

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER Deerfield Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 522 Main Street Delhi, LA 71232	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19098</p> <p>Based on observations, record reviews and interviews the facility failed to develop a plan of care for 1 (#28) of 1 (#28) residents for discharge planning and failed to implement the plan of care for 1 (#46) of 1 (#46) residents by failing to place a fall mat on the floor at the bedside.</p> <p>Findings:</p> <p>Resident #28</p> <p>On 05/12/2025 at 1:18 p.m., an interview with resident #28 revealed she spoke with S7Business Office Manager (BOM), whom was previously the social service director, over 6 months ago about getting her own apartment but she had not heard anything else about it.</p> <p>Review of the record for resident #28 revealed diagnoses including cerebral infarction, non-traumatic intracerebral hemorrhage with dysarthria and dysphagia, type 2 diabetes, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed resident #28 had a brief interview for mental status (BIMS) score of 13 which indicated the resident was cognitively intact.</p> <p>Review of the current plan of care revealed there was no focus area initiated for the resident's request to be discharged to the community.</p> <p>On 05/14/2025 at 2:20 p.m., an interview with S8SSD (Social Services Director) revealed S7BOM did speak with resident #28 a while back about getting her own appropriate apartment for her condition. S8SSD further revealed resident #28 had never asked her about moving into her own apartment.</p> <p>On 05/14/2025 at 2:35 p.m., an interview with S7BOM who was the previous SSD until January 2025 revealed she had spoken to resident #28 several times about getting her own apartment. S7BOM said she even called the State to come to the facility to assess the resident for a waiver and getting her own apartment but they determined resident #28 had too many limitations to be able to find housing in the area. S7BOM further revealed resident #28 also had a family member that lives in another state and had been trying to locate housing in that state for the resident.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/14/2025 at 3:16 p.m. an interview with S2Director of Nurses (DON) and S6MDS Coordinator revealed they were not aware resident #28 had been wanting to get her own apartment and there was no plan of care for resident #28 to discharge to the community.</p> <p>41829</p> <p>Resident #46</p> <p>Record review revealed resident #46 was admitted to the facility on [DATE]. Resident #46's diagnoses included essential hypertension, stage 2 pressure ulcer of sacral region, retention of urine unspecified, benign prostatic hyperplasia with lower urinary tract symptoms, unspecified osteoarthritis, anemia, hallucinations, chronic obstructive pulmonary disease, and paroxysmal atrial fibrillation.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed a brief interview for mental status score of 13 which indicated resident #46 was cognitively intact. Further review revealed resident #46 required partial/moderate assistance with toileting, shower/bathe, dressing lower body, putting on/taking off foot wear, personal hygiene, transfers, and walking 50 feet.</p> <p>Review of resident #46's fall risk assessment dated [DATE] revealed a score of 20 which indicated resident #46 was a high risk for falls.</p> <p>Review of the active care plans revealed resident #46 was at risk for falls. An intervention listed was for a fall mat to right side of bed.</p> <p>Review of the active May 2025 physician orders revealed an order dated 01/03/2024 for fall precautions in place/fall mat to right side of bed.</p> <p>On 05/12/2025 at 9:06 a.m., 05/13/2025 at 8:10 a.m., and 05/14/2025 at 8:20 a.m. observations of resident #46's room revealed there was no fall mat noted on either side of resident #46's bed.</p> <p>On 05/14/2025 at 9:00 a.m. an interview with S5Assistant Director of Nursing (ADON) confirmed there was no fall mat on the floor on either side of resident #46's bed. S5ADON further confirmed there should have been a fall mat on the floor beside his bed.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19098</p> <p>Based on observation, record review and interview the facility failed to ensure the resident's environment remained free from accident hazards by not conducting a bed rail/mattress safety assessment prior to implementing the use of side rails for 1 (#36) of 4 (#3, #36, #40, #50) residents reviewed for the use of side rails.