

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195386	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Legacy Nursing and Rehabilitation of Morgan City		STREET ADDRESS, CITY, STATE, ZIP CODE 740 Justa Street Morgan City, LA 70380	

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 0640</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41876</p> <p>Based on record reviews and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were transmitted within 14 days of completion for 3 (Resident #28, Resident #44, and Resident #241) of 5 (Resident #4, Resident #28, Resident #44, Resident #73, and Resident #241) residents reviewed for resident assessments.</p> <p>Findings:</p> <p>Resident #28</p> <p>Review of Resident #28's Quarterly MDS with an Assessment Reference Date (ARD) of 07/17/2024 revealed, in part, the MDS was completed on 07/18/2024.</p> <p>Review of the facility's MDS 3.0 Nursing Home (NH) Final Validation Report revealed, in part, Resident #28's Quarterly MDS with an ARD of 07/17/2024 was transmitted on 08/20/2024, which was greater than 14 days after the completion date.</p> <p>Resident #44</p> <p>Review of Resident #44's record revealed, in part, Resident #44 was admitted to the facility on [DATE] and discharged from the facility on 07/18/2024.</p> <p>Review of Resident #44's Quarterly MDS with an ARD of 07/17/2024 revealed, in part, Resident #44's Quarterly MDS was completed on 07/31/2024.</p> <p>Review of Resident #44's Discharge MDS with an ARD of 07/18/2024 revealed, in part, Resident #44's Discharge MDS was completed on 08/01/2024.</p> <p>Review of the facility's MDS 3.0 NH Final Validation Report revealed, in part, Resident #44's Quarterly MDS was transmitted on 08/20/2024, which was greater than 14 days after the completion date of 07/31/2024. Further review revealed, Resident #44's Discharge MDS with an ARD of 07/18/2024 was transmitted on 08/20/2024, which was greater than 14 days after the completion date of 08/01/2024.</p> <p>Resident #241</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 0640</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #241's record revealed, in part, Resident #241 discharged from the facility on 07/20/2024.</p> <p>Review of Resident #241's Discharge MDS with an ARD of 07/20/2024 revealed, in part, the discharge MDS was completed on 08/03/2024.</p> <p>Review of the facility's MDS 3.0 NH Final Validation Report revealed, in part, Resident #241's Discharge MDS with an ARD of 07/20/2024 was transmitted on 08/20/2024, which was greater than 14 days after the completion date.</p> <p>In an interview on 08/22/2024 at 3:21 p.m., S4MDS Corporate Nurse indicated an MDS assessment should be transmitted within 14 days of the assessment's completion date. S4MDS Corporate Nurse confirmed she transmitted the above mentioned MDS assessments on 08/20/2024.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34060</p> <p>Based on observations, record review, and interviews, the facility failed to ensure a pressure reducing wheelchair cushion was being utilized for a resident assessed as being at high risk for skin breakdown for 1 (Resident #5) of 3 (Resident #5, Resident #14, and Resident #17 sampled residents investigated for pressure injuries, pressure ulcers, or skin integrity).</p> <p>Findings:</p> <p>Review of Resident #5's Electronic Medical Record revealed, in part, Resident #5 had diagnoses which included, a Non-Pressure chronic ulcer of the left lower leg, chronic venous hypertension with ulcer and inflammation of the bilateral lower extremities, and diabetes. Further review revealed Special Instructions: wheelchair cushion listed in Resident #5's care tasks.</p> <p>Review of Resident #5's Minimum Data Set with an Assessment Reference Date of 05/22/2024 revealed, in part, Resident #5 had a Brief Interview for Mental Status score of 9 which indicated Resident #5's cognition was moderately impaired.</p> <p>Review of Resident #5's Braden Scale assessment dated [DATE] revealed, in part, Resident #5 had a score of 12 which indicated a high risk for skin concerns/breakdown (Score of 10-12=high risk for skin breakdown).</p> <p>Review of Resident #5 Care Plan revealed, in part, Resident #5 remained in his wheelchair all day and often slept in his wheelchair.</p> <p>In an interview on 08/20/2024 at 9:55 a.m., Resident #5 indicated he mentioned to the CNA when they provided incontinence care that his buttock was hurting.</p> <p>Observation on 08/20/2024 at 9:56 a.m., revealed a pressure reducing cushion was not in place for Resident #5's wheelchair.</p> <p>Observation on 08/20/2024 at 12:45 p.m., revealed a pressure reducing cushion was not in place for Resident #5's wheelchair.