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No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185272 | A. Building<br>B. Wing | 10/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| River Haven Nursing and Rehabilitation Center | 867 McGuire Avenue<br>Paducah, KY 42001 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>44370<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that included measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs as identified in the comprehensive assessment for 2 of 21 sampled residents (Resident (R)39 and R42).<br><br>1. R39 developed a facility acquired stage 4 pressure ulcer in 05/2024. However, there was no documented evidence the facility reviewed and further developed R39's care plan with additional interventions. Further, R39's comprehensive care plan (CCP) did not include measurable data elements to monitor progress towards the expected outcomes and goals.<br><br>2. R42 received tube feeding and was care planned to have the head of bed (HOB) elevated. However, observations on 10/21/2024 at 1:15 PM and 3:18 PM, revealed R42's HOB was flat.<br><br>The findings include:<br><br>Review of the facility policy, Comprehensive Care Plans Standard of Practice, dated 10/2020, revealed an individualized comprehensive care plan (CCP) that included measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs was to be developed for each resident. Continued review revealed each residents' CCP was to be designed to identify problem areas and incorporate risk factors associated with the identified problems. Per review, the CCP was to reflect treatment goals, timetables, and objectives in measurable outcomes to aid in preventing or reducing declines in a resident's functional status and or functional levels. Further review revealed areas of concerns that were triggered during the resident assessment were to be evaluated using specific assessment tools before interventions were added to the care plan. Additionally, review revealed assessments of residents was ongoing and care plans were revised as information about the resident and condition changes.<br><br>1. Review of the facility's, Admission Record for R39 revealed the facility admitted the resident on 01/10/2024, with diagnoses including paraplegia, unspecified; chronic pain syndrome; and multiple (6) pressure ulcers. Review of the Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 09/13/2024, revealed the facility assessed R39 to have a Brief Interview for Mental Status (BIMS) score of 12 of 15, which indicated moderate cognitive impairment.<br><br>(continued on next page) |

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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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Wound Care Provider's initial, Wound Evaluation and Management Summary, for R39's left heel wound dated 05/02/2024, revealed the Physician had made recommendations that included: offloading the wound; turning the resident side to side and front to back in bed every one to two hours if able.<br><br>Review of the Wound Evaluation and Management Summary dated 10/17/2024, revealed the Wound Physician's recommendations included: turning the resident side to side in bed every one to two hours, if able, and offload the wound.<br><br>Review of the facility's CCP for R39 revealed a focus problem for impaired skin integrity, dated 01/04/2424, that noted the resident had pressure sores with presence of skin breakdown or was at high risk for skin breakdown. Continued review revealed interventions dated 01/11/2024, that included: cushion pressure reduction; mattress pressure reduction; providing gentle support when turning, positioning, or transferring; and providing wound care as ordered by the Physician. In addition, review revealed the goal for R42 stated, improve nutritional status and avoid prolonged pressure to skin. However, review of the CCP further revealed no documented evidence the facility developed and implemented additional interventions for R39's actual pressure ulcer, such as use of the wedge cushion or heel boots. Additionally, there was no documented evidence the facility developed R39's CCP to include the Wound Physician's recommendations to turn the resident side to side in the bed every one to two hours if able and offload the wound.<br><br>Additional review of the CCP for R39 revealed a focus problem for pressure ulcer, actual, dated 01/11/2024, which noted pressure ulcers. Continued review revealed on 05/02/2024, documentation noting R39 developed a new stage 4 pressure wound of the left heel. Per review, the interventions were dated 01/19/2024, and included: pressure relieving device chair cushion; pressure relieving device mattress; applying skin treatments as ordered; and weekly skin rounds to monitor progress of pressure ulcers. Further review revealed the goal dated 01/19/2024, noted R39 would have a decrease in stage of pressure ulcer through the next review date of 01/06/2025. Additionally, review of the CCP documentation revealed R39's care plan was reviewed on: 04/10/2024, 04/29/2024, 07/08/2024, 07/11/2024, 07/29/2024, 08/20/2024, and 10/16/2024. Review revealed however, the care plan was not reviewed or updated with R39's new pressure ulcer noted on 05/02/2024. Review of the CCP further revealed no documented evidence the facility developed and implemented care plan interventions on 5/02/2024 when R39 developed the new pressure ulcer, such as use of a wedge cushion or heel boots. In addition CCP revealed there was no documented evidence the facility developed R39's CCP to include the Wound Physician's recommendations to turn the resident side to side in the bed every one to two hours if able and offload the wound.<br><br>Further review of the CCP for R39 revealed a focus problem for pain dated 01/11/2024, related to wounds and malnutrition. Per review, the interventions included adjusting daily routine as necessary to aid in pain relief; identifying location and rating pain prior to and after any interventions; medications as ordered; pain assessment as ordered and as needed; and reporting unrelieved or unacceptable levels of pain to the Physician as needed.<br><br>In interview with Certified Nursing Assistant (CNA) 3 on 10/25/2024 at 9:13 AM, she stated the CNA's received a report from other CNA's at the beginning of their shift. She stated the CNA's also reviewed the facility's resident care guide (RCG) for residents which let them know what care to provide. CNA 3 stated she was not aware of any interventions that were in place for R39.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In interview with CNA 8 on 10/25/2024 at 9:22 AM, she stated she was aware that R39 had wounds. CNA 8 stated that R39 had a pillow they placed between her knees, but she was not aware of any wedge cushions or heel boots that were to be used. She further stated she reviewed the RCG on the computer and could not recall seeing any heel boots or wedge cushions to be used for R39.<br><br>In interview on 10/25/2024 at 2:42 PM, UM 1 on the 100 unit, stated staff positioned R39 as the resident would allow. She stated she had not looked at R39's care plan and was not aware of interventions for the resident. The UM stated if pain medication was needed or was ineffective the NP or Physician was to be made aware. She stated she was unaware of recommendations from the Wound Physician for R39 to be turned side to side and stated recommendations were given to the NP. UM 1 further stated she did not know if a resident requiring side to side positioning, would have that information on their care plan.<br><br>In a post exit interview with the Wound Physician on 10/29/2024 at 3:18 PM, she stated she saw R39 weekly at the facility. She stated if she had given recommendations for R39 to be turned side to side, she would expect the facility to follow that recommendation, as the resident would allow.<br><br>2. Review of the facility's Admission Record for R42 revealed the facility admitted the resident on 01/29/2021, with diagnoses to include gastrostomy status, cerebral palsy, and epilepsy unspecified. Review of the Quarterly MDS Assessment with an ARD of 09/05/2024, revealed the facility assessed R42 as rarely or never understood. Further MDS review revealed R42 received total nutrition by artificial means.<br><br>Review of the Physician's order undated for R42, revealed an order for Jevity (tube feeding formula) 1.5 to infuse at 65 milliliters (ml) an hour for protein-calorie malnutrition.<br><br>Review of another undated Physician's order revealed the head of R42's bed was to be elevated 30 to 45 at all times except during care.<br><br>Review of the CCP for R42 revealed a nutritional services care plan dated 01/29/2021, related to the resident having a feeding tube due to diagnoses of cerebral palsy and dysphagia. Continued review revealed interventions that included tube feeding as ordered to meet nutritional needs; and head of bed elevated at least 30 degrees while delivering the tube feeds.<br><br>In additional interview with CNA 3 on 10/25/2024 at 9:13 AM, she stated she was aware that R42's HOB was to be elevated because of tube feeding and that information was on the resident's RCG.<br><br>In interview with the Minimum Data Set (MDS) Nurse on 10/25/2024 at 10:24 AM, she stated she was responsible for residents' care plans. She stated the baseline care plan was initiated on admission and completed within 48 hours. The MDS Nurse said the comprehensive admission MDS assessment built the comprehensive care plan. She stated the purpose of the care plan was to guide residents' care, so that staff would know what kind of care to provide. The MDS Nurse stated all nurses could and knew how to update and revise residents' care plans. She stated if residents needed to be turned and repositioned that information should be on their care plan and on the RCG. Per the MDS Nurse in interview, the Unit Managers (UM) were responsible for updating the RCG for the floor staff (CNA's). She further stated if the care plan was not updated to reflect the resident's current condition, then staff, the CNA's specifically, might not get the information they needed to provide the correct care for residents.<br><br>(continued on next page) |

