

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225219	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Bear Mountain at Worcester		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Acton Street Worcester, MA 01604	

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 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</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>37086</p> <p>Based on observations, records reviewed and interviews, on one of four nursing units (Unit #1) that specialized in the care and treatment of residents who were dependent on a tracheostomy and/or ventilator for breathing, whose residents all required Enhanced Barrier Precaution (EBP) to be utilized by nursing staff during the provision of care, and where there was on-going spread of Candida Auris (C. Auris, a type of yeast that can cause severe illness and spreads easily among patients in healthcare facilities, which can cause a range of infections from superficial (skin) infections to more severe, life-threatening infections, such as bloodstream infections), the Facility failed to ensure 1) that nursing staff on the unit were competent and had the necessary skill set to appropriately care for residents on EBP by donning the correct Personal Protective Equipment (PPE), when a nursing staff member was observed not following EBP when caring for a resident, and 2) the Unit Manager (for Unit #1) who was responsible for ensuring nursing staff on the unit followed established infection control procedures when caring for the residents on the unit, (who were all on EBP), was unable to verbalize the Facility's hand hygiene protocol for residents on EBP, both of which increased the risk of spread of infectious diseases (like C. Auris) to other residents on the unit.</p> <p>Findings include:</p> <p>Review of the Facility's policy titled Competent Nursing Staff, undated, indicated it was the practice of the Facility to employ nursing staff that have the competency and skills to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The Policy indicated nursing competencies would be performed during the orientation period to validate skills necessary to perform duties of the employees' job description and additional competencies may be conducted as indicated as standards of practice or regulation changes.</p> <p>Review of the Facility's policy titled Candida Auris (C.Auris), dated April 2024, indicated the following:</p> <p>-C. Auris is highly contagious in healthcare facilities and spreads easily in healthcare settings and can cause outbreaks.</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 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>-C. Auris can colonize in patients for many months, persists on surfaces, and is not killed by some commonly used healthcare facility disinfectants.</p> <p>-Hand hygiene, appropriate precautions, and environmental disinfection prevent and control outbreaks.</p> <p>-How it spreads:</p> <p>*Person to person contact: C. Auris can spread through direct contact with an infected person.</p> <p>*Contaminated surfaces: C. Auris can survive on surfaces for weeks, including bedrails, doorknobs, and medical equipment.</p> <p>*Shared equipment: C. Auris can spread through sharing medical equipment that has not been disinfected.</p> <p>-Recognizing that residents are at an increased risk of becoming colonized and developing infection, the facility will implement the use of Enhanced Barrier Precautions (EBP).</p> <p>-Enhanced Barrier Precautions targets the use of a gown and gloves during high contact care activities.</p> <p>-The Personal Protective Equipment (PPE) required when following Enhanced Barrier Precautions is a gown and gloves which are to be donned (applied) prior to the high contact care activity.</p> <p>-Hand hygiene is to be performed before donning PPE and after doffing (removed).</p> <p>-Examples of high contact care include (but not limited to): Device care or use, tracheostomy/ventilator.</p> <p>Review of the Enhanced Barrier Precaution sign, undated, indicated:</p> <p>-Everyone Must: Clean their hands including before and when leaving the room.</p> <p>-Providers and Staff Must Also: Wear a gown and gloves for the following High-Contact Resident Care Activities:</p> <p>*Dressing</p> <p>*Bathing/showering</p> <p>*Transferring</p> <p>*Changing Linens</p> <p>*Providing Hygiene</p> <p>*Changing briefs or assisting with toileting</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>*Device Care of Use: central line, urinary catheter, feeding tube, tracheostomy and</p> <p>*Wound Care: any skin opening requiring a dressing.</p> <p>Review of the Facility's Line List (a tracking tool used for infectious diseases) for Candida Auris (C. Auris- a type of yeast that can cause severe illness and spreads easily among patients in healthcare facilities, which can cause a range of infections from superficial (skin) infections to more severe, life-threatening infections, such as bloodstream infections) indicated that on Unit #1, there were three cases identified in December 2024 and an additional four more cases were identified in January 2025.</p> <p>1) Review of Nurse #2's Competency Assessment for Licensed Nurses, dated 07/19/24, indicated Nurse #2 was competent in the knowledge of infection prevention policies and applied the procedures.