</p> <p>In an interview on 08/20/2024 at 1:29 p.m., Resident #5 indicated he sometimes sleeps in his wheelchair and takes a nap.</p> <p>Observation on 08/20/2024 at 1:30 p.m. revealed a pressure reducing cushion was not in place for Resident #5's wheelchair.</p> <p>In an interview on 08/20/2024 at 2:45 p.m., S2Certified Nursing Assistant (CNA) indicated she did not recall the last time Resident #5 had a cushion for his wheelchair. S2CNA verified Resident #5 remained in his wheelchair the majority of the day.</p> <p>Observation on 08/21/2024 at 8:38 a.m. revealed a pressure reducing cushion was not in place for Resident #5's wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In interview on 08/21/2024 at 1:25 p.m., S2Director of Nursing (DON), indicated all residents should have a cushion on their wheelchair.</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47487</p> <p>Based on observation and interview, the facility failed to ensure residents were supervised and kept free from thermal burns for 2 (Resident #19 and Resident #49) of 2 (Resident #19 and Resident #49) sampled residents investigated for an accident/hazard related to burns.</p> <p>This deficient practice resulted in actual harm when on 02/04/2024 for Resident #49 and on 02/21/2024 for Resident #19, when Resident #19 and Resident #49 were left unsupervised and sustained first degree superficial burns from spilled coffee.</p> <p>Findings:</p> <p>Review of Appendix PP of the State Operations Manual, last revised on 08/08/2024, revealed, in part, third degree burns can occur within 1 to 2 seconds with hot water temperatures between 140 degrees Fahrenheit (F) and 155 degrees F.</p> <p>Review of the National Library of Medicine's Burn Evaluation and Management article, last revised on 08/08/2023, revealed, in part, burns may be caused by hot liquids. Further review revealed superficial burns (first degree) are red on the skin.</p> <p>Resident #19</p> <p>Review of Resident #19's Electronic Medical Record (EMR) revealed, in part, Resident #19 had diagnoses which included epilepsy (a seizure disorder) and Hemiplegia (muscle weakness or partial paralysis on one side of the body)/Hemiparesis (a condition that causes partial or total paralysis of one side of the body) following a cerebral infarction (a type of stroke) that affected Resident #19's Left Non-Dominant side.</p> <p>Review of Resident #19's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/08/2024 revealed, in part, Resident #19 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated Resident #19 cognition was severely impaired. Further review revealed Resident #19 required supervision and/or touching assistance (occasionally assisting to steady food) with eating.</p> <p>Review of Resident #19's progress note dated 02/21/2024 at 6:00 a.m., revealed, in part, Resident #19 received a thermal superficial burn from hot coffee with redness noted to the top of her fingers and the palm of her hand.</p> <p>Review of Resident #19's Skin and Wound Evaluation dated 02/21/2024 revealed, in part, Resident #19 had a reddened area on her left 3rd finger that measured 1.5 centimeters (cms) by 1 cm.</p> <p>In an interview on 08/22/2024 at 9:55 a.m., S7Licensed Practical Nurse (LPN) indicated the coffee pot in the main dining area was not supervised.</p> <p>Resident #49</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #49's EMR revealed, in part, Resident #49 had diagnoses which included anoxic brain damage, type 2 diabetes, and altered mental status.</p> <p>Review of Resident #49's MDS with an ARD of 11/22/2023 revealed, in part, Resident #49 had a BIMS score of 12 which indicated Resident #49's cognition was moderately impaired. Further review revealed Resident #49 required supervision and/or touching assistance with eating.</p> <p>Review of Resident #49's progress note dated 02/04/2024 at 10:46 p.m. revealed, in part, at 7:35 a.m., Resident #49 was yelling hospital hospital. Further review revealed, upon inspection, it was noted that Resident #49 spilled hot coffee on herself. Further review revealed Resident #49 had a red areas to lower left abdomen that measured 12 cm by 4 cm, right upper leg that measured 7cm by 2 cm, and right upper leg that measured 12 cm by 15 cm.</p> <p>Observation on 08/21/2024 at 10:08 a.m., revealed Resident #49 went up to the coffee pot in Dining Room a, placed a coffee cup under coffee dispenser spigot, and pressed the dispenser button to make herself a cup of coffee. Further observation revealed Resident #49 continuously repositioned the coffee cup under the spigot while attempting to fill the cup with coffee. Further observation revealed a staff member was present in the dining area, but had her back turned to the coffee dispenser. Further observation revealed staff did not intervene when Resident #49 attempted to pour coffee in her coffee cup.