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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 with the DON on 10/25/2024 at 3:11 PM, she stated care plans were updated with new orders during the facility's clinical meetings. She stated the MDS Nurse was responsible for updating resident's care plans and that floor nurses did not update residents' care plans. The DON further stated she would expect specific interventions to be on residents' care plans so staff were aware of those interventions.<br><br>In interview with the Administrator on 10/25/2024 at 5:03 PM, he stated he expected staff to follow residents' care plan. He further stated care plans were to be reviewed and updated if needed when a resident had a change in condition. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>47798<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 2 of 21 sampled residents (Resident (R)43, and R54).<br><br>1. R43 was tested for symptoms of a urinary tract infection (UTI) on 10/13/2024 and the laboratory (lab) results were finalized on 10/16/2024. However, the facility failed to ensure the lab results were received resulting in R43 not receiving the necessary treatment for a UTI until 10/23/2024, seven days later.<br><br>2. R54 received a recommendation for a gradual dose reduction on 09/15/2024. The recommendation was approved and signed by the facility Nurse Practitioner on 09/17/2024. However, the facility failed to initiate the recommendation until 10/18/2024, 33 days after the recommendation was made.<br><br>The findings include:<br><br>Review of the facility policy titled, Lab and Diagnostics Standard of Practice, reviewed 05/2021, revealed the facility was to provide or obtain laboratory services when ordered by a physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS). Continued review revealed the facility was to promptly notify the ordering physician, PA, NP, or CNS of results that were outside the clinical reference ranges or in accordance with the notification parameters per the ordering physician's orders.<br><br>Review of the Admission Face Sheet for R43 revealed the facility admitted the resident on 07/02/2020, with diagnoses to include: hemiplegia and hemiparesis following cerebral infarction, neurologic neglect syndrome, and generalized anxiety disorder.<br><br>Review of the Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 09/04/2024, revealed the facility assessed R43 to have a Brief Interview for Mental Status (BIMS) score of a 13 out of 15, indicating the resident was cognitively intact.<br><br>Review of the progress note dated 10/13/2024 at 5:54 PM, revealed the facility sent R43 to the emergency room (ER) after sustaining a fall while working with physical therapy (PT). Per review, R43 bent over too far while pulling up her pants and PT reported she fell on to her left side onto the wheelchair foot rest. Continued review revealed R43 complained of left sided rib pain, shortness of air, and left arm and hand pain. Further review revealed R43 also had three skin tears that were bandaged prior to EMS arrival.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Emergency Department (ED) Encounter for R43, dated 10/13/2024, revealed the resident reported concerns of having a UTI. Continued review revealed a urinalysis (U/A) was completed with abnormal findings of dark yellow urine, small blood, small leukocyte esterase (white blood cells). Per review, microscopic urinalysis showed the following abnormal findings: white blood cells of 15 and red blood cells of 12. Further review revealed the ER Physician documented a urine culture was sent to the lab. In addition, the ER Physician noted no antibiotics were started at that time for the UTI due to R43 reporting a history of Clostridium difficile (c-diff) on two (2) occasions.<br><br>Review of the progress note dated 10/13/2024 at 5:54 PM for R43, documented by Unit Manager (UM) 1, revealed the resident returned to the facility and had a UTI. Continued review revealed however, the ER doctor was waiting for the preliminary culture to decide if an antibiotic was needed.<br><br>Review of the urine culture lab results dated 10/16/2024, revealed a heavy growth of Escherichia coli (e-coli).<br><br>Review of the Result Care Coordination note, dated 10/16/2024 at 3:08 PM, completed by the Physician Assistant (PA), revealed the PA documented he attempted to call the results to the telephone (phone) number on file; however, that phone number was not a working number.<br><br>Continued review of the electronic medical record (EMR) for R43 revealed no documented evidence the urine culture results were obtained until 10/23/2024.<br><br>Review of the progress note dated 10/23/2024 at 6:59 PM for R43 revealed a new Physician's order for Macrobid (an antibiotic) 100 milligram (mg) twice a day for seven days to treat a UTI.<br><br>Review of the facility's Medication Administration Record (MAR) dated October 2024 for R43, on 10/23/2024, revealed an order for Nitrofurantoin (generic for Macrobid) 100 mg one capsule by mouth twice a day for 14 doses.<br><br>During interview with R43 on 10/22/2024 at 2:19 PM, she stated she had lower back pain and an odor to her urine for months, which she had reported to the floor nurses. R43 stated she was told to drink more water. The resident stated she sustained a fall on 10/13/2024, and was sent to the hospital. She further stated she had been she had blood and white blood cells in her urine and had a UTI, but she had not received any medication for it.<br><br>During interview with UM 1 on 10/24/2024 at 9:15 AM, she stated the UM or floor nurse was responsible to follow up on all lab results. UM 1 stated pending results were discussed during morning clinical meetings and added to the tracking board to ensure the results did not get overlooked. She stated R43's pending lab results were not added to the tracking board; however, should have been followed up on. UM 1 said the facility did not receive R43's urine culture results until 10/23/2024, which showed the resident had a UTI. She further stated she then notified the on call NP and was given an order for R43 to begin an antibiotic. The UM additionally stated R43 received the first dose of the antibiotic on 10/23/2024 on night shift.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview with the Assistant Director of Nursing (ADON) on 10/25/2024 at 9:12 AM, she stated typically the facility would have to call the hospital for lab results done in the ER, and the UM's were responsible for that task. The ADON stated the UM had called the hospital on 10/23/2024, (after the State Survey Agency [SSA] Surveyor had questioned staff about R43's complaints on that date) and the results were then faxed to the facility. She stated she expected the UM's to follow up on any pending lab results within three (3) days. The ADON further stated she also expected the UM's to reach out to the Physician or NP for orders to treat the resident if it was necessary.<br><br>During interview with the DON on 10/24/2024 at 10:15 AM, she stated the UM's were responsible for tracking pending results on their assigned hall. She stated UM 1 failed to follow up on R43's pending urine culture. She stated the facility realized they had not received R43's results on 10/23/2024 and called last night to obtain them. The DON stated the NP on call was notified once the results were obtained and she gave an order for R43 to begin an antibiotic to treat the UTI. She stated she expected results to be followed up on as they should to ensure residents received the proper treatment in a timely manner.