</p> <p>Findings:</p> <p>On 05/12/2025 at 3:20 p.m., observation of resident #36 revealed she was up in the wheelchair. Observation of resident #36's bed at that time revealed both the top quarter rail and the bottom quarter rail on the right side of the bed were in the upright position and the left side of the bed was against the wall.</p> <p>On 05/13/2025 at 8:20 a.m., observation of resident #36 revealed she was sitting up in a wheelchair asleep. Observation of resident #36's bed at that time revealed both the top quarter rail and the bottom quarter rail on the right side of the bed were in the upright position and the left side of the bed was against the wall.</p> <p>On 05/14/2025 at 9:45 a.m., observation of resident #36 revealed she was in the bed asleep with both the top quarter rail and the bottom quarter rail on the right side of the bed were in the upright position and the left side of the bed was against the wall.</p> <p>Review of the Bed Safety and Bed Rails policy and procedure revised August 2022:</p> <p>Policy Statement</p> <p>Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup.</p> <p>Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> 1. The resident's sleeping environment is evaluated by the interdisciplinary team. 2. Consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement. 3. Bed frames, mattresses and bed rails are checked for compatibility and size prior to use. 4. Bed dimensions are appropriate for the resident's size. 5. Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will be within the safety dimensions established by the Food and Drug Administration (FDA). 6. Side Rail Use Assessment Form to determine if side rails are beneficial for the resident. <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7. Any worn or malfunctioning bed system components are repaired or replaced using components that meet manufacturer specifications.</p> <p>8. Bed rails are properly installed and used according to the manufacturer's instructions, specifications and other pertinent safety guidance to ensure proper fit (e.g., ensure proper distance from the headboard and footboard, etc.)</p> <p>Use of Bed Rails</p> <p>1. Bed rails are adjustable metal or rigid plastic bars that attach to the bed. One-quarter rails are used in this facility.</p> <p>2. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent:</p> <p>a. The assessed medical needs that will be addressed with the use of bed rails;</p> <p>b. The resident's risks from the use of bed rails and how these will be mitigated;</p> <p>c. The alternatives that were attempted but failed to meet the resident's needs; and</p> <p>d. The alternatives that were considered but not attempted and the reasons.</p> <p>3. Consent for Bed Rail/Assist Bars Informed Consent for Use will be signed by the resident/responsible party.</p> <p>4. The staff shall report to the director of nursing and administrator any accidents or incidents associated with a bed or related equipment including the bed frame, side or bed rails, and mattresses. The Administrator shall ensure that reports are made to the Food and Drug Administration or other appropriate agencies, in accordance with pertinent laws and regulations including the Safe Medical Devices Act.</p> <p>On 05/14/2025 at 2:15 p.m. observation of resident #36's room with S2Director of Nursing (DON) revealed the upper quarter side rail and the lower quarter side rail were in the raised position on the right side of bed with the left side of bed was against the wall. S2DON stated they just bought some hospital beds from the local hospital and the side rails cannot be removed but can be put in the down position. S2DON confirmed the lower quarter side rail should not have been in the up position. S2DON further confirmed the Physician order for the side rail use was only for the upper quarter rail for resident #36 to use to position herself in the bed.</p> <p>On 05/14/2025 review of the bed rail/mattress safety assessment dated [DATE] revealed it was not complete. Further review revealed the bed rail use assessment form and the bed rails/assist bars informed consent for use were not completed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/14/2025 at 2:15 p.m. an interview with S2DON confirmed the bed rail/mattress safety assessment was not completed prior to the use of the upper and lower quarter rails on resident #36's bed. S2DON further confirmed the bed rail use assessment form, and the bed rails/assist bars informed consent for use were not completed prior to using the upper and lower quarter side rails on resident #36's bed.