| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 235139 | A. Building<br>B. Wing | 05/15/2025 |

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| Avista Nursing and Rehab | 2901 Galaxy Dr<br>Saginaw, MI 48601 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059<br><br>Based on observation, interview and record review, the facility failed to assess, monitor and document wound care timely for two residents (Resident #46, Resident #337) of three residents reviewed for wound care, resulting in missed treatments with the likelihood of worsening wounds.<br><br>Findings include:<br><br>Resident #337:<br><br>On 5/13/25, at 9:30 AM, Resident #337 was in their room. They had an occlusive dressing over their left elbow that was dated 5-8. CNA S entered the room and was asked what date they read on the elbow dressing and CNA S stated, it says 5/8.<br><br>On 5/13/25, at 11:35 AM, a record review of Resident #337 electronic medical record revealed an admission on 5/8/25 with diagnoses that included Aphasia, Hypertension and Stroke. Resident #337 required assistance with Activities of Daily Living.<br><br>A review of Treatment Administration Record 5/1/2025 - 5/31/2025 revealed cleanse left antecubital skin tear with wound cleanser pat dry apply nonstick dressing wrap with kerlix daily and prn until healed one time a day for skin tears -Start Date-05/09/2025 1100 -D/C Date- 05/13/2025 1215. For the days of Fri 9 Sat 10 Sun 11 there was nurse initials with check marks which revealed the treatments were completed.<br><br>On 5/14/25, at 11:56 AM, Nurse D was interviewed regarding Resident #337's left elbow skin tear and treatment. Nurse D was asked if they removed the old dressing and Nurse D offered, yes. Nurse D was asked if they saw the date of 5/8 on the old dressing and Nurse D shook their head yes but did not answer the question.<br><br>On 5/14/25, at 12:46 PM, an observation of Resident #337's left elbow along with Nurse D was conducted. There were two small skin tears.<br><br>On 5/15/25, at 9:47 AM, the Director of Nursing was interviewed regarding Resident #337 treatment record. The DON was asked why the nurses signed out that they completed the treatment when in fact the old dressing remained and the DON stated, the nurses that signed out the treatment were not the nurses that were doing the treatments for those days. The nurses were educated not to sign treatment records if they are not the nurse who completed the treatments.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 38471<br><br>Resident #46:<br><br>On 5/13/2025 at 12:15, Resident #46 was observed watching television in bed. He provided permission to look at the wound dressing on his right foot (enclosed in soft heel boot), the dressing which was dated 5/11/2025. Nurse Manager N was asked if his treatment was a daily order and after review of his physician orders, she stated it was. Manager N was asked to observe his right foot dressing and upon return she stated it was dated 5/11/25. The manager expressed understanding but offered only one treatment had possibly been missed not two. Manager N stated she would contact the nurse and follow up.<br><br>On 5/13/2025 at approximately 12:45 PM, a review was conducted of Resident #46 medical records, and it indicated the resident readmitted to the facility on [DATE] with diagnoses that included, Sepsis, Diabetes, Atrial Fibrillation, Guillain-Barre Syndrome, Bell's Palsy and Borderline Personality Disorder. Further review of Resident #46's records yielded the following:<br><br>Physician Orders:<br><br>Cleanse right food vascular area with wound cleanser, apply Santyl over wound bed, cover with an abd and secure with kerlix daily and prn.<br><br>On 5/13/2025 at 1:45 PM, Nurse N stated after speaking with the nurse she believed the dressing was dated incorrectly as the nurse thought yesterday was the 5/11/25. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927<br><br>Based on observation, interview and record review, the facility failed to 1) Implement one resident's (Resident #17) preventive pressure ulcer measure (air mattress), and 2) Prevent an erosion to the penis area for one resident (Resident #74) of 4 residents reviewed for pressure ulcers, resulting in the potential for pressure ulcer development, increased discomfort and pain with hospitalization .