</p> <p>Review of the Licensed Practical Nurse (LPN) job description, signed by Nurse #2 and dated 12/12/24, included the following:</p> <ul style="list-style-type: none"> -Ensures that safety and sanitation standards are maintained in residents' rooms. -Follows organizational policies and procedures when providing nursing care. <p>Resident #6 was admitted to the Facility in October 2024, diagnoses include respiratory failure, anoxic brain damage, cerebral infarction and tracheostomy.</p> <p>Review of Resident #6's Physician Orders dated 1/29/25 indicated he/she required Enhanced Barrier Precautions and tracheostomy care as needed.</p> <p>On 1/29/25 at 8:35 A.M., Surveyor #2 observed an Enhanced Barrier Precaution sign hanging in the doorway outside of Resident #6's room.</p> <p>Surveyor #2 further observed Resident #6 lying in bed and Nurse #2 wearing gloves and a mask, and without a gown, lean over Resident #6 to change the dressing around his/her tracheostomy. Nurse #2 removed the gauze dressing from Resident #6's tracheostomy site, wiped around the tracheostomy with another piece of gauze and applied a clean piece of gauze around the tracheostomy. Nurse #2 completed the dressing change, then placed a blood pressure cuff around Resident #6's arm to obtain his/her blood pressure and placed her stethoscope on Resident #6's chest. Nurse #2 exited Resident #6's room, removed her gloves and performed hand hygiene using hand sanitizer. Nurse #2 then wiped down the blood pressure cuff and stethoscope using Oxivir (broad spectrum disinfectant) wipes.</p> <p>During an interview on 1/29/25 at 8:48 A.M., with Surveyor #2, Nurse #2 said she had performed tracheostomy care and obtained vital signs for Resident #6. Nurse #2 pointed to a bin outside of Resident #6's room that was filled with gowns, as well as other personal protective equipment and said she should have worn a gown when she provided care for Resident #6. Nurse #2 said it was a mistake that she had not worn one.</p> <p>2) Review of the Unit Manager job description, signed by the Unit Manager and dated 05/14/24, indicated responsibilities of this position included the following:</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>37086</p> <p>Based on observations, records reviewed and interviews, for one of four nursing units (Unit #1), that specialized in the care and treatment of residents with a tracheostomy and/or ventilator, the facility failed to ensure it provided appropriate administrative oversight of Infection Control Practices when resident cases of Candida Auris (C. Auris- a type of yeast that can cause severe illness and spreads easily among patients in healthcare facilities, which can cause a range of infections from superficial (skin) infections to more severe, life-threatening infections, such as bloodstream infections) on Unit #1 continued to spread. Although Administration was aware of the on-going spread of this infection, the facility failed to ensure that resources available to the facility were used in an effort to prevent the spread of C. Auris and as a result the facility had a total of seven new cases of C. Auris between December 2024 and January 2025 on Unit #1, placing additional residents on the unit at risk for exposure and acquisition of C. Auris that could cause harm, including death.</p> <p>Findings include:</p> <p>Review of the Centers of Disease Control and Prevention (CDC) website, article titled Infection Control Guidance for Candida Auris, dated 04/24/24, indicated the following:</p> <p>-C. Auris typically affects patients with severe underlying medical conditions who may need invasive devices. These include lines and tubes, including central venous catheters, urinary catheters and tracheostomy (a surgical hole in the windpipe to aid in breathing) tubes. These devices can provide ways for C. Auris to enter the body.</p> <p>-The primary infection control measures for prevention of C. Auris transmission in healthcare settings are:</p> <p>*Hand hygiene</p> <p>*Setting-based precautions</p> <p>*Environmental disinfection with product effective against C. Auris</p> <p>-Ensuring that all healthcare personnel adhere to infection control recommendations is critical to preventing transmission of C. Auris, other Multiple Drug Resistant Organisms (MDRO), and communicable diseases. Consider taking the steps outlined below to enhance adherence:</p> <p>*Ensure that adequate supplies are available to implement and maintain appropriate infection control measures.</p> <p>*Monitor for adherence to appropriate infection control practices by performing audits.</p> <p>*Provide feedback on hand hygiene practices, donning (put on) and doffing (take off) of gowns and gloves, and environmental cleaning and disinfection.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>*Consider increasing the number of audits performed on units with C. Auris cases.