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19098</p> <p>Based on observations, record reviews and interview, the facility failed to 1.) review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation and 2.) assess the resident for risk of entrapment from bed rails prior to installation for 1 (#36) of 4 (#3, #36, #40, #50) residents reviewed for bed rails.</p> <p>Findings:</p> <p>Review of the Bed Safety and Bed Rails policy and procedure revised August 2022:</p> <p>Policy Statement</p> <p>Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup.</p> <p>Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> 1. The resident's sleeping environment is evaluated by the interdisciplinary team. 2. Consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement. 3. Bed frames, mattresses and bed rails are checked for compatibility and size prior to use. 4. Bed dimensions are appropriate for the resident's size. 5. Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will be within the safety dimensions established by the FDA. 6. Side Rail Use Assessment Form to determine if side rails are beneficial for the resident. 7. Any worn or malfunctioning bed system components are repaired or replaced using components that meet manufacturer specifications. 8. Bed rails are properly installed and used according to the manufacturer's instructions, specifications and other pertinent safety guidance to ensure proper fit (e.g., ensure proper distance from the headboard and footboard, etc.) <p>Use of Bed Rails</p> <ol style="list-style-type: none"> 1. Bed rails are adjustable metal or rigid plastic bars that attach to the bed. One-quarter rails are used in this facility. <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent:</p> <ul style="list-style-type: none"> a. The assessed medical needs that will be addressed with the use of bed rails; b. The resident's risks from the use of bed rails and how these will be mitigated; c. The alternatives that were attempted but failed to meet the resident's needs; and d. The alternatives that were considered but not attempted and the reasons. <p>3. Consent for Bed Rail/Assist Bars Informed Consent for Use will be signed by the resident/responsible party.</p> <p>4. The staff shall report to the director of nursing and administrator any accidents or incidents associated with a bed or related equipment including the bed frame, side or bed rails, and mattresses. The Administrator shall ensure that reports are made to the Food and Drug Administration or other appropriate agencies, in accordance with pertinent laws and regulations including the Safe Medical Devices Act.</p> <p>On 05/12/2025 at 3:20 p.m., observation of resident #36 revealed she was up in the wheelchair. Observation of resident 36's bed at that time revealed both the top quarter rail and the bottom quarter rail on the right side of the bed were in the upright position and the left side of the bed was against the wall.</p> <p>On 05/13/2025 at 8:20 a.m., observation of resident #36 revealed she was sitting up in a wheelchair asleep. Observation of resident #36's bed at that time revealed both the top quarter rail and the bottom quarter rail on the right side of the bed were in the upright position and the left side of the bed was against the wall.</p> <p>On 05/14/2025 at 9:45 a.m., observation of resident #36 revealed she was in the bed asleep with both the top quarter rail and the bottom quarter rail on the right side of the bed in the upright position and the left side of the bed was against the wall.</p> <p>On 05/14/2025 review of the record for resident #36 revealed diagnoses in part of unspecified psychosis, unspecified lack of coordination abnormalities of gait and mobility, seizures, dementia, pseudobulbar affect, and intellectual disabilities.</p> <p>Review of the physician order dated 04/13/2025 revealed may use bilateral upper side rails times 1 for bed mobility assistance, definition, safety and security.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #36 had a brief interview for mental status (BIMS) score of 9 indicating moderate cognitive impairment.</p> <p>Review of the functional abilities revealed no range of motion impairment to both upper and lower extremities and uses a wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the mobility MDS assessment revealed:</p> <p>Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed resident #36 required set up or clean up assistance.