</p> <p>A check of the coffee temperature on 08/21/2024 at 10:09 a.m. with S15Dietary Supervisor revealed the coffee in the coffee dispenser in Dining Room a was 150.8 degrees Fahrenheit.</p> <p>In an interview on 08/21/2024 at 10:45 a.m., S14Certified Nursing Assistant (CNA) indicated Resident #49 needed assistance and supervision with filling her coffee cup due to her cognition. S14CNA further indicate staff had to redirect and assist Resident #49 with the coffee pot.</p> <p>In an interview on 08/22/2024 at 10:56 a.m., S15Dietary Supervisor indicated the coffee dispenser in Dining Room a was not always supervised. S15Dietary Supervisor further indicated attempts were initially made to address the hot coffee issue, but nothing was put in place and supervision was not increased.</p> <p>In an interview on 08/22/2024 at 12:05 p.m., S1Administrator acknowledged a resident in the facility should not be burned.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>30587</p> <p>Based on observation, record reviews, and interviews the facility failed to ensure S6Licensed Practical Nurse (LPN) disposed of a resident's medication as required for 1 (S6LPN) of 3 (S6LPN, S7LPN, and S11LPN) nurses observed during medication administration.</p> <p>Findings:</p> <p>Review of the facility's Medication Administration Policy and Procedure with effective date of 03/03/2022 revealed, in part, medication shall be prepared immediately prior to administration. Further review revealed if a medication was held because of the nurse's discretion, a notation shall be made on the resident's medication record. Review also revealed wasted control drugs shall be witnessed and co-signed.</p> <p>Review of Resident #86's August 2024 Physician's Orders revealed, in part, Resident #86 was to be administered Oxycodone/Acetaminophen (a controlled medication to treat pain) 10/325 milligrams (mg) one tablet by mouth every 6 hours as needed for pain.</p> <p>Observation on 08/20/2024 at 1:09 p.m. revealed S6LPN assessed Resident #86 for pain. Resident #86 voiced he had a pain level of 8 out of 10 (0 indicating no pain and 10 indicating the worst pain imaginable). S6LPN then obtained Resident #86's Oxycodone/Acetaminophen 10/325mg from the blister pack and placed the medication in a medication cup. Further observation revealed S6LPN attempted to document the administration of Resident #86's Oxycodone/Acetaminophen 10/325mg in Resident #86's electronic medication record, and noted it was 20 minutes too early to administer Resident #86's Oxycodone/Acetaminophen 10/325mg. S6LPN then placed Resident #86's Oxycodone/Acetaminophen 10/325mg tablet from the medication cup back into Resident #86's Oxycodone/Acetaminophen 10/325mg blister pack. S6LPN then placed a piece of tape over the opening of Resident #86's blister pack.</p> <p>In an interview on 08/20/2024 at 1:15 p.m., S6LPN confirmed she should have disposed of Resident #86's Oxycodone/Acetaminophen 10/325mg when it was unable to be administered.</p> <p>In an interview on 08/21/2024 at 4:25 p.m., S2Director of Nursing (DON) indicated Resident #86's Oxycodone/Acetaminophen 10/325mg medication should have been disposed of when S6LPN removed the medication from the blister pack and was unable to administer it. S2DON further indicated S6LPN should not have placed Resident #86's Oxycodone/Acetaminophen 10/325mg medication back into the blister pack for administration.</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>41876</p> <p>Based on record reviews and interviews, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure a resident's most recent hospice plan of care and recertification of terminal illness was obtained from the contracted hospice agency (Resident #13); and, 2. Ensure facility staff were aware of the contracted hospice agency's responsibilities in implementing the hospice plan of care (Resident #13). <p>This deficient practice was identified for 1 (Resident #13) of 1 (Resident #13) sampled resident reviewed for hospice services.</p> <p>Findings:</p> <p>Review of Resident #13's Significant Change Minimum Data Set with an Assessment Reference Date of 05/08/2024 revealed, in part, Resident #13 received hospice services while a resident in the facility.</p> <p>Review of Resident #13's facility hospice care plan initiated on 04/26/2024 revealed, in part, the facility should coordinate Resident #13's care with the contracted hospice agency.