</p> <p>Review of the Massachusetts Department of Public Health's Infection Prevention and Control Resource Hub website indicated the Massachusetts Department of Public Health (MDPH) partnered with the Centers for Disease Control and Prevention (CDC) to offer healthcare facilities in Massachusetts onsite infection prevention and control assessments. An Infection Control Assessment and Response (ICAR) visit consists of an on-site, collaborative, non-regulatory visit from a Public Health Nurse and an Epidemiologist to assess and strengthen current infection prevention and control practices in Massachusetts Health Care Facilities, may be needed when a facility is experiencing an outbreak or after an infection control breach has been identified.</p> <p>During the entrance interview on 01/29/25 at 7:45 A.M., the Director of Nurses said that the residents who resided on Unit #1 had tracheostomies and/or were ventilator dependent (relied on a machine for breathing).</p> <p>Review of the Facility's Line List (a tracking tool used for infectious diseases) for C. Auris indicated there were a total of 10 cases identified in 2024, including three new cases in December 2024 and an additional four new cases were identified in January 2025, all of which occurred on Unit #1.</p> <p>Throughout the survey, the surveyors observed breaches of infection control practices by the staff on Unit 1, including inadequate hand hygiene, lack of and/or improper use of Personal Protective Equipment (PPE), and use of cleaning supplies that were not approved to treat C. Auris.</p> <p>-On 01/29/25 at 8:35 A.M., Surveyor #2 observed Nurse #2 provide a tracheostomy dressing change for a resident on Unit #1, without wearing a gown as required.</p> <p>-On 01/29/25 at 9:15 A.M., Surveyor #1 observed the Respiratory (RT) perform tracheal suctioning for a resident on Unit #1, without wearing a gown as required.</p> <p>-On 01/29/25 at 1:20 P.M., Surveyor #2 observed the Activity Director enter and exit multiple resident rooms on Unit #1, without performing hand hygiene upon room entry and exit.</p> <p>-On 01/29/25 at 11:12 A.M., Surveyor #2 observed Housekeeper #1 using cleaning products in resident care areas on Unit #1 that were ineffective against C. Auris.</p> <p>During an interview on 01/29/25 at 2:35 P.M., the Infection Preventionist said she had provided staff with education on proper hand hygiene and use of PPE in December of 2024, but that she had not conducted any audits to ensure staff were adhering to proper infection control guidelines including hand hygiene and appropriate use of PPE.</p> <p>During an interview on 02/05/25 at 3:28 P.M. with Surveyor #1 and Surveyor #2, the Director of Nurses (DON) said that she was aware of the on-going transmission of C. Auris on Unit #1. The DON said the Facility had several ICAR visits, the most recent one was conducted at the facility in November 2024. The DON said the Facility had implemented some, but not all, of the recommendations generated by the ICAR. The DON said the Facility's Administration had talked about plans to address the on-going transmission of C. Auris. The DON was unable to provide the surveyors with any documentation to support evidence of a facility plan.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 02/05/25 at 1:33 P.M., the Medical Director said she was aware of the on-going transmission of C. Auris in the Facility and that she expected all staff to adhere to infection control practices including proper hand hygiene and wearing the appropriate PPE for all resident interactions. The Medical Director said she assumed the Facility had consulted with an Epidemiologist from the Department of Public Health (DPH) regarding the on-going transmission of C. Auris.</p> <p>During an interview on 02/05/25 at 2:47 P.M., with Surveyor #1 and Surveyor #2, the Administrator said he was aware of the on-going transmission of C. Auris on Unit 1 and that it had his attention. The Administrator said they were still in the talking phase of how best to mitigate the spread of the infection. The Administrator said that he had not done anything directly, related to the management of C. Auris.</p>		

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<p>F 0865</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>37086</p> <p>Based on records reviewed, policy reviews and interviews, the Facility which had a known area of concern related to the continued spread of Candida Auris (C. Auris, a type of yeast that can cause severe illness and spreads easily among patients in healthcare facilities, which can cause a range of infections from superficial (skin) infections to more severe, life-threatening infections) an infectious disease on Unit #1, which specializes in care and treatment of residents' requiring a tracheostomy and/or ventilator to breathe, with new cases of the infection identified in December 2024 and several more new cases identified in January 2025, the Facility failed to ensure they developed, implemented and maintained a Quality Assurance and Performance Improvement (QAPI) program that was comprehensive, ensured the residents' received care in accordance with their Infection Control Program, and was focused on quality of care for residents in the facility.</p> <p>Findings include:</p> <p>Review of the Facility's QAPI Policy, dated 12/06/21, indicated the following:</p> <p>-Purpose: To provide a means of continuous assessment of care and services provided, and to identify and investigate areas that could be improved through a multi-disciplinary approach.