<br><br>Findings include:<br><br>Resident #74:<br><br>During an observation and interview on 05/15/25 at 09:11 AM, Licensed Practical Nurse (LPN) B went to Resident #74's room with the state surveyor for a penal erosion observation and measurements. In catheter observations the Resident #74 had on a regular catheter bag today left over from last night. Urinary catheter with secure device noted to be taunt from penis head to left thigh. Resident #74 had the large overnight catheter bag run down the left leg and it crossed to the right pant leg at the bottom of the pants. LPN B walked into the room and applied gown and gloves; no hand sanitizer was used. Resident #74 pulled down his pants and sat at the edge of the bed. LPN B held the penis to observe the penis head with left sided erosion noted to penis. The state surveyor observed left side penal erosion with measurement of 3 cm to 3.5 cm in length from the penis tip downward. LPN B then grabbed the leg bag container and opened the kit and attempted to pull the large overnight catheter bag from the urinary catheter, but the tubing stuck. LPN B asked the surveyor to get someone to help her separate the catheter bag from the catheter.<br><br>In an observation on 05/15/25 09:25 AM, LPN B attempted to change the catheter bag over to a leg bag. LPN B had artificial nails estimated to be 3/4 to 1 inch in length with jewelry attachments noted on the fingernails.<br><br>In an interview on 05/15/25 at 09:39 AM with Resident #74 stated that it does hurt the penis sore. also, the leg bag will get full and it gets heavy slides down my leg and pulls the tubing.<br><br>A record review of the National Institute of Health (NIH) website revealed the following:, https://pmc.ncbi.nlm.nih.gov/articles/PMC10891379 Catheter-Associate Meatal pressure injuries ([NAME]) . Mucosal membrane pressure injuries refer to injuries caused by prolonged pressure and shear forces on the moist membranes that line the respiratory, gastrointestinal, and genitourinary tracts and are typically iatrogenic-caused by medical devices (7). [NAME] occur when an ICD (Indwelling catheter) erodes the urethra and surrounding soft tissue, leading to complete cleavage of the penis in the most severe cases. This therefore represents significant morbidity and loss of quality of life.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A phone interview and record review was conducted via computer on 05/15/25 at 10:02 AM with Registered Nurse/Wound care RN A about Resident #74 penal erosion- it is in-house acquired. He does a lot of his own care, but yes, it was in-house acquired. The treatment is Bacitracin ointment. The treatment is limited to what we can do. We did a urology referral; they looked at it and took the urinary catheter out and he had issues with being able to urinate and the catheter had to be put back in. The facility inquired about a supra pubic catheter. When Resident #74 was first admitted he did have a large gauge catheter tubing upon admission. We recommend continuing with urology. The surveyor had the wound care nurse review the wound photos and measurements for the penal erosion in the electronic medical record. Wound nurse A stated that Measurement is difficult. The photograph only measures the skin that it picks up as reddened and it does not pick up the full tear from the penis tip to the tear opening on the penis. I use an IPAD and have to hold the penis/wound in position and still take quality photos.<br><br>In an interview on 05/15/25 at 11:33 AM, the Director of Nursing (DON) acknowledged that Resident #74's penal erosion came from the urinary catheter and was facility acquired. The DON stated that Resident #74 messes with his catheter. The erosion/tear was caused by the catheter, and we are treating it. He is seen by wound care nurse A, and the facility made a urology referral. But so far, we are just watching and treating the penal erosion/tear.<br><br>22347<br><br>Resident #17:<br><br>Review of the Face Sheet, care plans dated 11/24, and orders dated 2/23/25 through 5/14/25, revealed Resident #17 was [AGE] years old, admitted to the facility on [DATE], alert with a Guardian in place, and dependent on staff for Activities of Daily Living (ADL). The residents' diagnoses included diabetes, opioid dependence, depression, post-traumatic stress disorder, chronic pain, stroke with hemiplegia and hemiparesis, and muscle weakness. The resident used a ecteronic lift for transfers.<br><br>During observations made on 5/13/25 at 11:30 a.m., and on 5/14/25 at 10:38 a.m., the resident was in her bed and her air mattress was not plugged in, it was inflated, however it was not working (alternative air flow). Observation of the plug revealed a prong was completely bent and unable to be plugged in.