</p> <p>Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed resident #36 required set up or clean up assistance.</p> <p>Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support resident #36 required set up or clean up assistance.</p> <p>Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed resident #36 required partial or moderate assistance.</p> <p>Chair or bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) resident #36 required partial or moderate assistance.</p> <p>Review of the current plan of care for the use of side rails for resident #36 revealed:</p> <p>Impaired physical mobility due to cerebrovascular accident (CVA) or trans ischemia attack, general mentation and mental health disorders. May use bilateral upper side rails for bed mobility assistance, definition, safety and security.</p> <p>Interventions:</p> <p>Allow adequate time for resident's response,</p> <p>Assist resident in performing movements or tasks,</p> <p>Determine resident's ability to reposition in bed,</p> <p>Determine resident's ability to transfer,</p> <p>Educate resident or representative on safety precautions,</p> <p>Encourage use of prescribed assistive devices,</p> <p>Ensure call light is available to resident,</p> <p>Monitor for environmental barriers to mobility,</p> <p>Utilize repositioning devices in bed.</p> <p>On 05/14/2025 review of the bed rail/mattress safety assessment dated [DATE] revealed it was not complete. Further review of the bed rail use assessment form and the bed rails/assist bars informed consent for use were not completed prior to the use of the side rails.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/14/2025 at 2:15 p.m. observation of resident #36's room with S2Director of Nursing (DON) revealed the upper quarter side rail and the lower quarter side rail were in the raised position on the right side of bed with the left side of bed was against the wall. S2DON stated they just bought some hospital beds from the local hospital and the side rails cannot be removed but can be put in the down position. S2DON confirmed the lower quarter side rail should not have been in the up position. S2DON further confirmed the physician order for the side rail use was only for the upper quarter rail for resident #36 to assist in positioning in bed.</p> <p>S2DON further confirmed the bed rail/mattress safety assessment, bed rails/assist bars informed consent for use, and side rail use assessment form had not been completed prior to utilizing the side rails on resident #36's bed.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52271</p> <p>Based on record review and interviews, the facility failed to ensure that the licensed nurses have the competencies and skill sets necessary to care for residents' needs for 1 (#53) of 1 closed record review. S12Licensed Practical Nurse (LPN) failed to obtain vital signs after she was unable to obtain a pulse oximetry reading.</p> <p>Findings:</p> <p>Review of the medical record for resident #53 revealed an admitted [DATE] which diagnoses that included acute on chronic congestive heart failure, ischemic cardiomyopathy, atherosclerotic heart disease, hypertension, fluid overload, presence of coronary angioplasty implant/graft, and presence of cardiac defibrillator.</p> <p>Review of the nurses notes for resident #53 dated 02/21/2025 revealed an entry at 9:00 a.m. in which S12LPN documented a pulse oximetry reading was unable to be obtained due to resident #53's cold and swollen fingers. Further review revealed that resident #53 was administered his medications and then became nauseated.</p> <p>On 05/13/2025 at 2:30 p.m., an interview with S12LPN revealed she did not recall if vital signs were taken after being unable to obtain a pulse oximetry reading.</p> <p>On 05/14/2025 at 8:12 a.m., an interview with S5Assistant Director of Nursing (ADON) confirmed that vital signs should have been obtained after S12LPN was unable to obtain a pulse oximetry reading and resident #53 became nauseated.</p> <p>On 05/14/2025 at 11:52 a.m., an interview with resident #53's physician confirmed that he would expect vital signs to be checked when a pulse oximetry reading was unable to be obtained and an individual was nauseated.</p> <p>On 05/14/2025 at 3:15 p.m. S1Administrator and S2Director of Nursing were notified of the survey findings.