<br><br>During an interview with the Administrator on 10/25/2024 at 4:15 PM, he stated pending results should be taken to clinical meetings every morning and placed on the white board in the DON's office. He stated he expected any orders to be on the resident's medication administration record and administered as prescribed and all pending results should be followed up on by the Unit Managers. The Administrator further stated the Unit Managers should continue to follow up on the results until they had been received to prevent the resident from going untreated.<br><br>44370<br><br>2. Review of the facility's Pharmacy Policy titled, Consultant Pharmacist Provider Requirements, undated revealed, the consultant pharmacist would establish a system whereby the consultant pharmacist's observations and recommendations regarding customers' drug therapy are communicated to those with authority and or responsibility to implement and or respond to the recommendation in an appropriate and timely fashion.<br><br>Review of R54's Admission Record revealed the facility admitted the resident on 05/05/2022, with diagnoses of major depressive disorder, type 2 diabetes mellitus without complication, excoriation, and skin picking disorder.<br><br>Review of the Physician's orders dated 09/2024 for R54, revealed an order for Alprazolam (Xanax, an antianxiety medication) 0.25 milligrams (mg) 1 tablet two times a day.<br><br>Review of the Pharmacist Recommendation to Prescriber documentation dated 09/15/2024, revealed a Pharmacist's recommendation to decrease R54's Alprazolam to 0.125 mg two times a day. Further review revealed the recommendation was agreed to and signed by the Nurse Practitioner (NP) on 09/17/2024. However, further review of R54's electronic medical record (EMR) revealed no documented evidence of an order to decrease R54's Alprazolam, until an order was transcribed on 10/18/2024, 33 days after the recommendation was made.<br><br>Review of the progress note dated 09/16/2024 for R54, documented by the consulting Pharmacist revealed the medication regimen review had been completed and recommendations made.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Physician's order dated 10/18/2024 for R54, revealed an order for Xanax oral tablet 0.25 milligrams give 1/2 tab by mouth twice daily, which had been entered by the UM.<br><br>In an interview with the facility's NP on 10/24/2024 at 9:07 AM, she stated she had been the NP for the facility since August 2024. She stated she received the pharmacy's recommendations from the DON; reviewed and agreed with them or not; and then returned them to the DON. She stated she expected any recommendations or orders to be entered into a resident's EMR within 24 hours. The NP further stated she was unaware that R54's Alprazolam order had not been entered until the SSA Surveyor made her aware of that issue.<br><br>In interview with the Consultant Pharmacist on 10/24/2024 at 8:55 AM, she stated she performed monthly reviews of medications on all residents. She stated she emailed her recommendations to the DON and ADON. The Consultant Pharmacist stated she noticed R54's recommended Alprazolam reduction had been signed and returned to her; however, the order had not been entered and she made the DON aware of that issue.<br><br>During interview with UM 1 on 10/25/2024 at 2:00 PM, she stated she thought the facility's NP received the pharmacy recommendations from the DON and returned them to the DON after reviewing them. She stated she had not received R54's recommendation from the DON until 10/18/2024 when she entered the order.<br><br>During interview with the DON on 10/25/2024 at 8:23 AM, she stated she received pharmacy recommendations via email. She stated she printed those recommendations and gave them to the NP for review. The DON said the NP returned the recommendations back to her after review and she emailed them back to the Pharmacist and gave them to the UM. The DON further stated she had given R54's signed recommendation to UM 1 and did not know why the order had not been entered as required.<br><br>In interview with the Administrator on 10/25/2024 at 5:03 PM, he stated he expected the DON to follow up timely when the Consultant Pharmacist completed the monthly Medication Regimen Reviews and made any recommendations. He stated the DON was to give the recommendations to the UM's when she received them so they could be addressed timely. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>44370<br><br>Based on observation, interview, record review, and review of facility policy, the facility failed to ensure residents received care consistent with professional standards for 1 of 3 residents sampled as at risk for developing pressure ulcers out of the total sample of 21 (Resident (R)39).<br><br>In interview on 10/22/2024 at 9:48 AM, R39 stated she had been at the facility since January and had a wound on her foot. Observation, at the time of interview, revealed R39 lying on her back on an alternating pressure mattress (APM), with two wedge cushions and a heel boot stored on a shelf in the corner of the room. R39 stated she received the heel boot for her left heel at the hospital; however, staff removed it when she returned to the facility. She stated the left heel boot had not been placed back on her since. R39 stated staff did not utilize wedge cushions or pillows for positioning her. Additional observations on that date at 11:08 AM, 1:50 PM, 4:18 PM, and 8:15 PM, revealed R39 remained lying on her back on the pressure reducing mattress. In addition, review of R39's EMR revealed R39 documentation noting the resident had developed a new stage 4 pressure ulcer.<br><br>The findings include:<br><br>Review of the facility policy titled, Skin Care Standard of Practice dated 07/2020, revealed, the facility would ensure a resident received care consistent with professional standards of practice, to prevent pressure ulcers. Per review, the facility was also to ensure residents did not develop pressure ulcers unless the individual's clinical condition demonstrated they were unavoidable. Continued review revealed a resident with pressure ulcers was to receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br><br>In interview with the Director of Nursing (DON) on 10/22/024 at 1:30 PM, she stated the facility did not have a policy on Pressure Ulcer Prevention.<br><br>Review of the facility's, Admission Record for R39 revealed the facility admitted the resident on 01/10/2024, with diagnoses including multiple (6) pressure ulcers; paraplegia, unspecified; and chronic pain syndrome.<br><br>Review of the Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 09/13/2024, revealed the facility assessed R39 to have a Brief Interview for Mental Status (BIMS) score of 12 of 15, indicating moderate cognitive impairment. Continued review revealed the facility assessed the resident as dependent on staff to roll from side to side and to a supine (laying on the back) position while in bed. Additionally, the facility assessed the resident as having pressure ulcers and as at risk for the development of pressure ulcers.<br><br>(continued on next page) |