<br><br>Review of the residents' facility Physician orders dated 2/23/25 through 5/13/25, revealed no documentation of any orders to check the air mattress for functionality and to be sure it was set on alternative pressure. Review of the Physician orders dated 5/14/25, stated Adaptive Device: low air mattress check that settings are on and static is off and weight to be 250 DEN, every day, every shift. Nurse Manager N had put in an order for staff to check functionality and settings of the mattress every shift after this surveyor brought it to her attention there was no order to check the air mattress and the residents' air mattress was not functional (per observation done on 5/13/25).<br><br>During an interview on 5/14/25 at 10:40 a.m., Nurse, LPN G looked at the plug with the bent prong and stated, I am not sure why the mattress is not on. Nurse G reviewed the resident's MAR (medication administration record) and TAR (treatment administration record), and neither had documentation of confirming the air mattress was on. The nurse was unable to locate where nursing was to document they checked the resident's air mattress to make sure it was on.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/14/25 at 11:00 a.m., Director of Maintenance O observed the bent prong, he fixed the prong and plugged the air mattress in. Director of Maintenance O stated on 5/14/25 at 11:05 a.m., I usually leave it (air mattress) on static, and it cycles. Per the guidelines for use of this air mattress, it is not put on static for this mattress to use alternative pressure.<br><br>During an interview done on 5/14/25 at 11:18 a.m., Nurse Manager, RN N stated it's on the Kardex, I can't find where it is documented that it was checked by nursing to ensure it's on alternative pressure. It needs to be on alternative pressure; it needs to be put on the tasks list. Nurse Manager N said she was putting instructions to check the residents' air mattress every shift on the residents' tasks so staff documented checking it.<br><br>Review of the resident's Kardex revealed that prior to 5/14/25, instructions to check the air mattress were not on it. Review of the residents' Kardex dated 5/14/25, stated Low air loss mattress; check setting are set to alternative pressure and is functioning properly. The residents' air mattress was not to be put on static function.<br><br>During an interview on 5/14/25 at 11:37 a.m., Nursing Assistant/CNA P stated We are all supposed to look at it (air mattress), we don't document it. Yes, I did look at it earlier today (the resident's air mattress that was not turned on). |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471<br><br>Based on observation, interview and record review the facility failed to ensure one resident's (Resident #24) trapeze (bed mobility device) was within reach out of five residents reviewed for assistive devices.<br><br>Findings Include:<br><br>Resident #24:<br><br>On 5/13/2025 at approximately 2:20 PM, Resident #24 was laying in bed and her trapeze was not hanging in a place that was accessible to her as it was flipped over the stabilization bar its connected too. Resident #24 was asked if she was able to reach the trapeze and she stated she was unable to and attempted to reach for it but was unable to access it.<br><br>On 5/14/2025 at 10:55 AM, Resident #24 was observed sleeping peacefully in bed. Her trapeze was not accessible to the resident as it was flipped over the bar.<br><br>On 5/14/2025 at approximately 11:30 AM, a review was conducted of Resident#24's records and it revealed she admitted to the facility on [DATE] with diagnoses the included, Diabetes, Dementia, Atrial Fibrillation and Hypertension. Further review yielded the following:<br><br>Care Plan<br><br>I prefer a trapeze for bed mobility. Initiated on 8/15/2023<br><br>On 5/14/2025 at 3:27 PM, Resident #24 was observed with the DON (Director of Nursing) sleeping. Her trapeze was still not accessible to her. The DON reported she is not certain if staff flipped it up when they were providing care and did not place it back down. The DON stated she would follow up regarding the concern.<br><br>On 5/14/2025 at 4:05 PM, Nurse Manager N reported Resident #24 does utilize the trapeze for mobility in bed and she was assessed as being safe to utilize the trapeze. She expressed understanding with concern.<br><br>On 5/15/2025 at 8:50 AM, Therapy Director R reported she spoke with the resident yesterday who stated she recently stopped using the trapeze. Resident #24 was asked if they could remove it and she agreed with it. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347<br><br>Based on observation, interview and record review, the facility failed to ensure that one resident (Resident #25) of 2 residents observed had their dry nebulizer mask stored in a storage bag when not in use, resulting in the potential for cross contamination with respiratory infection, and increased antibiotic usage.