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118</p> <p>Based on record review and interview, the facility failed to ensure each resident's medication regimen was free from unnecessary medications by failing to administer insulin as ordered for 1 (#32) of 5 (#3, #4, #8, #32, and #36) residents reviewed for unnecessary medications.</p> <p>Findings:</p> <p>Review of the facility's policy and procedure for Administering Medications Policy revised April 2019 revealed the following, in part:</p> <p>Medications are administered in a safe and timely manner, and as prescribed.</p> <p>4. Medications are administered in accordance with prescriber orders, including required time frame.</p> <p>Review of the medical record for resident #32 revealed diagnoses of schizoaffective disorder, edema, hypokalemia, dementia, muscle wasting, altered mental status, hypothyroidism, diabetes mellitus, and hyperlipidemia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #32's Brief Interview for Mental Status indicated the resident had severe cognitive impairment for daily decision making, and required assistance with activities of daily living.</p> <p>Review of the current care plan revealed resident #32 had diabetes mellitus and interventions included to obtain fasting serum blood sugar as ordered by the physician and to administer Regular Insulin as ordered by the physician.</p> <p>Review of the May 2025 physician orders revealed an order dated 7/28/2024 for Insulin Regular (Human) 100 units/milliliter, inject 10 units subcutaneously as needed for hyperglycemia if blood sugar is greater than 300.</p> <p>Review of the May 2025 Medication Administration Record (MAR) revealed resident #32's blood sugar reading on 05/04/2025 at 4:00 p.m. was 425 milligrams/deciliter (mg/dL), and on 05/08/2025 at 4:00 p.m. her blood sugar was 381 mg/dL. Review of the record revealed no documented evidence that the insulin was administered as ordered for blood sugar readings greater than 300.</p> <p>On 05/13/2025 at 2:50 p.m. interview with S2Director of Nursing (DON) confirmed the insulin was not given as ordered when resident #32's blood sugar was greater than 300.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>52271</p> <p>Based on observation and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. The facility failed to ensure: 1) freezer temperatures were maintained at a level to keep frozen food solid; 2) frozen foods and noodles were properly sealed and not left open to air; 3) storage containers for flour, corn meal, and sugar were free from spills and splatters; 4) frozen chopped meat was thawed appropriately, and 5) hygienic practices were followed during food service. S4Dietary Manager (DM) reported that 53 residents were served meals from the kitchen.</p> <p>Findings:</p> <p>Observation of the kitchen on 05/12/2025 at 8:18 a.m. revealed the following:</p> <ul style="list-style-type: none"> -the freezer had multiple thawed items including: 2 packs of onion rings, 1 box of waffles, 1 box of egg patties open to air, 1 box of waffles, 1 box of oatmeal raisin cookies, and 1 box of omelets open to air; -the dry storage area had an opened bag of noodles stored in an opened plastic zip bag; -storage containers for flour, corn meal, and sugar were visibly soiled with food particles and a sticky substance; and -frozen chopped ham was in a sink thawing at room temperature. <p>On 05/12/2025 at 9:00 a.m., an interview with S4DM confirmed the areas of concern identified upon observation.</p> <p>On 05/12/2025 at 11:30 a.m., during the lunch meal, S4DM was observed touching serving trays and plates with gloved hands. S4DM then placed the bread on residents' plates without changing her gloves prior to touching the bread with her contaminated gloves.</p> <p>On 05/12/2025 at 11:35 a.m., an interview with S4DM confirmed she should have not touched the bread with the contaminated gloved hands and should be using tongs to place the bread on the residents' plates.</p> <p>On 05/14/2025 at 3:15 p.m., S1Administrator and S2Director of Nursing (DON) were informed of the findings in the kitchen.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>51983</p> <p>Based on record review and interview the facility failed to have quarterly quality assessment and assurance (QAA) meetings with required members of the QAA committee present. The failed practice was evidenced by the facility's lack of documentation of 4th quarter of 2024 and 1st quarter of 2025 QAA meetings.