

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185447	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Villaspring of Erlanger		STREET ADDRESS, CITY, STATE, ZIP CODE 4220 Houston Road Erlanger, KY 41018	

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 - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46710</p> <p>Based on observation, interview, record review, review of the manufacturer's instructions for use, and review of the facility's policies, the facility failed to maintain infection prevention and control measures to help prevent the development and transmission of communicable diseases and infections for 2 of 5 residents sampled for transmission-based precautions (Resident (R) 36 and R107) and 1 of 3 residents reviewed for use of sit-to-stand mechanical lifts (R21).</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Infection Control: Transmission Based Precautions, dated 9/2024, revealed the facility was to implement contact precautions for residents known or suspected to be infected with microorganisms that could be transmitted by direct or indirect contact with the resident or the resident's environment. Further review revealed infections indicating use of contact precautions included multi-drug resistant organisms. Per the policy, staff was to wear gloves and gown for interactions that involved contact with the resident.</p> <p>Review of the facility's policy titled, Standard Precautions, revised 09/2023, revealed reusable equipment used for resident care was not used for the care of another resident until it had been appropriately cleaned and reprocessed.</p> <p>Review of the manufacturer's instruction for use of the Hoyer Ascent lift, not dated, revealed the lift should be cleaned using a damp cloth and to wipe clean with ordinary soap and water and/or using any hard surface disinfectant.</p> <p>1. a. Review of R36's Admission Record revealed the facility admitted the resident on 09/08/2023 with diagnoses including unspecified dementia and type 2 diabetes.</p> <p>Review of R36's Care Plan, not dated, revealed the facility identified the resident had an infection with a multi-drug resistant organism and included the intervention of placing the resident in contact precautions.</p> <p>Review of R36's Order Details, dated 10/02/2024, revealed the physician ordered the resident to be in contact precautions for extended-spectrum beta-lactamase (ESBL-a multi-drug resistant organism) in her urine.</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 10/10/2024 at 10:59 AM revealed the facility posted a sign on the personal protective equipment (PPE) container outside R36's room, indicating the resident was in contact precautions. Further observation revealed the sign indicated staff was to don (put on) a gown and gloves prior to entering R36's room. Continued observation revealed Licensed Practical Nurse (LPN) 6 entered R36's bed space without donning PPE, including a gown and gloves. Per additional observation, LPN6 administered R36's insulin (medication given to reduce blood glucose level with a subcutaneous route) without donning gown or gloves.</p> <p>In an immediate interview, LPN6 stated she never wore PPE for insulin administration. She further stated she believed PPE was only required in contact precaution rooms when aides were providing incontinence care or helping a resident get dressed, and she was not expected to wear PPE when administering insulin.</p> <p>In an interview on 10/10/2024 at 11:14 AM, the 100 Unit Manager stated staff was to don PPE prior to entering a room for a resident in contact precautions, especially if the staff member came into direct contact with the resident.</p> <p>b. Observation on 10/11/2024 at 9:03 AM revealed State tested Nurse Aide (STNA) 18 carried a food tray into R107's room without donning PPE. Per observation, she put the tray on R107's bedside table, exited the room, and applied hand sanitizer. Further observation revealed the sign on the door frame indicated for visitors to check at the nurse's desk. Additional observation revealed a container of PPE located to the right of the doorway had a sign on the top for contact precautions.</p> <p>In an interview on 10/11/2024 at 9:13 AM, STNA18 stated, When residents are in enhanced barrier precautions we do not need to put on PPE. If they are in contact precautions, we should put on PPE before bringing the tray into the room. Did I not do that? After the State Survey Agency (SSA) Surveyor told her she did not wear PPE and R107 was in contact precautions, STNA 18 responded, I am sorry.</p> <p>In an interview on 10/11/2024 at 9:09 AM, the 200 Unit Manager stated if a resident was in contact precautions, staff was required to don PPE for tray delivery and remove PPE before exiting the room.</p> <p>In an interview on 10/10/2024 at 4:12 PM, the Assistant Director of Nursing/Infection Preventionist stated she expected all nurses to don a gown and gloves prior to entering the resident room to administer insulin when the resident was in contact precautions.</p> <p>In an interview on 10/11/2024 at 10:58 AM the Director of Nursing (DON) stated he expected staff to don a gown and gloves prior to coming in contact with a resident in contact precautions, including for insulin administration.</p> <p>In an interview on 10/11/2024 at 9:37 AM, the Administrator stated staff were to don PPE, including gown and gloves, prior to entering a room of a resident in isolation.</p> <p>44000</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 - Some</p>	<p>2. Observation on 10/09/2024 at 10:22 AM revealed Nurse Aide in Training (NAT) 3 and STNA13 used the Hoyer Ascend lift to assist R21 to the toilet. They secured a cloth sling around R21's back and together assisted her to stand. They then moved R21 to the toilet. The strap to the sling fell on R21's abdomen and upper perineal area. They then assisted R21 to the wheelchair. They removed the sling and put the sling on the lift. STNA13 then took the Hoyer Ascent lift to the shower room on the 1100 Hall. She left the shower room and failed to clean the lift.</p> <p>During interview with STNA13 on 10/09/2024 at 10:42 AM in the hallway after she left the shower room, she stated she forgot to clean the lift. She stated she should have cleaned the lift with disinfectant wipes.</p> <p>Registered Nurse (RN) 1 appeared during the interview with STNA13. He had the Hoyer Ascent lift and stated he was going to clean the lift with disinfectant wipes, which were kept in the locked room adjacent to the shower room. However, when RN1 came out of that room, he stated there were no disinfection wipes in the room, and he was going to get some wipes. He then placed the lift back in the shower room and left to get wipes.</p> <p>During interview with STNA13 on 10/09/2024 at 10:44 AM, she stated she did not have a key to the locked room adjacent to the shower room.</p> <p>During interview with RN1 on 10/09/2024 at 11:02 AM, he stated disinfectant wipes were not kept in the shower room because staff was concerned a resident might use the wipes in an inappropriate way. He stated the disinfectant wipes were always in a locked room.</p> <p>During interview with RN7, the Wound Care/Infection Preventionist, on 10/09/2024 at 12:54 PM, she stated the facility did not audit the cleaning of multiuse resident equipment. She stated staff was educated on cleaning the multiuse equipment with bleach wipes. She stated the multiuse wipes were available on the treatment carts and were usually in the shower room.</p> <p>During interview with the DON on 10/10/2024 at 10:07 AM, he stated staff was to clean the lifts after each use and was to use disinfectant wipes. He stated staff was educated in orientation and yearly on infection control.</p> <p>During interview with the Administrator on 10/11/2024 at 10:11 AM, she stated she relied on the Infection Preventionists and the DON to assure the equipment was cleaned appropriately.</p>		