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|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER River Haven Nursing and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 867 McGuire Avenue Paducah, KY 42001 | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility's, Comprehensive Care Plan (CCP) for R39 revealed a focus problem for impaired skin integrity, dated 01/04/2424, related to pressure sores with presence of skin breakdown or as at high risk for skin breakdown. Per review, the interventions dated 01/11/2024 included: pressure reduction cushion; mattress pressure reduction; and providing gentle support when turning, positioning, or transferring. Continued review revealed the interventions also included: providing protein supplements; providing wound care as ordered by the Physician; and providing skin care regularly. Review revealed the goals read: improve nutritional status and avoid prolonged pressure to skin. Further review revealed however, no documented evidence the facility developed and implemented additional interventions for R39's risk for pressure sores or skin breakdown, such as use of the wedge cushion or heel boots.<br><br>Continued review of the CCP for R39 revealed a focus problem for pressure ulcer, actual, dated 01/11/2024, noting the resident had pressure ulcers. Per review, on 05/02/2024, R39 developed a new stage 4 pressure wound of the left heel. CCP review revealed the interventions dated 01/19/2024, included pressure relieving device chair cushion; pressure relieving device mattress; and weekly skin rounds to monitor progress of pressure ulcers. Further review of the CCP revealed however, no documented evidence the facility developed and implemented additional interventions for R39's actual pressure ulcer, such as use of the wedge cushion or heel boots.<br><br>Review of the Wound Evaluation and Management Summary, for R39 dated 05/02/2024, revealed the resident had developed a non-pressure wound to the left heel documented as moisture associated skin damage (MASD). Further review revealed the wound measured 2 centimeters (cm) x 3 cm x 0.1 cm.<br><br>Review of the Wound Evaluation and Management Summary, for R39 dated 10/17/2024, revealed the area to the left heel was documented as a stage 4 pressure wound which measured 6.5 cm by 4.0 cm by 0.3 cm.<br><br>Observation on 10/22/2024 at 9:48 AM, revealed R39 lying on an alternating pressure mattress on the bed. In interview, at the time of observation, R39 stated she had a wound on her foot. Continued observation revealed R39 was lying supine (on her back) on the bed with no devices (such as heel boots or wedge cushions) in use. Observation revealed however, two wedge cushions and a heel boot stored on a shelf in the corner of the resident's room. Additional observations on 10/22/2024 at 11:08 AM, 1:50 PM, 4:18 PM, and 8:15 PM, revealed R39 remained lying supine on the bed with no devices in use.<br><br>Observation on 10/24/2024 at 11:20 AM, revealed Unit Manager (UM) 1 completed a dressing change for R39's pressure wound. Observation revealed the wound had tissue loss, and the appearance of a stage 4 pressure ulcer to the left heel. Continued observation revealed the UM measured the wound as 6 cm by 4.5 cm; however, the UM failed to measure the depth of the wound. In interview, at the time of observation, the UM stated she thought R39's heel wound was a stage 3 pressure ulcer.<br><br>During an interview with Certified Nursing Assistant (CNA) 3 on 10/25/2024 at 9:13 AM, she stated she was aware R39 had wounds and used to have boots on her feet when she was in bed. CNA 3 stated she could not recall any other devices for R39 (to assist with pressure relief). She stated R39 did not like to turn as it caused her pain. The CNA further stated CNA's had the resident care profiles (RCP) to look at for residents' care needs. She additionally stated however, she was not aware of what interventions were on the RCP for R39.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with CNA 8 on 10/25/2024 at 9:22 AM, she stated she was aware R39 had wounds, as she had assisted the nurses with dressing changes. CNA 8 stated R39 had a pillow placed between her knees, but she was not aware of any wedge cushions or heel boots that should be used for the resident.<br><br>In interview with UM 1 on 10/25/2024 at 2:00 PM, she stated R39 had an air mattress in place for pressure prevention. She stated she did not know if the facility had a policy on prevention of pressure ulcers. The UM stated she had not looked at R39's care plan to see what interventions were in place for the resident. She stated staff repositioned R39 as she would allow; however, the resident preferred to lie on her back. UM 1 further stated she was unaware of any wound physician's recommendations for R39 to be turned side to side.<br><br>During an interview with the Director of Nursing (DON) on 10/25/2024 at 3:11 PM, she stated all residents had a pressure-reducing mattress on their beds and R39 had an air mattress for pressure relief on her bed. She stated R39 had been admitted with multiple wounds and was followed by the wound care physician weekly. The DON stated R39 often refused care; however, she was unsure if the refusals were care planned. She further stated wedge cushions or pillows, as well as turning and repositioning were interventions and should be on the resident's care plan and the RCP. The DON additionally stated wounds had the potential to not heal if interventions were not in place.<br><br>In interview with the Medical Director on 10/25/2024 at 4:39 PM, he stated R39 had wounds, but she was in much better shape than when she was first admitted to the facility. He further stated the facility should have policies in place for pressure ulcer prevention.<br><br>In interview with the Administrator on 10/25/2024 at 5:03 PM, he stated he expected staff to follow the Physician's orders and to contact the Physician if clarification of orders were needed. He stated he expected residents to have interventions for pressure ulcers in place. The Administrator further stated possible (negative) outcomes for residents with pressure ulcers would be worsening of the wound and/or development of new wounds. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>44370<br><br>Based on observation, interview, and record review, it was determined the facility failed to ensure a resident fed by enteral means (feeding tube) received the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia for 2 of 7 residents receiving enteral feeding (Resident (R)39, R42).<br><br>In interview the Director of Nursing (DON) stated it was a standard of practice for a resident's head of bed (HOB) to be elevated during (tube) feedings and for the tube feeding to be changed every 24 hours.<br><br>1. However, observation on 10/21/2024 at 1:15 PM, revealed R42's HOB was flat when the resident was receiving enteral feeding. Additionally, the enteral feeding R42 was receiving was dated 10/20/2024 at 10:08 AM (over 24 hours). Observation revealed R42 continued lying flat two hours later at 3:18 PM.<br><br>Observation on 10/22/2024 at 9:58 AM, revealed R42's feeding pump was turned off and was not attached to the resident. In addition, R42's feeding bottle remained unchanged (as it was still dated 10/20/2024 at 10:08 AM). Observation at 10:08 AM, revealed Licensed Practical Nurse (LPN) 7 entered R42's room with new feeding to hang.<br><br>2. Observation of R39's room on 10/21/2024 at 1:35 PM, 4:37 PM, and on 10/22/2024 at 9:46 AM, revealed a feeding pump with a dried wash cloth over it and a piston syringe present dated 10/15/2024.<br><br>The findings include:<br><br>In interview with the DON on 10/22/2024 at 1:30 PM, she stated the facility did not have a policy on gastrostomy tubes or enteral feeds. She stated it was a standard of practice for (tube) feedings to be changed every 24 hours and for the HOB to be elevated. When asked by the State Survey Agency (SSA) Survey what told her that, she stated she just knew it.<br><br>1. Review of the facility's, Admission Record for R42 revealed the facility admitted the resident on 01/29/2021, with diagnoses to include gastrostomy status, cerebral palsy, gastrostomy status, and epilepsy unspecified. Review of the Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 09/05/2024, revealed the facility assessed R42 as rarely or never understood. Further MDS review revealed R42 received total nutrition by artificial means.<br><br>Review of the physician's order, undated for R42, revealed an order for Jevity (tube feeding formula) 1.5 to infuse at 65 milliliters (ml) an hour for protein-calorie malnutrition.<br><br>Review of another undated physician's order, revealed the head of bed was to be elevated 30 to 45 at all times except during care.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R42's Comprehensive Care Plan (CCP) revealed a Nutritional Services care plan dated 01/29/2021, related to R42 having a feeding tube due to diagnoses of cerebral palsy and dysphagia. Continued review revealed interventions that included tube feeding as ordered to meet nutritional needs; and head of bed elevated at least 30 degrees while delivering the tube feeds.<br><br>Review of the facility's Resident Care Profile (RCP), the care guide for Certified Nursing Assistants, dated 03/19/2024, revealed under special instructions, (R42's) HOB was to be elevated at 45 degrees.<br><br>However, observation on 10/21/2024 at 1:15 PM, revealed R42 receiving enteral feeding with the head of bed (HOB) flat. Continued observation revealed a piston syringe and feeding bottle dated 10/20/2024 at 5:00 AM, which indicated the tube feeding had been hanging for 32 hours. Observation at 3:18 PM, revealed R42's HOB remained flat.<br><br>Observation on 10/22/2024 at 9:58 AM, revealed the (tube) feeding pump was turned off and was not attached to R42. Per observation, the tube feeding bottle remained unchanged, as it was still dated 10/20/2024 at 5:00 AM. Additional observation at 10:08 AM, revealed LPN 7 entered R42's room with new tube feeding and piston syringe.<br><br>In interview with LPN 7 on 10/22/2024 at 11:33 PM, she stated she provided care for R42 and worked one day a week. She stated R42 received medication and the resident's tube feedings were to be held (stopped) one hour before and one hour after administration. The LPN stated she had elevated R42 s bed that morning when she went in and saw that it was not elevated.<br><br>2. Review of the facility's Admission Record for R39 revealed the facility admitted the resident on 01/10/2024, with diagnoses including paraplegia; chronic pain syndrome; and reduced mobility.<br><br>Review of R39's Quarterly MDS, with an ARD of 09/13/2024, revealed the facility assessed the resident to have a BIMS score of 12 of 15, indicating moderate cognitive impairment.<br><br>Review of the physicians' order for R39, undated, revealed an order for Glucerna 1.2 to infuse at 60 milliliters (ml) per hour from 6:00 PM to 6:00 AM. Additionally, review revealed an undated order to flush R39's gastrostomy tube (G-tube) with 30 ml water before and after medication pass at 6:00 AM, 11:00 AM and 3:00 PM.<br><br>Observation of R39's room on 10/21/2024 at 1:35 PM, and at 4:37 PM; and on 10/22/2024 at 9:46 AM, revealed a tube feeding pump present with a dried wash cloth over it and a piston syringe that was dated 10/15/2024.<br><br>In interview with CNA 5 on 10/22/2024 at 8:42 PM, she stated R42 and R39 had feeding tubes and the heads of their beds were to be elevated. She stated that information was on the residents' RCP.<br><br>In interview with CNA 9 on 10/23/2024 at 8:54 AM, she stated R42 had a feeding tube and when the tube feeding was turned on the HOB was to be elevated. She stated if R42 was having a seizure the HOB might not be elevated. CNA 9 stated R39 received tube feeding at night; however, the HOB was usually elevated during the day. She further stated she never paid attention to the syringes present with the tube feedings, as the nurses took care of those.<br><br>(continued on next page) |