<br><br>Findings Include:<br><br>Resident #25:<br><br>Review of the Face Sheet, care plans dated 2/25 through 4/25, orders and electronic medication admission record/EMAR dated 4/25 and 5/25, revealed Resident #25 was [AGE] years old, admitted to the facility on [DATE], alert with a Guardian in place, and required staff assistance with all Activities of Daily Living. The residents' diagnosis included, chronic heart and lung disease, Alzheimer's Disease, weakness, acute on chronic respiratory failure with hypoxia, Myocardial Infarction, Anxiety Disorder, Adjustment Disorder, Depression, and cerebral aneurysm.<br><br>Review of the residents' Physician orders dated 2/25, stated Albuterol Sulfate Inhalation Nebulization Solution 0.083% 3 ml inhale orally via nebulizer four times a day for COPD (chronic heart and lung disease).<br><br>Review of the facility Nebulizer Process policy dated 1/25, stated Once completely dried (nebulizer mask), place in storage bag.<br><br>Observation was made on 5/13/25 at 9:21 a.m., of the residents' nebulizer mask attached to oxygen tubing sitting on top of a plastic bag next to the nebulizer treatment machine. The mask was completely dry and not found in a storage bag.<br><br>During an interview done on 5/13/25 at 9:21 a.m., Resident #25 stated I got my last treatment about 2 hours ago.<br><br>Review of the residents' EMAR dated 5/13/25, revealed she had received her last breathing treatment at 0600 (6 a.m.). The mask had ample time to dry and be put in a storage bag.<br><br>During a second observation made on 5/14/25 at 12:18 p.m., the residents' nebulizer mask attached to oxygen tubing was found sitting inside the closed top drawer of her nightstand next to the top of her bed. The oxygen tubing was hanging out of the drawer.<br><br>During an interview done on 5/14/25 at 12:20 a.m., Clinical Nurse Manager, RN J stated They (nebulizer treatment masks) should be in a bag |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>22927<br><br>Based on observation, interview and record review, the facility failed to store and discard medications for 4 of 4 medication carts reviewed, resulting in a lack of dating of multi-dose medications, opened and undated medications, and the potential for residents to receive medications with altered efficiency.<br><br>Findings include:<br><br>Record review of the facility 'Storage of Medications' policy dated 8/2024, revealed medications and biological's are stored safely, securely, and properly, following manufacture's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Section III: Expiration dating- 3. Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmic . blood sugar testing solutions and strips require an expiration date shorter than the manufacture's expiration date once opened to ensure medication purity and potency.<br><br>Observation and interview on 05/13/25 at 09:22 AM with Registered Nurse (RN) D of the 300-unit medication cart revealed:<br><br>Resident #59- Ventolin HFA 90mcq/ACT multi-dose inhaler. RN D stated that the resident no longer resided at the facility, but the medications were still in cart although not a resident.<br><br>Resident #76- Albuterol HFA 90mcq/ACT multi-dose inhaler with no open date. RN D stated that the resident no longer resided at the facility, but the medications were still in cart although not a resident.<br><br>Resident #80- Novolin Flex pen opened with on open date or expiration date noted. RN D stated that Insulin pens have a shorter use life of 28 days.<br><br>Accu check 50 stick container opened and not dated.<br><br>2 white loose tablets in the second drawer of the med cart.<br><br>Observation and interview on 05/13/25 at 09:33 AM with licensed Practical Nurse (LPN) B of the 200-unit medication cart revealed:<br><br>Resident #57- latanoprost 0.005% Ophthalmic drops multi-dose bottle were opened and not dated with open date or expiration date.<br><br>Accu check 50 strips container opened with no opening date.<br><br>Resident #51- fluticasone 50mcq multi-dose bottle nasal spray opened with no date.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #6- fluticasone 50mcq multi-dose bottle nasal spray open dated 5/12/2025 no expiration date. Resident #6 also had Lantus Solostar multi-dose insulin pen with no open date on the insulin pen.<br><br>loose white tablet located in the third drawer of medication cart.<br><br>Resident #9- Albuterol sulfate multi-dose inhaler with no open dated noted.<br><br>Resident #8- Lantus insulin multi-dose insulin pen- no open date noted on pen or expiration date. LPN B acknowledged that insulin pens do have a shortened expiration date once opened.<br><br>Observation and interview on 05/13/25 at 10:21 AM with Licensed Practical Nurse (LPN) E of the 1A hall medication cart revealed:<br><br>Three loose tablets in the second drawer of the medication cart: one oval yellow, one round tan and one round pink tablet.