</p> <p>-Policy: QAPI encompasses all administrative, managerial, clinical, and environmental services as well as external providers and suppliers of care and services. QAPI is a comprehensive program by which the facility identifies problems or issues early on, develops a plan to address the root causes of the problems and prevent adverse events throughout the system while involving the entire team in using the data to understand and work to improve performance.</p> <p>-Procedure: The facility will incorporate the following five elements of a QAPI plan:</p> <p>*Design and Scope: Ongoing and comprehensive, all services offered, all departments.</p> <p>*Governance and Leadership: Led by Administration, input from staff, residents, families.</p> <p>*Feedback, Data Systems, and Monitoring: Systems to monitor care and services, draws data from multiple sources.</p> <p>*Systematic Analysis and Systematic Action: Determine when in-depth analysis is needed and understand the problem, causes, implications of change.</p> <p>Review of the Facility's Line List (a tracking tool used for infectious diseases) for Candida Auris, [which included documentation that the facility had cases of C. Auris as far back as 2021] indicated there were a total of 10 cases in 2024, including three new cases in December 2024 and an additional four new cases in January 2025.</p> <p>Review of the QAPI Meeting Minutes, dated 12/27/24, indicated there was no documentation to support that newly identified cases and on-going spread of C. Auris was identified or investigated.</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the QAPI Meeting Minutes, dated 01/15/25, indicated that C. Auris management and planning was on-going.</p> <p>The Facility was unable to provide the surveyors with documentation to support that a QAPI project had been developed and maintained, related to the continual spread of C. Auris.</p> <p>During an interview on 02/05/25 at 3:28 P.M., the Director of Nurses (DON) said between December 2024 and January 2025, facility administration had talked about what they could do to address and prevent the spread of C. Auris. The DON said they had no documentation to support that audits had been carried out to ensure staff were performing hand hygiene or using Personal Protective Equipment appropriately, (both of which can help minimize or stop the spread of infection). The DON said they had not developed a QAPI project, initiated a Root Cause Analysis, or documented any data to analyze, related to the ongoing spread of C. Auris.</p> <p>During an interview on 02/05/25 at 10:42 A.M., the Administrator said the QAPI committee had reviewed the on-going spread of C. Auris at the January 2025 QAPI meeting but they were still in the talking phase of how best to mitigate its spread. The Administrator said he was aware it was a problem in December 2024 because of the three new positive cases, with an additional four new cases in January 2025. The Administrator said he had not done anything directly related to the management of the on-going spread of C. Auris.</p>

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>37086</p> <p>Based on observations, interviews, and record reviews, for one of four nursing units (Unit #1) that specialized in the care and treatment of residents with a tracheostomy and/or ventilator, with an average daily census of 27 residents all of whom were on Enhanced Barrier Precautions (EBP) which required staff to use Personal Protective Equipment (PPE) during the provision of care, and had a known issue with the spread of Candida Auris (C. Auris, a type of yeast that can cause severe illness and spreads easily among patients in healthcare facilities, which can cause a range of infections from superficial (skin) infections to more severe, life-threatening infections, such as bloodstream infections), the Facility failed to ensure they implemented and maintained an infection control program that helped prevent the development and spread of infections, when staff 1) were observed not following infection control practices in accordance with posted Precaution Signs, 2) were observed not performing hand hygiene at appropriate intervals, 3) did not maintain respiratory equipment, and 4) were observed not using appropriate cleaning products in resident areas with confirmed C. Auris cases, all of which increased the potential for additional residents to be exposed and at risk for contracting C. Auris.</p> <p>Findings include:</p> <p>Review of the Facility's policy titled Candida Auris (C. Auris), dated April 2024, indicated the following:</p> <ul style="list-style-type: none"> -C. Auris is highly contagious in healthcare facilities and spreads easily in healthcare settings and can cause outbreaks. -C. Auris can colonize in patients for many months, persists on surfaces, and is not killed by some commonly used healthcare facility disinfectants. -Hand hygiene, appropriate precautions, and environmental disinfection prevent and control outbreaks. <p>-How it spreads:</p> <ul style="list-style-type: none"> *Person to person contact: C. Auris can spread through direct contact with an infected person. *Contaminated surfaces: C. Auris can survive on surfaces for weeks, including bedrails, doorknobs, and medical equipment. *Shared equipment: C. Auris can spread through sharing medical equipment that has not been disinfected. <p>-Recognizing that residents are at an increased risk of becoming colonized and developing infection, the facility will implement the use of Enhanced Barrier Precautions (EBP).