10:05 AM, the Director of Nursing reported the process for advanced directives was a process they had been working on at the facility to ensure the resident's code status information was correctly entered into the EHR.</p> <p>In an interview 9/26/24 at 10:10 AM, the Clinical Quality RN Specialist reported she went through and reviewed all of the residents' IPOST's but did not compare the IPOST information to each resident's EHR to see that the code status matched.</p> <p>An Advanced Directive Policy revised 9/2024 revealed the IPOST or another document directed the resident's health care and their wishes. The Advance Directive document located in the resident's medical record and readily retrievable by any team member. Changes to the resident's choices for Advance Directives documented in the resident Care Plan, State specific documents (such as the IPOST), and the physician's orders to reflect the new choices as applicable.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500</p> <p>Based on clinical record review, resident and staff interviews, and facility document review, the facility failed to evaluate the need for and offer scheduled nutrition interventions related to on-going weight loss and poor intake at meals. The facility also failed to update Resident 72's Care Plan to accurately reflect current staff interventions for weight loss, if any provided, and update the Care Plan for one of three residents reviewed for nutrition (Resident #72). The facility reported a census of 92 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] indicated that the Brief Interview for Mental Status could not be completed and Resident #72's cognitive skills for daily decision making were severely impaired. Diagnoses include Alzheimer's disease, Parkinson's disease, heart failure, anxiety disorder, and depression. The MDS revealed Resident #72 required set-up or clean-up assistance at meals and was independent with walking at least 150 feet. Resident #72 also assessed as independent to move from sit to stand or lying position without the use of assistive devices.</p> <p>The Care Plan with the next scheduled review date of 12/19/24 documented Resident #72 was able to eat independently after set-up and needed cueing at times. The Care Plan also indicated Resident #72 had a potential problem related to low food intake with a goal to consume 75-100% of diet offered. Interventions include:</p> <ul style="list-style-type: none"> a. Develop an activity program that includes exercise, mobility. Offer activities of choice to help divert attention from food with an initiation date of 7/21/23 b. Invite resident to activities that promote additional intake with an initiation date of 7/21/23 c. Registered Dietitian (RD) to evaluate and make diet change recommendations PRN with an initiation date of 7/21/23 d. Resident would like to have time to consume meals, do not rush with an initiation date of 7/21/23 e. Resident would like to have documented and recorded meal intake with an initiation date of 7/21/23 <p>No interventions related to low food intake identified on the current Care Plan since 7/21/23.</p> <p>The diet card, maintained by the Director of Dining Services, noted on 8/8/24 that Resident #72 had a history of refusing meals and to offer coffee drinks that comply with order. The diet card directed staff to offer plastic silverware as adaptive equipment. No further information regarding intolerances, likes, or dislikes noted. The diet card did not indicate current or past use of oral nutrition supplements or use of fortified foods.</p> <p>The Weights and Vitals summary obtained on 9/26/24 show the following weights from January 2024: (continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1/4/24 144.8 Lbs</p> <p>2/1/24 142.4 Lbs</p> <p>3/1/24 142.0 Lbs</p> <p>4/1/24 136.0 Lbs</p> <p>4/3/24 136.0 Lbs</p> <p>5/1/24 137.6 Lbs</p> <p>6/5/24 134.8 Lbs</p> <p>7/5/24 130.6 Lbs</p> <p>8/1/24 112.8 Lbs</p> <p>9/1/24 127.8 Lbs</p> <p>The documented weight of 112 Lbs on 8/1/24 was struck out by the RD on 9/18/24 as a technical error. No further documented weight for the month of August identified.</p> <p>The Order Summary Report, obtained on 9/26/24, did not list the use of oral nutrition supplements or the use of fortified foods.</p> <p>The POC Response History for the task related to Nutrition-Amount Eaten obtained on 9/26/24 indicated Resident #72 eating greater than 50% for 70 meals out of 87 meals offered over the past immediate 30 days.