<br><br>Resident #41 - Brimonidine 0.2% ophthalmic multi-dose eye drops with no open date on bottle one or the box. Dorzol/timolol 22.3mg/6.8 ophthalmic multi-dose eye drops with no open date noted.<br><br>Resident #1 - Tresiba FlexTouch multi-dose pen with open date or expiration date. (Only good for 8 weeks after opening)<br><br>Resident #22- fluticasone 50mcq multi-dose nasal spray opened with no dates. Acular 0.5% ophthalmic multi-dose eye drops container was opened with no date.<br><br>Resident #25- Combivent Respimat 20/100 mcg/ACT multi-dose inhaler opened and used with no open date on device or box, pharmacy label noted to discard after 3 months. Oxymetazoline 0.05% multi-dose nasal spray opened with no open date or expiration date noted.<br><br>Resident #5- Combigan 0.2-0.5% ophthalmic solution (Brimonidine Tartrate-Timolol) multi-dose eye drops opened with no open date or expiration date.<br><br>discharged resident that no longer resided within the facility- Breztri aerosphere multi-dose inhaler opened and used with no open dates, left in the medication cart after resident discharged .<br><br>Resident #69- ipratropium bromide solution 0.03% multi-dose nasal spray opened and used with no open date or expiration date noted on container.<br><br>Resident #44- Abilify (aripiprazole) liquid 1mg/ml antipsychotic medication multi-dose bottle opened and not dated with open date. LPN E stated that she was not sure if dates needed to be added to the containers, or what the policy was.<br><br>Observation and interview on 05/13/25 at 10:45ish AM with Licensed Practical Nurse (LPN) F of the 1B hall (front of hall) medication cart revealed:<br><br>Accu checks sticks opened and not dated 6 left in bottle.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #7- Advair HFA 115-21 mcg/ACT aerosol multi-dose inhaler opened and used with no date, also Fluticasone propionates 50 mcg/ACT multi-dose nasal spray open and used with no open date on bottle or box.<br><br>Resident #52- ipratropium-albuterol solution 0.5-2.5 (3) mg/ml nebulizer ampules/vials foil packet opened with no date on foil packet or box.<br><br>Resident #17- Lantus insulin 10ml multi-dose bottle opened with vial top off with no open date, also, Fluticasone propionates 50mcq/ACT multi-dose nasal opened/used and not dated.<br><br>Resident #54- Fluticasone propionates 50mcq/ACT multi-dose nasal opened/used and not dated.<br><br>Resident #30- Fluticasone propionates 50mcq/ACT multi-dose nasal opened and not dated.<br><br>one loose table peach colored in bottom drawer of cart with punch card medications.<br><br>Record review of the facility 'Medication Administration' policy dated 1/2025 revealed implementation #12.) The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. |

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|---|---|---|---|
| | 235139 | A. Building<br>B. Wing | 05/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avista Nursing and Rehab | 2901 Galaxy Dr<br>Saginaw, MI 48601 |

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|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>38471<br><br>Based on observation, interview and record review the facility failed to 1). Maintain food service equipment (steam table lids, food trays, plate warmers and refrigerator, 2) Ensure kitchen cookware was sanitary and dry; and 3). Maintain the walk- in freezer to be free of ice/snow buildup, resulting in an increased potential for cross-contamination and foodborne illness for all residents who consume meals from the kitchen.<br><br>Findings include:<br><br>On 5/13/2025 at approximately 10:00 AM, a kitchen tour was completed in the presence of Dietary Manager Q and the following was observed:<br><br>Refrigerator:<br><br>- At the bottom corner of right door, the seal was observed to be ripped/flapping.<br><br>- There were crumbled food particles in the bottom right-side corner of the door.<br><br>- The outside bottom of the refrigerator had streaks/smears and Manager Q explained when they attempted to wipe it off it would not come off. A dampened towel was requested and upon wiping the soiled area the streak marks were easily removed.<br><br>Trays/Plate Warmer:<br><br>- Seven trays (located next to the juice machine) were jagged on the edge. Manager Q stated the trays were utilized to serve residents meals on.<br><br>- Four- clean and ready for use plate warmers were found to be dirty with dried food particles on them.<br><br>Steam Table:<br><br>-Five of the lids, had one or two bent corners and dried food particles atop them.