</p> <p>Findings:</p> <p>Review of the QAA meetings revealed that the facility held meetings in the second and third quarters of 2024. Further review of the QAA meetings binder revealed that the facility did not have QAA meetings in the 4th quarter of 2024 and 1st quarter of 2025 with required participants.</p> <p>Interview with S1Administrator and S2DON on 05/14/2025 at 4:00 p.m. confirmed that the facility was not able to provide documentation of QAA meetings with required participants during the 4th quarter of 2024 and the 1st quarter of 2025.</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>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118</p> <p>Based on observations, record reviews, and interviews, 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 by failing to:</p> <ol style="list-style-type: none"> 1) implement policies and procedures for Enhanced Barrier Precautions (EBPs) by not wearing the appropriate personal protective equipment during care for 4 (#7, #8, #11, and #46) of 4 residents, 2) have signage or an indicator outside of rooms to determine residents that should be on EBPs for 6 (#2, #7, #8, #11, #46, and #50) of 6 residents that required EBPs, and 3) ensure infection control practices were maintained during catheter care for 1 (#16) of 1 residents observed for catheter care. <p>Findings:</p> <p>Review of the facility's Enhanced Barrier Precautions policy, not dated, revealed in-part:</p> <p>Policy Statement: Enhanced barrier precautions (EBPs) are utilized to prevent spread of multi-drug resistant organisms (MDROs) to residents.</p> <p>Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organism (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. <ol style="list-style-type: none"> a. Gloves and gowns are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPR) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. d. Hand hygiene is to be performed between residents. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: <ol style="list-style-type: none"> a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; <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>e. changing linens;</p> <p>f. changing briefs or assisting with toileting;</p> <p>g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and</p> <p>h. wound care (chronic wounds, not shorter lasting wounds, such as skin breaks or skin tears).</p> <p>5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.</p> <p>6. EBPs remains in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at risk.</p> <p>9. Staff are trained prior to caring for residents on EBPs.</p> <p>10. Avoid posting signs on door/wall (due to privacy). Symbols may be used. Signage can be at the facility's discretion, as long as staff know which residents require EBP. (Orange sticker on the name of resident's room).</p> <p>11. PPE is available on EBP cart located on each hall where where applicable.</p> <p>Review of the facility's Catheter Care, Urinary policy revised August 2022 revealed in part:</p> <p>15. Use a clean washcloth with warm water and soap (or bathing wipe) to cleanse and rinse the catheter from insertion site to approximately four inches outward.</p> <p>18. Discard disposable items into designated containers. Remove gloves and discard into designated container. Wash and dry your hands thoroughly.</p> <p>19. Reposition the bed covers. Make the resident comfortable.</p> <p>Resident #7</p> <p>Review of the record for resident #7 revealed diagnoses of atherosclerosis of native arteries of right leg with ulceration of the foot, arterial ulcer right foot, intermittent claudication of right leg, presence of vascular implants and grafts, and surgical amputation of left below the knee.</p> <p>Review of the current physician orders for wound care to the first digit of the right foot revealed the following: clean with wound cleanser, pat dry, apply alginate and cover with dry dressing every other day.</p> <p>On 05/13/2025 at 9:30 a.m., an observation of resident #7's door prior to entering the room to observe wound care revealed there was no indication resident #7 was on EBPs. Observation of wound care to resident #7's right first digit performed by S3Licensed Practical Nurse (LPN) and S2Director of Nursing (DON) revealed S3LPN and S2DON did not wear a gown during wound care.</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>On 05/13/2025 at 2:52 p.m., an interview with S10Certified Nurses Aide (CNA) revealed if a resident was on EBPs there would be a sign on the door indicating the resident was on EBPs.</p> <p>On 05/13/2025 at 2:50 p.m., an interview with S3LPN confirmed she failed to wear a gown during wound care to resident #7. S3LPN further confirmed S2DON also did not wear a gown during wound care.