</p> <p>Review of Resident #13's August 2024 Physician's Orders revealed, in part, an order to admit Resident #13 to the contracted hospice agency on 04/26/2024.</p> <ol style="list-style-type: none"> 1. <p>Review of the facility and contracted hospice agency's Residential Hospice Agreement dated 06/23/2022 revealed, in part, the Hospice Plan of Care was a written care plan established, maintained, reviewed, and modified, if necessary, at intervals established by the contracted Hospice Interdisciplinary Group (IDG), which included: an assessment of each hospice patient's needs; an identification of the Hospice Services; and, details of the scope and frequency of such Hospice services. Further review revealed the contracted hospice agency will develop a Plan of Care for each Residential Hospice Patient and promptly furnish it to the nursing facility. Review also revealed the facility's designee to implement the facility and contracted hospice agency's Residential Hospice Agreement was listed as the administrator.</p> <p>Review of Resident #13's contracted hospice agency's binder revealed, in part, the following:</p> <ul style="list-style-type: none"> -Resident #13 was admitted to the contracted hospice agency on 04/26/2024; -Resident #13's certification period was from 04/26/2024 through 07/24/2024; <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The only hospice plan of care documented was Resident #13's Hospice Interim Plan of Care dated 04/26/2024, which did not identify Resident #13's hospice services needs or detail the scope and frequency of such hospice services; and,</p> <p>-No documented evidence of a current certification of Resident #13's terminal illness.</p> <p>There was no documented evidence, and the facility was unable to present any documented evidence of current hospice information for Resident #13.</p> <p>In an interview on 08/21/2024 at 3:45 p.m., S2Director of Nursing (DON) confirmed Resident #13 received hospice services from the contracted hospice agency.</p> <p>In an interview on 08/22/2024 at 11:18 a.m., S6Licensed Practical Nurse (LPN) indicated she was unsure how often Resident #13's contracted hospice agency updated the information in Resident #13's hospice binder.</p> <p>In an interview on 08/22/2024 at 11:46 a.m. S2DON indicated Resident #13's hospice binder contained the most current information the facility had regarding Resident #13's contracted hospice agency. S2DON further indicated it was not the facility's policy to ensure Resident #13's hospice binder was up to date.</p> <p>In an interview on 08/22/2024 at 2:51 p.m., Resident #13's Contracted Hospice Agency Case Manager (CHACM) indicated Resident #13's last hospice IDG meeting to review Resident #13's hospice plan of care was on 08/20/2024. Resident #13's CHACM confirmed hospice care plans were updated at least every 60 days. Resident #13's CHACM confirmed Resident #13's 04/26/2024 Hospice Interim Plan of Care was not Resident #13's current plan of care. Resident #13's CHACM indicated the contracted hospice agency should bring updated hospice documents to the facility at least every 2 weeks.</p> <p>In an interview on 08/22/2024 at 2:51 p.m., S1Administrator confirmed he was the facility staff designated to ensure the facility and contracted hospice agency's agreement was followed. S1Administrator indicated he was not aware Resident #13's hospice binder was not kept up to date. S1Administrator confirmed the only hospice plan of care for Resident #13 was dated 04/26/2024.</p> <p>2.</p> <p>Review of the facility's undated Hospice Benefit Care Requirements Policy and Procedure revealed, in part, the contracted hospice agency and the facility should be aware of the other's responsibilities in implementing the plan of care.</p> <p>Review of Resident #13's hospice binder revealed no documented evidence, and the facility was unable to present any documented evidence the facility was aware of the frequency in which Resident #13's hospice personnel were to provide services.</p> <p>In an interview on 08/22/2024 at 11:18 a.m., S6LPN indicated she was unsure how often Resident #13's contracted hospice nurse visited. S6LPN further stated she was unsure how often the hospice agency updated the resident's binder.</p> <p>(continued on next page)</p>		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/22/2024 at 11:46 a.m., S2DON indicated the contracted hospice agency nurse's visits change based on the individual hospice resident's needs and condition, so S2DON was unable to determine how often Resident #13's contracted hospice agency nurse visited Resident #13.		