</p> <p>The Nutrition/Dietary Notes written by the RD revealed the following:</p> <p>On 3/23/24 at 2:21 PM: Ht: 66 CBW (current body weight): 142.0# BMI (body mass index): 22.9. Wt Hx (weight history): stable x 180 d. General diet, regular textures, thin liquids. Avg meal intakes >50% w/ 120-240 mL fluid q meals. Eats independently w/ plastic silverware. Own teeth w/ no reports of difficulty chewing/swallowing. No PI (pressure injury) or edema present. No GI (gastrointestinal) concerns noted. No recs at this time, continue POC (plan of care). Weight loss, skin breakdown, fecal impaction, and dehydration may be expected/unavoidable outcomes as disease progresses. Continue to encourage intakes/hydration as resident desires on hospice cares. Will continue to monitor. Notify RD of sig changes.</p> <p>On 4/24/24 at 2:26 P: Ht: 66 CBW: 136.0# BMI:21.9. Wt Hx: -4.2% x 30 d, -6.1% x 90 d, -4.1% x 180 d. No sig (significant) wt (weight) changes. General diet, regular textures, thin liquids. Avg meal intakes 50-100% w/ 120-240 mL fluid q meals. Eats independently w/ plastic silverware. No recs at this time, continue POC. Weight loss, skin breakdown, fecal impaction, and dehydration may be expected/unavoidable outcomes as disease progresses. Continue to encourage intakes/hydration as resident desires on hospice cares. Will continue to monitor. Notify RD of sig changes.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/29/24 at 5:03 PM: Ht: 66 CBW: 136.0# BMI: 22.2. Wt Hx: stable x 30 d, -3.4% x 90 d, -5.7% x 180 d. No sig wt changes. General diet, Regular textures, Thin liquids ordered. Meal intakes dropping recently, ~2 meal refusals/d x 1 wk w/ 240-480 mL fluid q meals. Eats independently w/ plastic silverware. No recs at this time. Weight loss, skin breakdown, fecal impaction, and dehydration may be expected/unavoidable outcomes as disease progresses. Continue to encourage intakes/hydration as resident desires on hospice cares. Will continue to monitor. Notify RD of sig changes.</p> <p>On 6/19/24 at 11:33 AM: Ht: 66 CBW: 134.8# BMI: 21.8. Wt Hx: -2.0% x 30 d, -5.1% x 90 d, -5.2% x 180 d. No sig wt changes, trending down. General diet, Regular textures, Thin liquids ordered. Meal intakes varied; <50% on avg. x 1 wk w/ 240-480 mL fluid q meals. Eats independently w/ plastic silverware. No noted chewing or swallowing issues. No recent edema, PU, or GI issues noted. No new dietary recs. Weight loss, skin breakdown, fecal impaction, and dehydration may be expected/unavoidable outcomes as disease progresses. Continue to encourage intakes/hydration as resident desires on hospice cares. Will continue to monitor. Notify RD of sig changes.</p> <p>On 8/20/24 at 2:58 PM:Ht: 66 CBW:112.8# BMI: 18.2. Wt Hx: -13.6% x 30 d, -16.3% x 90 d, -20.6% x 180 d. No sig wt changes, trending down. General diet, Regular textures, Thin liquids ordered. Meal intakes remain subpar, <50% on avg w/ 240-480 mL fluid q meals. Eats independently w/ plastic silverware. No noted chewing or swallowing issues. No recent edema, PU, or GI issues noted. No new dietary recs. Weight loss, skin breakdown, fecal impaction, and dehydration may be expected/unavoidable outcomes as disease progresses. Continue to encourage intakes/hydration as resident desires on hospice cares. Will continue to monitor. Notify RD of sig changes.</p> <p>The above note summarized Resident #72's weight loss as non-significant and trending down. The weight loss calculations referenced in the note did meet criteria for significant losses at 30 and 180 days.</p> <p>On 9/18/24 at 11:18 AM: Ht: 66 CBW: 127.8# BMI: 20.6. Wt Hx: -5.2% x 90 d, -10.0% x 180 d (sig). EEN: 1750-1900 kcals/d, 58g pro/d, <1900 mL fluid/d. General diet, Regular textures, Thin liquids ordered. Meal intakes varied; <50% on avg. x 1 wk w/ 240-480 mL fluid q meals. Eats independently w/ plastic silverware. No noted chewing or swallowing issues. No recent edema, PU, or GI issues noted. No new dietary recs. MD notified of sig wt loss; likely unavoidable at this stage. MNA indicates at risk of malnutrition. Form submitted w/ recommendation to add moderate protein calorie malnutrition to Dx AEB sig wt loss x 180 d and intakes <50%. Weight loss, skin breakdown, fecal impaction, and dehydration may be expected/unavoidable outcomes as disease progresses. Continue to encourage intakes/hydration as resident desires on hospice cares. Will continue to monitor. Notify RD of sig changes.