</p> <p>-Enhanced Barrier Precautions targets the use of a gown and gloves during high contact care activities.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>-The Personal Protective Equipment (PPE) required when following Enhanced Barrier Precautions is a gown and gloves which are to be donned (applied) prior to the high contact care activity.</p> <p>-Hand hygiene is to be performed before donning PPE and after doffing (removing).</p> <p>-Examples of high contact care include (but not limited to): Device care or use, tracheostomy/ventilator.</p> <p>Review of the Facility's Policy, titled Hand Hygiene, dated 5/28/21, indicated the following:</p> <p>-It is the policy of the facility that staff will perform hand hygiene as a means of cleaning hands by either soap and water (hand washing), or antiseptic hand rub (alcohol based hand rub-ABHR), to decrease the risk of transmission of infection.</p> <p>-Gloves are not a substitute for hand hygiene.</p> <p>-If your task involves gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment.</p> <p>-Perform hand hygiene before donning gloves and immediately after doffing.</p> <p>-Always perform hand hygiene when moving from the care of one resident to the care of another.</p> <p>Review of the Enhanced Barrier Precaution sign, undated, indicated:</p> <p>-Everyone Must: Clean their hands including before and when leaving the room.</p> <p>-Providers and Staff Must Also: Wear a gown and gloves for the following High-Contact Resident Care Activities:</p> <ul style="list-style-type: none"> *Dressing *Bathing/showering *Transferring *Changing Linens *Providing Hygiene *Changing briefs or assisting with toileting *Device Care of Use: central line, urinary catheter, feeding tube, tracheostomy and *Wound Care: any skin opening requiring a dressing <p>During the initial tour of Unit #1 on 01/29/25 at 8:20 A.M., the surveyors observed that there were Enhanced Barrier Precautions signs on the doorways of every resident's room.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Bear Mountain at Worcester		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Acton Street Worcester, MA 01604	
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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>1A. Resident #3 was admitted to the Facility in December 2024, diagnoses included acute respiratory failure with hypoxia (low oxygen level), pneumonia, tracheostomy (surgical opening in the windpipe to aid in breathing and sepsis (life threatening response to infection).</p> <p>Review of Resident 3's medical record indicated that he/she had tested positive for Candida Auris (C. Auris) on 12/11/24.</p> <p>Review of Resident #3's Physician Orders dated 1/29/25 indicated he/she required:</p> <ul style="list-style-type: none"> -Enhanced Barrier Precautions -Trach (tracheostomy) care every shift and prn (as needed), -Suction (a procedure to remove secretions from the respiratory tract) every shift and prn, -Administer Ipratropium-Albuterol Inhalation Solution (a medication to make breathing easier) 0.5-2.5 3 milligrams (mg)/3 milliliters (ml) - 3 ml via trach four times daily. <p>On 1/29/25 at 8:55 A.M., Surveyor #2 observed an Enhanced Barrier Precaution sign posted at the entrance doorway to Resident #3's room. Surveyor #2 further observed the Respiratory Therapist (RT) don (put on) gloves and enter Resident #3's room, and without donning/wearing a gown, the RT proceeded to Resident #3's bedside and started tracheal suctioning. The RT continued to suction Resident #3 for approximately three minutes. Resident #3 was observed to cough during the procedure. The RT finished the procedure, exited the room, removed his gloves and performed hand hygiene using hand sanitizer.</p> <p>During an interview on 1/29/25, at 9:30 A.M., the Respiratory Therapist said he knew that Resident #3 was on Enhanced Barrier Precautions and that he should have worn a gown to perform suctioning on Resident #3, but he had not. The RT said there was a risk of exposure to respiratory secretions, and said he forgot to put a gown on before the procedure.</p> <p>On 01/29/25 at 11:39 A.M., Surveyor #1 observed the Respiratory Therapist administer a nebulizer treatment to Resident #3.</p> <ul style="list-style-type: none"> -The RT performed hand hygiene prior to entering Resident #3's room, donned a gown and gloves, and entered Resident #3's room. The RT removed the nebulizer cup (holds medication) and the nebulizer tubing out of a bag which was on the side of a respiratory equipment treatment cart in the resident's room. The treatment cart held shared supplies for Resident #3 and his/her roommate. -The RT placed the medication into the nebulizer cup and attached the nebulizer to Resident #3's tracheostomy tubing for administration of the medicine. -The RT then reached for the Yankeaur suction tip, (a rigid plastic suction catheter used to remove secretions from the airway) which was stored in its original plastic sheath package, on top of the treatment cart. The RT suctioned Resident #3's mouth with the Yankeaur and placed it back in its package when he was done. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>-The RT removed his gloves, and without performing hand hygiene, put on a new pair of gloves and went back to Resident #3's bedside where he disconnected the nebulizer connector including the medication cup from the tracheostomy tubing, performed tracheal suctioning, then removed his gloves, and without performing hand hygiene put on a new pair of gloves.</p> <p>-The RT picked up the nebulizer medication cup and tubing and brought them into Resident #3's bathroom where he rinsed the medication cup with tap water, then placed the nebulizer medication cup back in the bag on the side of the treatment cart.</p> <p>-The RT removed his gloves, and without performing hand hygiene, put on new gloves, reached into the shared treatment supplies cart, touched several items, did not remove anything, removed his gloves, and without performing hand hygiene, put on a new pair of gloves.</p> <p>-The RT picked up the pulse oximeter (a small machine used to measure the amount of oxygen in blood) from Resident #3's bed and placed it on his/her bedside table. The RT removed his gown and gloves in Resident #3's room, exited the room and then performed hand hygiene.</p> <p>During an interview on 01/29/25 at 2:56 P.M. with Surveyor #1, the Respiratory Therapist said that he changed his gloves several times during Resident #3's nebulizer treatment and did not need to perform hand hygiene because he had remained with the same resident. The RT said he only needed to do hand hygiene between glove changes if he was working between two different residents.</p> <p>B. Resident #4 was admitted to the Facility in November 2024, diagnoses included indwelling urinary catheter, tracheostomy and dependence on respiratory ventilator.</p> <p>Review of Resident #4's Physician's orders, dated January 2025, indicated he/she required Enhanced Barrier Precautions.</p> <p>On 01/29/25 at 9:15 A.M., Surveyor #1 observed an Enhanced Barrier Precaution sign posted at the entrance doorway to Resident #4's room. Surveyor #1 observed the Respiratory Therapist (RT) enter Resident #4's room without performing hand hygiene, the RT then proceeded to Resident #4's bedside where he donned a pair of gloves, not a gown, and began tracheal suctioning. The RT finished Resident #4's tracheal suctioning, removed his gloves, exited Resident #4's room and performed hand hygiene using hand sanitizer.</p> <p>During an interview on 01/29/25 at 9:20 A.M., the Respiratory Therapist said he had been a full time Respiratory Therapist at the Facility for the last eight years. The RT said that when a resident was on Enhanced Barrier Precautions, he only needed to wear a mask and gloves to perform tracheal suctioning.</p> <p>C. Resident #6 was admitted to the Facility in October 2024, diagnoses include respiratory failure, anoxic brain damage, cerebral infarction and tracheostomy.</p> <p>Review of Resident #6's Physician Orders dated 1/29/25 indicated he/she required Enhanced Barrier Precautions and tracheostomy care as needed.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 1/29/25 at 8:35 A.M., Surveyor #2 observed an Enhanced Barrier Precaution sign posted at the doorway entrance of Resident #6's room. Surveyor #2 further observed Resident #6 lying in bed and Nurse #2 wearing gloves and a mask, but without a gown, as she leaned over Resident #6 to change the dressing around his/her tracheostomy. Nurse #2 removed the gauze dressing from Resident #6's tracheostomy site, wiped around the tracheostomy with another piece of gauze and applied a clean piece of gauze around the tracheostomy. Nurse #2 completed the dressing change, then placed a blood pressure cuff around Resident #6's arm to obtain his/her blood pressure and placed her stethoscope on Resident #6's chest. Nurse #2 exited Resident #6's room, removed her gloves and performed hand hygiene using hand sanitizer. Nurse #2 then wiped down the blood pressure cuff and stethoscope using Oxivir (broad spectrum disinfecting) wipes.</p> <p>During an interview on 1/29/25 at 8:48 A.M., with Surveyor #2, Nurse #2 said she had performed tracheostomy care and obtained vital signs for Resident #6. Nurse #2 pointed to a PPE bin outside of Resident #6's room that was filled with gowns and other personal protective equipment and said she should have worn a gown when she provided tracheostomy care for Resident #6. Nurse #2 said it was a mistake that she had not worn one.</p> <p>2. On 1/29/25 at 1:20 P.M., Surveyor #2 observed the following on Unit #1:</p> <ul style="list-style-type: none"> -The Activity Director entered a resident's room and failed to perform hand hygiene upon entry. -The Activity Director was in the room for approximately two minutes, exited the room, and failed to perform hand hygiene. -The Activity Director walked down the corridor and entered a second resident room and failed to perform hand hygiene upon entry. The Activity Director was in that room for approximately five minutes, exited the room and failed to perform hand hygiene. -The Activity Director entered a third resident room, failed to perform hand hygiene, stayed in the room for approximately five minutes and washed her hands in the sink in the room then exited the room. <p>During an interview on 1/29/25, at 1:33 P.M., the Activity Director said that she did not need to perform hand hygiene when entering and exiting resident rooms because she was not caring for the residents. The Activity Director said that she did not usually do hand hygiene when entering and exiting resident rooms. During the interview, the Activity Director then observed the Enhanced Barrier Precautions signs posted outside the resident rooms on the unit (Unit #1) and said that now she knew she needed to do hand hygiene when entering and exiting all resident rooms.