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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>Provide and implement an infection prevention and control program.</p> <p>30587</p> <p>Based on record review, observations, and interviews, the facility failed to ensure:</p> <ol style="list-style-type: none"> S8Certified Nursing Assistant (CNA) performed hand hygiene after providing incontinence care for 1 (Resident #19) of 1 (Resident #19) sampled residents observed during incontinence care; S5Treatment Nurse (TN) performed hand hygiene during wound care for 2 (Resident #5 and Resident #17) of 3 (Resident #5, Resident #14, and Resident #17) sampled residents observed for wound care; S6Licensed Practical Nurse (LPN) did not handle Resident #86's medication with ungloved hands for 1 (S6LPN) of 3 (S6LPN, S7LPN, and S11LPN) nurses observed during medication administration; S6LPN performed hand hygiene after removing her gloves and prior to applying clean gloves for 1 (S6LPN) of 3 (S6LPN, S7LPN, and S11LPN) nurses observed during medication administration; Clean items in the facility's laundry room were not kept in the contaminated laundry area; and, Staff identified and took corrective action when a cluster of 3 bacterial urinary tract infections were identified for residents who resided in close proximity of each other in the facility. <p>Findings:</p> <p>Review of the facility's Hand Washing/Hand Hygiene Policy and Procedure revealed staff were to perform hand hygiene prior to applying gloves and after removing gloves.</p> <ol style="list-style-type: none"> <p>Observation on 08/20/2024 at 12:52 p.m., revealed S8CNA put on a pair of gloves and completed incontinence care for Resident #19. Further observation revealed S8CNA did not remove her gloves nor perform hand hygiene and proceeded to pulled up Resident #19's blankets, adjusted Resident #19's pillow, adjusted Resident #19's bed using the bed remote, handed Resident #19 a television remote, and opened Resident #19's side table drawer with the same gloved hands used during incontinence care.</p> <p>In an interview on 08/20/2024 at 1:09 p.m., S8CNA acknowledged she did not remove her gloves or perform hand hygiene after completing Resident #19's incontinence care before touching the above mentioned items, and should have.</p> <p>In an interview on 08/22/2024 at 8:50 a.m., S2Director of Nursing (DON) acknowledged S8CNA should have removed her gloves and performed hand hygiene after completing Resident #19's incontinence care, and prior to touching before touching the above mentioned items in Resident #19's room.</p> <p>Resident #5</p> <p>(continued on next page)</p> 		

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NAME OF PROVIDER OR SUPPLIER Legacy Nursing and Rehabilitation of Morgan City		STREET ADDRESS, CITY, STATE, ZIP CODE 740 Justa Street Morgan City, LA 70380	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 08/20/2024 at 9:42 a.m. revealed S5Treatment Nurse (TN) applied two pairs of gloves on her hands before performing wound care to Resident #5's left buttock wound. Observation revealed after removing Resident #5's soiled dressings S5Treatment Nurse removed the top pair gloves, did not remove the second pair of gloves, and did not perform hand hygiene prior to providing treatment to Resident #5's right lower leg wound.</p> <p>Resident #17</p> <p>Observation on 08/21/2024 at 11:18 a.m. revealed S5TN hand sanitized and applied gloves and went into Resident #17's room and set up her wound care supplies. S5Treatment Nurse removed her gloves did not perform hand hygiene and then applied two sets of gloves on each hand. S5Treatment Nurse then removed the dirty dressing and cleaned Resident #17's right ischium wound. S5Treatment Nurse removed the first set of gloves and did not remove the second set of gloves or perform hand hygiene and then applied Resident #17's collagen and creams, and clean dressing.</p> <p>In an interview on 08/21/2024 at 11:25 a.m., S5TN indicated she had always double gloved for wound care and had not realized she was to perform hand hygiene after removing gloves.</p> <p>In an interview on 08/21/2024 at 4:28 p.m., S2DON indicated S5TN should have changed her gloves and performed hand hygiene between clean and dirty procedures.</p> <p>3.</p> <p>Observation on 08/20/2024 at 1:09 p.m. revealed S6Licensed Practical Nurse (LPN) pulled Resident #86's Oxycodone/Acetaminophen (narcotic pain medication used to treat pain) 10/325 milligrams (mg) from the blister pack and into a medication cup. Further observation revealed S6LPN identified she was unable to administer Resident #86's Oxycodone/Acetaminophen 10/325 mg. Further observation then revealed S6LPN did not perform hand hygiene,, and used her ungloved hand to remove Resident #86's Oxycodone/Acetaminophen 10/325 mgh back into the blister pack.</p> <p>In an interview on 08/20/2024 at 1:15 p.m., S6LPN confirmed she should not have grabbed Resident #86's medication with an ungloved hand and placed in the blister pack for administration.</p> <p>4.