</p> <p>All of the above Nutrition/Dietary Notes written by the RD failed to indicate the rationale for the lack of nutritional interventions when non-significant weight loss and/or sub-optimal intake at meals were identified. The Nutrition/Dietary Notes failed to document any previous attempts at nutritional interventions when non-significant weight loss and/or sub-optimal intake at meals identified.</p> <p>During a brief interaction on 09/26/24 10:40 AM, Resident #72 responded I'm hungry when asked how he was doing.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 9/24/24 at 1:50 PM, Staff H, Certified Nursing Assistant, reported Resident #72's intake had improved recently. Unit snacks may be offered in the afternoon but do not follow any specific menu or diet spreadsheet. Staff H not aware of Resident #72 needed plastic silverware at meals, as outlined on the diet card.</p> <p>In an interview on 9/25/24 at 9:15 AM, the Director of Dining reported weekly weight meetings with the RD and household coordinators attending. During which trending weights are reviewed and interventions discussed, if applicable. She voiced facility-specific dietary interventions may include the use of fortified foods, such as fortified cereals, super mashed potatoes, addition of extra sauce/gravy or double protein The Director of Dining indicated none of the above interventions listed on Resident #72's diet card.</p> <p>In an interview on 9/25/24 at 2:44 PM, the RD reported the weekly meetings are to review resident weight loss and condition. Nutritional interventions are discussed. The RD stated no formal minutes or notes taken. Present staff members may write a Progress Note in the medical record and/or alert the primary care provider if indicated. Regarding Resident #72, the RD was informed by nursing staff that family was not agreeable with nutritional supplements and there should be documentation in a Progress Note. RD could not provide a timeframe of when this information was known. The RD acknowledged no nutritional interventions are currently in place for Resident #72. The RD reported Resident #72 was medically declining at one point but has rebounded. The RD acknowledged that Resident #72 has received hospice services for an extended period, since September '23, and indicated if a resident is receiving hospice services, may let it (weight loss) slide.</p> <p>In an interview on 9/26/24 at 1045 AM, the Director of Nursing (DON) discussed the weekly weight meetings and discussion of possible interventions. The DON was not aware of any documented or scheduled nutritional interventions for Resident #72. The DON voiced family was not interested in supplements but unable to provide a timeframe or further explanation regarding family wishes.</p> <p>In a follow-up interview at 12:30 PM, the DON explained unable to locate further documentation from hospice or facility staff related to family's wishes towards supplement use or further nutritional interventions. The DON reiterated Resident #72's medical decline where interventions were not appropriate in mid to late July. DON acknowledged Resident #72 has medically improved since then and eating better overall. The DON reported facility staff does offer snacks and drinks to Resident #72 frequently but did not note if these were scheduled snacks or if provided as needed.</p> <p>The Nutrition Intervention Program policy, with a revised date of 8/2024, indicated attempts will be made to maintain a high nutritional status and weight acceptable to bodily structure and physical condition. The clinical team will monitor food consumption and weights and will intervene nutritionally on residents experiencing significant weight loss. Procedures include:</p> <p>a. Each resident experiencing a 5% weight loss for one (1) month period, 7 1/2% weight loss for a three (3) month period, or a 10% weight loss for a six (6) month period will be entered into the nutritional intervention program.</p> <p>b. Resident care plans will be adjusted to address the resident's weight loss or gain.</p> <p>(continued on next page)</p>		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Dietitian will document an initial nutrition assessment upon notification of a weight loss or gain and at least bi-monthly for those in the nutritional intervention program with appropriate interventions added by the Interdisciplinary Team. Documentation will be maintained in the resident's medical record.		