</p> <p>During an interview on 01/29/25 at 3:40 P.M., with Surveyor #1 and Surveyor #2, the Unit Manager #1 said that all residents on her unit (Unit #1) required Enhanced Barrier Precautions. Unit Manager #1 said staff were not required to perform hand hygiene to enter and exit a resident room on the unit if they were not providing high-contact resident care. Unit Manager #1 said that when staff performed high-contact resident care activities they were supposed to wear a gown and gloves.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During interviews on 01/29/25 at 10:18 A.M. and 2:35 P.M., with Surveyor #1 and Surveyor #2, the Infection Preventionist (IP) said the staff were required to wear a gown and gloves when they performed any high-contact activities with residents who were on EBP. The IP said that she expected all staff, and anyone who entered the residents' rooms who were on EBP, to perform hand hygiene upon entering and exiting the residents' rooms.</p> <p>The Infection Preventionist said that although she was aware of the on-going transmission of C.Auris in the Facility (on Unit #1), said she was new to the role of IP and had not yet been able to do much work related to the on-going transmission of C. Auris.</p> <p>During an interview on 1/29/25, at 4:00 P.M. with Surveyor #1 and Surveyor #2, the Director of Nursing (DON) said that all residents residing on Unit #1 required Enhanced Barrier Precautions because they had indwelling medical devices or wounds. The DON said it was her expectation that any staff member entering residents' rooms would adhere to the posted Enhanced Barrier Precautions signage and said that the Respiratory Therapist should have worn a gown when suctioning a resident due to the increased risk of exposure to infections during high-contact resident care activities. The DON said that all staff should perform hand hygiene every time they change their gloves.</p> <p>3. Resident #5 was admitted to the Facility in September 2023, diagnoses included acute respiratory failure with hypoxia, tracheostomy and dependence on a ventilator.</p> <p>Review of Resident #5's Physician Orders for the month of January 2025 included the following:</p> <ul style="list-style-type: none"> -Change all canisters (used to hold the secretions from suctioning), tubing tracheostomy strap (to secure it in place), tracheostomy mask, oxygen tubing and Yankeaur, every week on Wednesday. -Vent settings, AC (ventilator delivers a set number of breaths) 500, rr (respiratory rate) 14, Peep (positive end-expiratory pressure- maintains a certain amount of pressure in the lungs at the end of expiration) +5, Oxygen (0-8) 3 liters every evening and night shift. <p>On 1/29/25, at 11:35 A.M., Surveyor #2 observed Resident #5 sitting in a chair near his/her bed. Resident #5's oxygen and tracheostomy tubing were in a bag attached to the bedside rail. One end of the oxygen tubing was attached to the oxygen concentrator and was labeled with a piece of tape, and was dated 12/23 [12/23/24]. One end of the tracheostomy tubing was attached to the ventilator and near the connection was dated 12/23 [12/23/24] with black marker.</p> <p>During an interview on 01/29/25, at 11:35 A.M., Resident #5 said he/she wore the oxygen and tracheostomy tubing only in the evening and overnight, not during the day. Resident #5 said that the nursing staff applied them both at 6:00 P.M. every evening.</p> <p>Review of Resident #5's Respiratory Flow Sheet documentation for the month of January 2025 indicated there was an order to; change all canisters, tubing trach strap, trach mask, oxygen tubing and Yankeaur every week on Wednesday, and that the flow sheet had been signed off by a Respiratory Therapist as having been completed on 01/01/25, 01/08/25, 01/15/25 and 01/22/25.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/29/25, at 2:56 P.M, the Respiratory Therapist (RT) said that the respiratory therapists changed the oxygen tubing once a week and the tracheostomy tubing monthly. The RT said that they wrote the date of the change right on the tubing. The RT said the date written on Resident #5's tubing [12/23] was the date that it had been changed.</p> <p>During an interview on 01/29/25, at 3:40 P.M., Unit Manager #1 said that the Respiratory Therapists change oxygen tubing weekly and label it with the date. Unit Manager #1 said the date [12/23] written on Resident #5's equipment was the date that it was last changed. Unit Manager #1 said that Resident #5 had an order to use oxygen and ventilator on the evening and overnight shifts, not during the day, Unit Manager #1 said that although Resident #5's Respiratory Flow Sheet indicated the equipment had been changed as ordered, said it had not been changed.