</p> <p>On 05/13/2025 at 2:55 p.m., an interview with S11CNA revealed there were no residents on the hall with EBPs even though resident #7 required wound care.</p> <p>Resident #8</p> <p>Record review revealed resident #8 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #8's diagnoses included but not limited to the following: hypertension, edema, blister (non-thermal) left lower leg, chronic venous insufficiency, pain, unspecified osteoarthritis unspecified site, muscle wasting and atrophy multiple sites, tremors unspecified, major depressive disorder, bipolar disorder, anemia, diabetes mellitus, anxiety, and dementia.</p> <p>Review of the May 2025 physician orders revealed a treatment order dated 04/23/2025 for a small ruptured blister to left lower extremity as follows: cleanse with dermal wound cleanser and gauze, apply Aquacel silver to wound bed, cover with dry dressing every other day (qod) and as needed (prn).</p> <p>On 05/12/2025 at 10:25 a.m. and 05/13/2025 at 8:25 a.m. observations revealed no signage on resident #8's door indicating resident was on EBPs.</p> <p>On 05/13/2025 at 10:08 a.m. an observation of wound care to resident #8's left lower extremity by S3LPN revealed S3LPN did not wear a protective gown while performing wound care to resident #8.</p> <p>On 05/13/2025 at 1:20 p.m. an interview conducted with S2DON and S3LPN revealed they are using an orange colored sticker by the resident's name outside their door to inform staff the resident required EBPs. S2DON confirmed there was no orange sticker or signage posted outside resident #8's door indicating that resident #8 was on EBPs. S2DON further confirmed S3LPN should have worn a protective gown while providing resident #8's wound care.</p> <p>Resident #11</p> <p>Review of the record for resident #11 revealed diagnoses of vascular dementia, acute kidney failure, pressure ulcer of sacral region stage 4, chronic obstructive pulmonary disease, peripheral vascular disease and type 2 diabetes mellitus.</p> <p>Review of the current wound care orders to the sacral pressure ulcer revealed the following: clean with wound cleanser, pat dry, apply skin prep to the peri-wound, apply collagen powder to the wound bed, lightly pack with Iodoform gauze, cover with foam, secure with dry dressing every other day.</p> <p>On 05/13/2025 at 8:45 a.m., an observation of resident #11's door revealed no signage indicating resident #11 required EBPs. Further observation of the wound care performed by S3LPN and S2DON revealed S3LPN and S2DON only wore gloves and did not wear a gown during wound care.</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>On 05/13/2025 at 2:50 p.m., an interview with S3LPN confirmed she failed to wear a gown during wound care to resident #11. S3LPN further confirmed S2DON also did not wear a gown during wound care.</p> <p>On 05/13/2025 at 2:55 p.m., an interview with S11CNA revealed there were no residents on the hall with EBPs even though resident #11 required wound care.</p> <p>Resident #46</p> <p>Record review revealed resident #46 was admitted to the facility 01/02/2024 with diagnoses of essential hypertension, stage 2 pressure ulcer of sacral region, retention of urine unspecified, benign prostatic hyperplasia with lower urinary tract symptoms, anemia, hallucinations, chronic obstructive pulmonary disease, and paroxysmal atrial fibrillation.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed a brief interview for mental status score of 13 which indicated resident #46 was cognitively intact. Further review revealed resident #46 had an indwelling catheter and a stage 2 pressure ulcer.</p> <p>Review of the May 2025 physician orders revealed an order dated 04/07/2025 for wound care to a stage 2 pressure injury to coccyx: cleanse with dermal wound cleanser, pat dry with gauze, apply skin prep to peri-wound, apply Medihoney to slough, then cover with gauze, cover with foam and secure with border dressing every other day and as needed. Further review revealed an order dated 09/05/2024 for an indwelling catheter 16 French Coude catheter change every 30 days.</p> <p>On 05/12/2025 at 9:06 a.m. and 05/13/2025 at 8:10 a.m., observations outside resident #46's door revealed no signage indicating resident #46 was on EBPs.</p> <p>On 05/13/2025 at 8:32 a.m. an observation of resident #46's wound care to her coccyx by S3LPN revealed S3LPN did not wear a protective gown while providing wound care to resident #46. S2DON was present during resident #46's wound care.