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817</p> <p>Based on record review, observations, staff interviews, and facility policy review, the facility failed to follow enhanced barrier precautions (EBP) and infection control practices to prevent the potential spread of infection or disease for 2 of 18 residents sampled (Resident #37). The facility staff also failed to appropriately cleanse and disinfect resident care devices after a tube feeding and medications administered through a gastrostomy tube (Resident #69). The facility staff also failed to wash hands or complete proper hand hygiene in-between dirty to clean tasks for 1 of 6 households observed. The facility reported a census of 92 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment date 9/23/24 revealed Resident #37 readmitted to the facility from the hospital on 9/23/24.</p> <p>The Medical Diagnosis list in the electronic health record (EHR) revealed the resident had diagnoses of methicillin susceptible staphylococcus aureus (MSSA) (a staph bacteria) infection effective 9/20/24, an extradural (epidural space of the spine or skull) and subdural abscess (a collection of pus that forms in the subdural space between the arachnoid and dura mater of the brain) (added 9/23/24), and elevated white blood cell count (indicating an infection) (added 9/24/24).</p> <p>The Care Plan initiated 9/24/24 revealed the resident had an epidural abscess of the cervical spine at the C2-C3 and MSSA bacteremia (bacteria in the blood). The Care Plan directed staff to administer antibiotics per physician's orders and check the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for PICC line cares to the right upper extremity.</p> <p>The MAR dated 9/2024 revealed cefazolin sodium (an antibiotic used to treat serious bacterial infections) 2 grams intravenously every 8 hours related to MSSA infection. The MAR documented Staff A, Licensed Practical Nurse (LPN), administered the scheduled 4:00 PM dose on 9/24/24.</p> <p>During observations on 9/24/24 at 3:32 PM, Staff A, LPN, obtained supplies and prepared cefazolin 2 grams in 50 milliliters (ml) of dextrose solution. Staff A mixed the powdered medication and the solution in the bag until the medication dissolved. Staff A placed the IV bag on the IV pole with an infusion pump. At the time, an IV tubing was draped over the IV pump and the spike of the IV tubing exposed to air (uncapped) and not attached to an IV bag. Staff A sanitized her hands, donned a pair of gloves, then took an alcohol swab and cleansed the spike on the IV tubing that hung over the IV pump. Staff A then pierced the bag of cefazolin with the spike from the IV tubing, and hung the bag back on the IV pole. Staff A removed an orange cap covering the end of the PICC line, took an alcohol swab and cleansed the PICC line. Staff A flushed the PICC line with 10 ml normal saline, primed the IV tubing, the attached the IV cefazolin to the PICC line. Staff A set the IV pump to infuse the medication over 30 minutes. Staff A removed her gloves and sanitized her hands.</p> <p>Staff A did not utilize a gown while she performed cares and administered medications through the resident's PICC line.</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>During observation on 9/24/24 at 4:34 PM, Staff A, LPN, checked the IV bag and reported the antibiotic medication infused. Staff A sanitized her hands, donned a pair of gloves, and stopped the IV pump. Staff A removed the IV tubing from the PICC line, then took an alcohol swab and cleansed the PICC line port, and flushed the PICC line with 10 ml normal saline. Staff A removed her gloves. Staff A took a black marker and crossed the resident's name and personal information on the IV bag. Staff A threw the IV bag and tubing in the trash, then sanitized her hands. Staff A did not utilize a gown while she handled the resident's PICC line and completed medication administration. The Director of Nursing (DON) stood in the room and observed Staff A during this time.</p> <p>During an interview 9/24/24 at 9:00 AM, Staff A reported the pharmacy sent the IV tubing along with the IV medication infusion. The resident's IV tubing was changed out every 24 hours.</p> <p>During an interview 9/25/24 at 3:03 PM, Staff C, RN, reported personal protective equipment (PPE) such as gown and gloves required whenever she worked with a resident's catheter, a wound, or if the resident had COVID-19.</p> <p>During an interview 9/25/24 at 3:14 PM, Staff E, certified nursing assistant (CNA), reported a gown and gloves worn if a resident was really sick or had COVID, and whenever she emptied a resident's catheter.</p> <p>During an interview 9/25/24 at 3:15 PM, Staff D, RN, reported EBP's consisted of donning a gown and gloves whenever staff worked with a resident with an open wound and tube feeding, but EBP's not necessary when worked with a resident's PICC line. An isolation precautions card placed in the resident's room or on the door and PPE supplies placed inside the resident's room whenever a resident on isolation or EBP's.