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F 0693

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

In continued interview with LPN 7 on 10/22/2024 at 11:33 PM, she stated she also provided care for R39. She stated R39 did not receive tube feeding on day shift and she had not noticed the syringe dated 10/15/2024 present in the resident's room. The LPN further stated she would change the syringe immediately.

In interview with LPN 3 on 10/22/2024 at 8:15 PM, she stated she worked the 100 hall three nights a week and provided care for both, R39 and R42. She stated she was sure there was a policy on feeding tubes but she was not certain. LPN 3 stated it was standard procedure to change feedings and syringes every 24 hours. She said she learned that a long time ago. The LPN further stated the heads of R39's and R42's beds should have been elevated when their tube feeds were infusing. She additionally stated that information was on the residents' treatment administration records (TARs).

In interview with Unit Manager (UM) 1 on 10/22/2022 AT 8:30 PM, she stated the syringe for enteral feeds was to be changed daily. The UM said tube feeding could hang for 48 hours; however, she would have to look at the manufacturers' recommendations. She stated she did not know if the facility had a policy on enteral feeds or G-tubes, but she would ask the Staff Development Coordinator (SDC) or the Assistant Director of Nursing (ADON) and would follow what they told her. She further stated she did not know what reference the facility used for standards of practice.

In additional interview with UM 1 on 10/25/2024 at 2:00 PM, she stated new hires were trained by the facility nurses. She stated she had not been aware the facility did not have a policy regarding tube feedings. UM 1 stated tube feeding included the tubing and piston syringes which were to be changed daily.

In interview with the SDC on 10/23/2024 at 10:01 AM, she stated the facility did not have a policy on enteral feedings or G-tubes. The SDC stated the facility followed the physician's orders. She stated the orders should include changing of the tube feeding bottles and syringes every 24 hours. The SDC stated for residents receiving tube feeding, their HOB was to be elevated. Per the SDC in interview, there was to be an order for their tube feedings and that information was to be reflected on the residents' care plan. She further stated the nurses did competency checks on hire and all facility nurses had been checked off on tube feedings. During the interview the SSA Surveyor requested to review the facility's competency checks for nurses.

The SSA Surveyor received the competency checks from the SDC, on 10/23/2024 at 2:15 PM. The SDC stated at that time that feeding tubes and enteral feeds were not part of the facility's competency check list.

In interview with the facility's Nurse Practitioner (NP) on 10/24/2024 at 9:07 AM, she stated she had been the facility's NP since August 2024. She stated she did not have long-term care experience and was learning. The NP stated she had no expectations of staff at the facility, as that was not part of her job. She stated the DON and ADON handled the staff at the facility. The NP further stated for residents receiving enteral feedings, their HOB was to be elevated; however, she was unaware of how often the piston syringes or feeding formulas should be hung.

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In interview with the DON on 10/25/2024 at 3:11 PM, she stated she had been the DON for a year. She stated she expected the nurses to follow what they learned in nursing school when caring for residents' G-tubes. The DON said the facility used an online training portal for staff education. She stated she expected staff to ensure the HOB of residents receiving tube feeding was elevated during the tube feeding. The DON further stated a potential (negative) outcome if the HOB of a resident receiving tube feeding was not elevated was aspiration of the feeding.<br><br>In interview with the Administrator on 10/25/2024 at 5:03 PM, he stated he expected staff to follow the physician's orders and to contact the physician if clarification was needed. He stated he expected the HOB of residents receiving tube feeding to be elevated. The Administrator further stated possible (negative) outcomes for a resident whose HOB was not elevated, was potential aspiration. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>44370<br><br>Based on observation, interview and review of the facility policy, it was determined the facility failed to ensure pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 21 sampled residents (Resident (R)39).<br><br>Observation on 10/24/2024 at 11:20 AM, during the left heel dressing change for R39 revealed the resident had a grimace on her face prior to being turned by staff. R39 was observed placing the neckline of her gown in her mouth and biting down to keep from yelling out. R39 had tense facial expressions, facial grimacing and verbalizations of oh, oh, oh me during the dressing change. The State Survey Agency (SSA) Surveyor requested the wound care halted and R39 be assessed for pain. The Unit Manager (UM) stated R39 had received pain medication prior to the dressing change. However, review of R39's narcotic sign out sheet with the Regional Nurse revealed R39 had not received the pain medication since 10/22/2024.<br><br>The findings include:<br><br>Review of the facility policy titled, Pain Management Standard of Practice, dated 07/2020 revealed, the facility worked to ensure compliance with the regulatory intent of F697. Per policy review, the facility worked to ensure compliance by ensuring pain management was provided to residents consistent with professional standards of practice, the comprehensive care plan, and the resident goals and preferences. Continued review revealed in conjunction with the resident's physician, the facility was to work to prevent or manage pain, consistent with the care plan and the resident's goals and preferences, and to address/treat the underlying cause(s) of pain to the extent possible. Further review revealed the facility was to consider both non-pharmacological and pharmacological interventions/approaches, modify approaches to pain management as necessary and recognize expressions of pain might be verbal or nonverbal and were subjective.<br><br>Review of the facility's, Admission Record revealed the facility admitted R39 on 01/10/2024 with diagnoses including chronic pain syndrome, paraplegia, unspecified, and reduced mobility.<br><br>Review of the Quarterly Minimum Data Set (MDS), Assessment with an Assessment Reference Date (ARD) of 09/13/2024, revealed the facility assessed R39 as having a Brief Interview for Mental Status (BIMS) score of 12 of 15, which indicated the resident was moderately cognitively impaired.<br><br>Review of the Comprehensive Care Plan (CCP) for R39 revealed a focus problem for pain, risk for alteration on comfort related to wounds and malnutrition, dated 01/11/2024. Continued review revealed the interventions included adjusting daily routine as necessary to aid in pain relief; identify location and rate pain prior to and after any interventions, and medications as ordered. Per review, additional interventions included: notifying family/responsible party of any changes; pain assessment as ordered and as needed; reporting unrelieved or unacceptable levels of pain to the Physician as needed. Further review revealed R39 s goal noted to maintain tolerable level of pain through the next review, and for the resident to be free from constipation related to narcotic analgesic for 90 days.<br><br>(continued on next page) |

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F 0697

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of the Physician's orders dated 10/12/2024, revealed an order for R39 to receive Oxycodone/Acetaminophen (Percocet) oral tablet 5/325 milligrams (mg) one tablet every six hours as needed for chronic pain syndrome.