</p> <p>Observation on 08/20/2024 at 1:09 p.m. revealed S6LPN applied gloves and grabbed the handle of the water pitcher. S6LPN then administered Resident #86's medication. Further observation revealed S6LPN proceeded to remove her gloves and apply a new pair of gloves without performing hand hygiene, and then cleaned Resident #86's PICC (peripherally inserted central catheter) hub.</p> <p>In an interview on 08/20/2024 at 1:15 p.m., S6LPN confirmed she should have performed hand hygiene after removing her gloves.</p> <p>5.</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>Observation on 08/20/2024 at 8:35 a.m. of the contaminated area of the facility's laundry room revealed a yellow contamination bag of soiled laundry was on the floor, and the above mentioned laundry bag was leaned against a rack of clean clothing.</p> <p>In an interview on 08/20/2024 at 8:35 a.m., S10Laundry confirmed the yellow contamination bag of soiled laundry was on the floor was leaning against a rack of clean clothing.</p> <p>In an interview on 08/20/2024 at 8:57 a.m., S10Housekeeping Supervisor indicated the rack of clean clothing should not have been stored on the contaminated side of the laundry room.</p> <p>In an interview on 08/22/2024 at 12:05 a.m., S2DON confirmed the rack of clean clothing should not have been stored on the contaminated side of the laundry room.</p> <p>6.</p> <p>Review of the facility's undated Infection Control Policy and Procedure revealed, in part, the facility's infections would be tracked and trended on a monthly basis by infection category, infection culture, and location. Further review revealed, in part, the Director of Nursing or designee would conduct in-service training for staff on the infection control program as needed.</p> <p>Review of Resident #17's laboratory results revealed, in part, Resident #17's urine culture collected on 06/05/2024 was positive for Proteus Mirabilis (a gram-negative bacteria).</p> <p>Review of Resident #48's laboratory results revealed, in part, Resident #48's urine culture collected on 06/05/2024 was positive for Proteus Mirabilis.</p> <p>Review of Resident #64's laboratory results revealed, in part, Resident #64's urine culture collected on 06/07/2024 was positive for Proteus Mirabilis.</p> <p>Review of the facility's June 2024 Antibiotic Use Tracking Sheet revealed, in part, the following:</p> <ul style="list-style-type: none"> -Resident #17 had a urinary tract infection caused by Proteus Mirabilis; -Resident #48 had a urinary tract infection caused by Proteus Mirabilis; and, -Resident #64 had a urinary tract infection caused by Proteus Mirabilis. <p>Review of the facility's June 2024 infection tracking floor map revealed, in part, Resident #17, Resident #48, and Resident #64 were documented to have the same type of infection and resided in close proximity to each other.</p> <p>There was no documented evidence, and the facility did not present any documented evidence S3Assistant Director of Nursing/Infection Preventionist (ADON/IP) was able to identify the above mentioned cluster of infections in June 2024 or that facility staff took corrective actions such as monitored, educated, or audited on infection control practices during pericare and/or catheter care following Resident #17's, Resident #48's, and Resident #64's urinary tract infections caused by Proteus Mirabilis.</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>In an interview on 08/22/2024 at 2:30 p.m., S3ADON/IP indicated she did not identify Resident #17, Resident #48 and Resident #64 having the same type of infection caused by the same organism while residing in close proximity to one another was considered a cluster. S3ADON/IP further indicated she had not identified Proteus Mirabilis as the predominate bacteria in Resident #17's, Resident #48's, and Resident #64's urinary tract infections. S3ADON/IP confirmed she did not monitor or complete audits of staff for proper hand hygiene during pericare and/or catheter care. S3ADON/IP further confirmed she did not implement any staff education and training on hand hygiene or methods to reduce the risk of cross contamination between residents.</p> <p>In an interview on 08/22/2024 at 2:48 p.m., S2DON stated the facility's infections were monitored on the facility logs for tracking and training purposes, which included identifying clusters of infections on the facility's floor map. S2DON agreed in June 2024, S3ADON/IP used the facility floor map to document infections, but S3ADON/IP did not identify Proteus Mirabilis as the dominant bacteria in residents with urinary tract infections. S2DON further indicated the S3ADON/IP did not identify the potential cause of Proteus Mirabilis in the trending urinary tract infections for June 2024 and/or implement preventative measures to decrease the risk of further Proteus Mirabilis urinary tract infections, and should have. S2DON confirmed S3ADON/IP should have completed pericare audits, hand hygiene check-offs, and nurse audits for catheter changes and/or insertions.</p> <p>34060</p> <p>46361</p> <p>47487</p>		