</p> <p>An email received from the facility's Clinical Quality RN Specialist on 9/26/24 at 8:23 AM revealed the facility did not have an IV medication administration policy. The Clinical Quality RN Specialist wrote the facility's nursing staff just followed the nursing standards of care.</p> <p>During an interview 9/26/24 at 9:45 AM, Staff D, RN, reported the IV tubing came from the pharmacy. IV tubing was changed out every 24 hours. Staff D reported the IV bag discarded after the IV infusion completed, but she recapped the end of the IV tubing in order to use for IV tubing for the next IV medication infusion up to 24 hours. Staff D reported she just found out a gown should be worn whenever staff worked with a resident's PICC line. Staff D reported signage regarding PPE use placed in Resident #37's room.</p> <p>During an interview 9/26/24 at 9:51 AM, Staff F, CNA, reported gown and gloves worn whenever a resident on EBP's. Staff F reported she just found out she needed to wear a gown and gloves if resident had a PICC line.</p> <p>During an interview 9/26/24 at 10:07 AM, the DON reported she would leave the IV tubing connected to the bag and use the IV tubing for the next IV medication administration. She would get a new IV tubing rather than wipe the spike on the IV tubing with alcohol. The DON reported she expected staff wore a gown and gloves for EBP's and whenever working with a resident's PICC line.</p> <p>The facility's IV and PICC Management policy revised 6/2020 lacked information or the procedure for infusion of IV medication through the PICC line.</p> <p>(continued on next page)</p>		

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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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A pharmacy's Medication Administration infusion therapy policy and procedure revised 2023 revealed the sterility of the IV bag and equipment inspected prior to medication administration, and pharmacy called if any problems noted.</p> <p>An Enhanced Barrier Precautions policy revised 4/2024 revealed EBP's is a method for reducing the spread of multi-drug resistant organisms (MDRO). A gown and gloves worn to prevent contamination of healthcare personnel hands and clothing during care activities that have the highest risk of transfer of MDRO's. Residents with risk factors like indwelling medical devices may unknowingly have a MDRO and develop a serious infection and spread MDRO's to others. EBP can effectively reduce the spread of MDRO's. EBP's used whenever a resident had an indwelling device such as a central vascular and central catheter lines.</p> <p>50500</p> <p>2. Tube feeding and medication administration for Resident #69 observed on 9/24/24 at 7:00 AM with Staff G, Registered Nurse. Staff G observed washing hands in the bathroom sink prior to the start of administering medications and tube feeding. After medications were given, the tube feeding product was provided as directed via syringe feedings. Once the feedings were complete, Staff G gather the used supplies, which included two graduates (one used for tube feeding product and the other used for water), a 60 cc syringe, and the gastric-tube (g-tube) extension. The graduate used for water was also the same graduate used earlier in the observation to mix and administer medications. Staff G placed the g-tube extension in the bathroom sink. Staff G proceeded to rinse out the two graduates and syringe over the g-tube extension. After the items were rinsed, Staff G removed the g-tube extension from the sink, rinsed and flushed out with water. Supplies were left on the bathroom counter to air dry with the g-tube extension in one of the graduate.</p> <p>During an interview 9/26/24 at 1045 AM, the Director of Nursing (DON) indicated she would have rinsed the g-tube extension first instead of laying it in the sink to reduce the risk of cross contamination.</p> <p>3. Lunch preparation and service on the Zuid [NAME] unit observed on 9/25/24 at 11:30 AM with Staff I, cook. After pureeing a serving of chicken alfredo with noodles, Staff I proceeded to hand wash the blender for use on the next puree food item. Staff I was observed washing out the blender several times to ensure all food residue was removed. Once the blender was clean, Staff I pureed the zucchini and squash vegetable dish. When the task was completed, Staff I continued to prepare for lunch service up until approximately 12:00 PM when it was time to plate food for resident. No hand hygiene observed during this time frame nor was it observed at the start of plating lunch.</p> <p>During an interview on 9/25/24 at 12:30 PM, the Director of Dining acknowledged the lack of hand hygiene from Staff I as she was present during lunch preparation and service.</p> <p>An email received on 9/26/24 at 11:45 AM, the Clinical Quality RN indicated there was not a separate policy for dietary and hand hygiene. It is all the same hand hygiene policies within the infection control manual.</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>Per the Food and Drug Administration Food Code 2017 (2-301.14 When to Wash), hand washing should be performed before engaging in food preparation, after handling soiled equipment and utensils, and during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.</p>