Observation on 10/24/2024 at 11:20 AM, of the pressure ulcer dressing change for R39, revealed the resident was observed with non-verbal signs of pain that included, tense facial expressions with facial grimacing, placing her gown in her mouth and biting down on it. Per observation, R39's verbalizations of pain included, oh, oh, oh me. The Unit Manager (UM)stated R39 received pain medication prior to dressing changes. The SSA Surveyor left R39's room to inquire when R39 had received the pain medication.

Review of R39's narcotic sign out sheet with the Regional Nurse, revealed no documented evidence the resident had received pain medication since 10/22/2024. The SSA Surveyor requested R39's wound care be stopped and the resident assessed for pain and for the wound care to be completed after lunch. The SSA Surveyor reviewed R39's Medication Administration Record (MAR) on 10/24/2024 at 2:20 PM, to ensure the resident had been administered pain medication; however, there was no documented evidence R39 had received pain medication.

In interview with R39 at 2:25 PM, she stated she had not received any pain medication.

In interview on 10/24/2024 at 2:28 PM, the Staff Development Coordinator (SDC), who was working as a floor nurse, stated she could not recall UM 1 telling her to administer pain medication to R39. The SDC then administered Oxycodone/Acetaminophen oral tablet 5/325 milligrams to R39 at 2:38 PM.

UM 1 informed the SSA Surveyor on 10/24/2024 at 4:00 PM, she was ready to continue with R39's dressing change. In interview at that time, R39 stated she was okay to proceed with the dressing change. Per observation, R39 continued to have facial grimacing during the dressing change; however, stated she was okay.

During an interview with Certified Nursing Assistant (CNA) 3 on 10/25/2024 at 9:13 AM, she stated she provided care for R39 and said the resident always had pain with any movement. She stated R39's pain was better now than it was when the resident was first admitted . CNA 3 further stated R39 seldom voiced pain, but would bite her gown and have a pained expression on her face when being moved.

During an interview with CNA 8 on 10/25/2024 at 9:22 AM, she stated she was aware that R39 had wounds. She stated R39 often had facial grimacing and chewed on her gown to keep from crying out. The CNA stated R39 had facial grimacing with movement to her legs due to contractures, but never verbally complained of pain.