</p> <p>On 05/13/2025 at 1:20 p.m. an interview with S2DON and S3LPN revealed resident #46 was on EBPs. S2DON revealed they are using an orange colored sticker by the residents name outside their room to inform staff that residents are on EBPs. An observation of resident #46's name outside his door revealed there was an orange sticker. S2DON confirmed S3LPN should have worn a protective gown while providing wound care to resident #46.</p> <p>On 05/13/2025 at 3:00 p.m. an interview with S12LPN revealed resident #46 was on EBPs related to having an indwelling catheter and a wound on his coccyx. S12LPN revealed the orange sticker beside his name on the door plate indicated he was on EBPs.</p> <p>Resident #2</p> <p>Review of the medical record for resident #2 revealed an admitted [DATE]. Resident #2 had diagnoses including heart disease, thrombocytopenia, depression, sepsis, aortic valve stenosis, and end stage renal disease.</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>Review of resident #2's quarterly MDS assessment dated [DATE] revealed resident had moderate cognitive impairment for daily decision making and required assistance with activities of daily living (ADLs).</p> <p>Review of the physician orders dated 07/03/2024 revealed an order to monitor dialysis access site to right chest wall for signs and symptoms of infection.</p> <p>On 5/12/2025 at 11:00 a.m., interview with resident #2 revealed she had dialysis treatments three times a week and she had a dialysis access in her chest. Observation of the outside of resident #2's room revealed no written signage or an orange dot on the name plate to indicate the resident was on EBPs.</p> <p>On 5/13/2025 at 8:30 a.m. observation of the outside of the resident's room revealed no written signage or an orange dot on the name plate to indicate the resident was on EBPs.</p> <p>On 05/13/2025 at 1:30 p.m. an interview was with S2DON and S3LPN revealed they use an orange colored sticker by the resident's name outside their door to inform staff the resident was on EBPs. S2DON confirmed there was no orange sticker or signage posted outside of resident #2's door to indicate the resident was on EBPs for having a dialysis access.</p> <p>Resident #50</p> <p>Review of the medical record for resident #50 revealed an admitted [DATE]. Resident #50 had diagnoses including dysphagia, hypoglycemia, schizoaffective disorder, hypothyroidism, hyperkalemia, unspecified intellectual disabilities, cardiomegaly, and pleural effusion.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #50 had severe cognitive impairment for daily decision making and required assistance with ADLs.</p> <p>On 05/12/2025 at 10:45 a.m. and on 05/13/2025 at 8:10 a.m. observations of resident #50 revealed the tube feeding was infusing at 50 cubic centimeters (cc) per hour. Observations of the outside of resident #50's room revealed no indicator that the resident was to be on EBPs due to having a Percutaneous Endoscopic Gastrostomy (PEG) tube.</p> <p>On 05/13/2025 at 1:30 p.m. an interview was conducted with S2DON and S3LPN revealed they use an orange colored sticker by the resident's name outside their door to inform staff the resident was on EBPs. S2DON confirmed there was no orange sticker or signage posted outside resident #50's door to indicate resident #50 was on EBPs for having a PEG tube.</p> <p>Resident #16</p> <p>Review of the medical record for resident #16 revealed an admitted [DATE] with diagnoses that included Parkinsonism, neuromuscular dysfunction of bladder, and abnormal posture.</p> <p>Review of the Annual MDS assessment dated [DATE] revealed a BIMS score of 10 which indicated that resident #16 had moderately impaired cognition.</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>Review of resident #16's current plan of care revealed that catheter care should be performed every shift and as needed.</p> <p>On 05/13/2025 at 11:00 a.m., an observation of indwelling catheter care by S13CNA was performed.</p> <p>S13CNA was noted wiping towards the indwelling catheter insertion site during the catheter care and S13CNA did not change gloves after the task was completed and touched resident #16's gown, bed linens, and rails with contaminated gloves.</p> <p>On 05/14/2025 at 3:15 p.m., S1Administrator and S2DON were notified of the survey findings and confirmed S13CNA did not use proper technique while performing pericare for resident #16.</p> <p>19098</p> <p>41829</p> <p>52271</p>