</p> <p>4. The Facility was unable to provide the surveyors with a policy or process related to the cleaning and disinfecting of resident areas where C. Auris was present.</p> <p>During an observation on 1/29/25, at 11:12 A.M., Surveyor #2 observed the following on Unit #1:</p> <ul style="list-style-type: none"> -Housekeeper #1 cleaning a Resident's room who had an Enhanced Barrier Precaution sign posted on the door. -Housekeeper #1 wore gloves and removed two bags from two barrels in the resident's room that were filled with used Personal Protective Equipment and other waste. - Housekeeper #1 exited the resident's room with her gloves on and walked down the corridor to dispose of the bags in a utility room. -Housekeeper #1 then re-entered the resident's room and failed to remove her soiled gloves or perform hand hygiene. -Housekeeper #1 then removed a spray bottle containing a pink liquid solution (later identified as n-alkyl dimethyl benzyl ammonium chloride) from her cleaning cart and started spraying the solution on the surfaces of the resident's room including his/her over-the-bed table, windowsills and doorknobs. -Housekeeper #1 turned and saw Surveyor #2 observing the process. -Housekeeper #1 then placed the bottle of pink solution on the cleaning cart and removed the Oxivir cleanser. -Housekeeper #1 sprayed the same surfaces using Oxivir, then wiped all the surfaces using a rag. After wiping the surfaces, she mopped the floor using a floor cleaner from the bucket on the cart. -Housekeeper #1 mopped the entire floor, set up a wet floor sign, and left the room. -Housekeeper #1 then removed her gloves, did not perform hand hygiene, put on new gloves and walked down the hallway pushing the housekeeping cart. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>-Housekeeper #1 then entered another resident's room which also had an Enhanced Barrier Precaution sign posted on the door. Housekeeper #1 gathered her cleaning supplies and entered the resident's room wearing the same gloves.</p> <p>During an interview on 1/29/25 at 11:55 A.M. with Surveyor #2, Housekeeper #1 said she did not do hand hygiene after throwing the trash away or between resident rooms. Housekeeper #1 said she normally did, but said she forgot to that day. Housekeeper #1 showed Surveyor #2 the pink liquid solution she used to clean the surfaces of the resident's rooms on Unit #1, the bottle was labeled n-alkyl dimethyl benzyl ammonium chloride. Housekeeper #1 said she should not have used it on the surfaces because it was a deodorizer and not a cleaner.</p> <p>Housekeeper #1 said when she saw the Surveyor, she changed the cleaning product to Oxivir solution which she should have used to clean the residents' rooms. Housekeeper #1 said she used the yellow cleaner (bottle was labeled Quat 64 from Simoniz) stored in the Housekeeping Closet to clean the floors. Housekeeper #1 demonstrated that she fills the bucket on her cart with the solution and said she uses a new mop head for each room.</p> <p>Review of the Safety Data Sheet and Information Sheet for Quat 64 Lemon Liquid Disinfectant by Simoniz, undated, indicated a list of the pathogens including bacteria, viruses and Fungi that it is effective against. The Information Sheet did not indicate that Quat 64 was effective against Candida Auris.</p> <p>Review of the United States Environmental Protective Agency's list of Registered Antimicrobial Products Effective Against Candida Auris (List P), undated, did not include Quat 64 by Simoniz or n-alkyl dimethyl benzyl ammonium chloride.</p> <p>During an interview on 1/29/25 at 2:00 P.M., with Surveyor #2, the Housekeeping Director said that the residents' rooms were cleaned every day. The Housekeeping Director said the Housekeeping Staff should use Oxivir on the flat surfaces like tables, doorknobs and windowsills. The Housekeeping Director said that Housekeeper #1 should not have used the pink solution (n-alkyl dimethyl benzyl ammonium chloride), to clean the rooms because it was deodorizer which was used to remove foul odors. The Housekeeping Director said the facility recently started using Oxivir because it was effective against Candida Auris. The Housekeeping Director showed Surveyor #2 the system for cleaning the floors and said they were using Quat 64 to clean all floors, but added it was not effective against Candida Auris.</p> <p>During an interview on 1/29/25, at 4:10 P.M., the Administrator said he left the management of the Candida Auris outbreak to the Director of Nursing (DON). The Administrator said he knew that the DON was in contact with an Epidemiologist at the Department of Public Health. The Administrator said he was not aware that the Quat 64 Disinfectant used to clean all the floors in the facility was not effective against Candida Auris. The Administrator asked if it made a difference about what disinfectant was used on the floors and said he would talk with the Housekeeping Director about it.</p> <p>During an interview on 02/05/25 at 1:33 P.M., the Medical Director said she was aware of the on-going transmission of C. Auris in the Facility and that she expected all staff to adhere to infection control practices including proper hand hygiene and wearing the appropriate PPE for all resident interactions.</p>		