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In interview with Registered Nurse (RN) 8 on 10/25/2024 at 9:38 AM, she stated a resident's pain was assessed and documented on their MAR. She started R39 was able to voice pain but seldom did that. The RN stated she had observed nonverbal signs of pain in R39, such as facial grimacing and biting down on her gown. She stated she had administered pain medication to R39 before, but was unable to recall if it was before wound care was provided. She stated R39 had an air mattress for wound prevention and a pillow placed between her knees. RN 8 stated she was not aware of any non-pharmacological interventions to use for pain relief. She stated all residents were turned and repositioned and that should be on the residents' care plan. RN 8 stated the CNAs usually reported when residents had pain and they (CNAs) were made aware of new interventions for residents by open communication to the staff.<br><br>In interview on 10/25/2024 at 2:42 PM, UM 1, on the 100 unit, stated she had asked the nurse on the hall to administer pain medication to R39 at 8:30 AM, after the resident complained of pain with the dressing change to the G-tube site. She stated she found out it had not been administered after she completed the dressing change to the left heel. UM 1 stated we stopped the wound care at approximately 11:30 AM; however, said R39 did not receive pain medication until 2:30 PM. She further stated she did not know why it took so long for the pain medication to be administered to R39.<br><br>During an interview with the DON on 10/25/2024 at 3:11 PM, she stated residents' pain was assessed and documented on their MAR each shift. She stated she expected nurses to assess residents' pain and administer pain medication if the residents had pressure ulcers, before completing wound care so it lessened the residents' pain.<br><br>In interview with the Administrator on 10/25/2024 at 5:03 PM, he stated pain management was different with each resident. He stated if pain was identified he would expect the nurse to administer any ordered pain medication. The Administrator further stated a resident's pain should be reassessed as needed and staff should consult with the NP on how to treat pain if current regimen was not working. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/25/2024 |
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| NAME OF PROVIDER OR SUPPLIER River Haven Nursing and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 867 McGuire Avenue Paducah, KY 42001 | |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49350<br><br>Based on observation, interview, and review of facility policy, the facility failed to ensure drugs and biologicals used in the facility were safely stored and labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>Observation on [DATE] of the 300 hall medication storage room revealed multiple expired medical supplies. Observation further revealed a small refrigerator utilized for storage of milk and beer with the temperature reading out of the acceptable range according to the internal thermometer of the device.<br><br>The findings include:<br><br>Review of the facility's policy entitled, Medication administration standard of practice, dated ,d+[DATE], revealed medications were to be administered in a safe and timely manner, and as prescribed.<br><br>Observation of the 300 hall medication room on [DATE] at 2:30 PM, with the Unit Manager (UM), revealed the following expired medical supplies: three individual boxes of glucose test strips with an expiration date of , d+[DATE]; four individual bottles of wound cleanser with an expiration date of ,d+[DATE]; suction tubing product DYND50216 with an expiration date of ,d+[DATE]; and two individual boxes of tracheostomy (trach) tubes with an expiration date of ,d+[DATE].<br><br>Continued observation of the 300 hall medication room on [DATE] at 2:30 PM, revealed a small refrigerator utilized for storing milk and beer had a temperature reading of 50 degrees Fahrenheit (F), which the UM indicated during that observation, the temperature was out of the acceptable temperature parameters. Observation also revealed upon entering the medication room the State Survey Agency (SSA) Surveyor observed water on the floor which was leaking from the refrigerator. The UM stated, at the time of observation, the problem with the refrigerator temperature was because a staff member told her that day a resident complained of the milk being too cold, so the staff member turned up the temperature. She stated she would discard the observed supplies from the refrigerator which included milk and beer.<br><br>During an interview with the Director of Nursing (DON) on [DATE] at 10:00 AM, she stated, If the care plan had a diabetes care plan for sugar checks and the supplies were expired, they could get a false blood sugar reading. The DON stated it was part of the UM's monthly routine to check for expired supplies, and Pharmacy staff came in as well to look through things for us. She stated the expectation was for management to look through medication rooms and medication carts as well, looking for expired items, throw the expired items away, and if supplies were missing, they needed to restock them. The DON said if any packaging had damage we get rid of it. She stated night shift nurses were in charge of checking (refrigerator) temperatures. The DON stated They fill out a paper log for the temperature and leave it in the room. She further stated nursing staff should report an unacceptable refrigerator temperature reading to leadership and management. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>44370<br><br>Based on observation, interview, and review of facility policies, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. These failures had the potential to affect eighty-two (82) of eighty-eight (88) residents in the facility who consumed food from the kitchen.<br><br>The findings include:<br><br>Review of the facility's policy titled, Food Storage: Cold Foods, dated 04/2018, revealed All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, were to be appropriately stored in accordance with guidelines of the FDA [Food and Drug Administration] Food Code .All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.<br><br>Observation during the initial kitchen tour on 10/22/2024 at 9:10 AM, with the Certified Dietary Manager (CDM), revealed the walk in cooler contained a larger plastic container half full of cut up raw potatoes in water that were not labeled or dated; a larger plastic container half full of prepared apple crisp that was dated 10/17/2024 - 10/23/2024; and a small container of red peppers that were not labeled or dated. Observation revealed the CDM removed the items from the cooler.<br><br>In an interview with the CDM on 10/25/2024 at 2:19 PM, she stated she expected staff to follow the guidelines as stated and to use items that were opened first. She stated day one starts the day that you open a container and depending on what the food item was, items could be stored up to seven days. The CDM stated leftovers (such as the apple crisp) could only be stored for three to four days. She further stated everything stored was to be dated and labeled properly and if items were found stored past the dates they should be discarded immediately.<br><br>In an interview with the Administrator on 10/25/2024 at 5:03 PM, he stated the kitchen staff were contracted and he expected them to label and date items prior to storing them. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>47567<br><br>Based on observation, interview, and review of the facility's policy, it was determined the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections.<br><br>Observations of Certified Nursing Assistant (CNA) 10 on 10/22/2024 at 11:40 AM, revealed she pulled gloves from a box sitting on top of a medication cart and placed them in her pants pocket prior to entering Resident 7 ' s room to provide care.<br><br>The findings include:<br><br>Review of the facility policy titled, Infection Control revised 10/01/2018, revealed the facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage the transmission of diseases.<br><br>Review of facility policy titled, Infection Control Program Standard of Practice, revised 11/01/2016, revealed the facility's standard of practice was for all isolation precautions and hand washing techniques to be followed per the www.cdc.gov/longtermcare/guidelines.<br><br>Observation on 10/22/2024 at 11:40 AM, this State Surveyor Agency (SSA) revealed Personal Protective Equipment (PPE) Bin 1 did not contain disposable gloves or gowns for staff's use, and only contained face masks. Per observation, Bin 1 was located in front of two (2) residents' rooms which were noted to be on Enhanced Barrier Precautions (EBP). Continued observation revealed staff were pulling gloves from a box stored on top of a medication cart and stuffing the gloves in their pants pockets before going into residents' rooms to provide care.<br><br>In interview with Certified Nursing Assistant (CNA) 10 on 10/22/2024 at 11:49 AM, she stated PPE was kept in a cabinet outside of the residents' rooms in the hall. She stated before staff went into a resident's room to provide care they put gloves in their pockets; performed hand hygiene; donned a gown if needed; and then went into a resident's room to perform care. CNA 10 stated she thought it would be more convenient if the supplies were left in the resident's room and readily available for staff. She further stated there could be a possible infection control issue by for residents with staff carrying gloves around in their pockets.<br><br>In interview with Unit Manager (UM) 1 on 10/25/24 at 1:31 PM, she stated before 10/01/2024 the facility had two (2) central supply employees who had been responsible for making sure the PPE bins were stocked. UM 1 stated however, one of the central supply employees got promoted to another position after that date and she was unsure who was responsible now. She stated she tried her best to make sure the PPE bins on her hall stayed stocked and if she was made aware she would go track down the necessary supplies. The UM stated it was okay not having the bins stocked in the rooms it just made the day a little bit longer. She stated she just started in her position eight months ago and at that time the facility was not keeping gloves stored in the residents' rooms. UM 1 stated she was always used to grabbing gloves before she went in a room and that did not bother her. She further stated she had not seen any CNAs grab gloves and put them in their pockets.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In interview with the Infection Preventionist/Assistant Director of Nursing (IP/ADON) on 10/25/24 at 9:30 AM, she stated staff putting gloves in their pockets was an infection control issue. She stated staff had been educated on not doing that and gloves had been placed back in residents' rooms for accessibility. The IP/ADON further stated the nursing staff had pocket sized hand sanitizer containers they kept on their person to help with hand hygiene.<br><br>In interview with the Director of Nursing (DON) on 10/25/24 at 3:11 PM, she stated staff placing gloves in their pockets was a cause for concern regarding infection control, as she did not know what they kept in their pockets. She stated the facility in general was responsible for making sure nursing staff had the necessary PPE supplies they needed to perform their job duties. The DON said this responsibility mainly fell on the Staff Development Coordinator (SDC) and Central Supply Department. She stated as far as she knew there was always someone in the Central Supply Department ordering supplies and putting the supplies away. Per the DON in interview, if staff just let her know they did not have what they needed she would get it for them. She further stated it was her expectation of staff to inform her if they were needing supplies to perform their job duties, in order for her to obtain the necessary items.<br><br>In interview with the Administrator on 10/24/2024 at 4:52 PM, he stated he had not been made aware of the facility being out of some of their supplies. He stated he usually went out and purchased what was needed if staff happened to run out before the next shipment arrived. The Administrator said sometimes things like that just happened, but his expectation was for staff to let him know what was needed. He said if they were out supplies and having trouble obtaining them from the vendors staff needed to let him know. The Administrator stated he was opposed to not having gloves stored in residents' rooms and had expressed his concerns to his superiors. He further stated however, he was not given instructions on returning the gloves to residents' rooms until that week. In addition, the Administrator stated it was an infection control issue with staff placing gloves in their pockets. |