<br><br>Garbage Can:<br><br>-The lid had white substance observed on the push door.<br><br>Clean and ready for use rack:<br><br>-Four small, stacked, metal pans all found wet inside.<br><br>-A bin of lids and seven of the metal coverings had dried food particles and/or unknown debris on them.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -One -long, stacked baking pan found wet inside<br><br>Back Kitchen Hallway:<br><br>-Three- tier trolley with resident eaten meal tray atop it and one foot pedal on the second tier. The trolley had a pink unknown substance on the outside of it. Manager Q stated upon residents completing their meal staff are supposed to place the trays on the metal rack, not on the trolleys.<br><br>Walk in Cooler:<br><br>-Cooler has trail of water leading into the freezer<br><br>Walk in Freezer:<br><br>-Door frame, top of ceiling, above fan and the inside of the door there is thick snow and ice buildup. The buildup hinders the door from being able to close properly.<br><br>- There is condensation with ice buildup on the plastic curtains leading into the freezer and the door frame.<br><br>-A delivery was occurring at the time of the tour and the top of the boxes had wet marks from the ceiling of the freezer dripping on the boxes.<br><br>-The floor in the freezer was visibly wet and tracking back into the walk-in cooler.<br><br>Manager Q stated she recently noticed the buildup of the ice/snow in the freezer.<br><br>On 5/13/2025 at approximately 1:15 PM, Maintenance Director M explained he was aware of the ice/snow build up in the walk-in freezer and its form the dietary staff not tightly closing the freezer door.<br><br>Review was completed of the facility policy entitled, Sanitization, dated October 2008. The policy stated, .All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions .Food preparation equipment and utensils that are manually washed will be allowed to air dry whenever practical . |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347<br><br>Based on observation, interview and record review, the facility failed to 1) Ensure that one resident's (Resident #38), who was on isolation precautions, room was free of soiled linen, 2) Ensure two residents (Residents #15, Resident #64) of 2 residents observed for wound care were free of cross-contamination, and 3) Ensure that kitchen staff wore hair nets properly (covering all hair) and that no artificial finger nails were allowed on kitchen staff while preparing foods, resulting in the potential for cross contamination, resident illness, and increased risk for infection during wound care.<br><br>Findings Include:<br><br>During the initial tour of the facility kitchen, Dietary Manager Q was had a hair net on, however on the right and left side of her face were long tendrils of hair that were not covered by the hair net. Dietary Manger Q also had long artificial nails at the time.<br><br>During an interview done on 5/13/25 at 10:00 a.m., Dietary Manager Q stated I just got my hair done; no we are not supposed to have fake nails.<br><br>During an interview done on 5/13/25 at 2:54 p.m., Infection Control Nurse, RN I stated she (Dietary Manager Q) should of had her hair in the hair net, and no artificial nails.<br><br>During an interview done on 5/14/25 at 2:35 PM, the Director of Nursing/DON stated The CDC recommends clean cut own nails<br><br>Review of the facility Preventing Forborne Illness-Employee Hygiene and Sanitary Practices policy dated 2001, stated Hair nets or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens.<br><br>22927<br><br>Resident #15:<br><br>Observation and interview on 05/13/25 at 08:54 AM with Licensed Practical Nurse (LPN) B of Resident #15's peg tube site at abdomen. LPN entered the resident's room and did not apply enhanced barrier precautions (gown, or gloves). LPN B proceeded to lift Resident #15's shirt as she was laying on the bed. LPN B and surveyor observation of peg tube site was a double lumen access peg tube. Resident #15 was observed with scratch marks on her belly, with no dressing in place. Licensed practical Nurse B had to lift Resident #15's left breast to get the tube out from under the breast.<br><br>Resident #64:<br><br>Observation and interview on 05/14/25 at 07:29 AM with Licensed Practical Nurse (LPN) B of resident #64's skin. LPN B Checked the physician orders, due to the wound nurse was in the previous day, looking for updated orders. LPN B gathered wound care supplies of<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | wound cleanser, alginate/Demarginate Ag, / gauze sponges/ Comfort foam border dressing. LPN B gathered a clean towel from the utility room and proceeded to Resident #64's room. upon entering Resident #64's room LPN B put on gown and gloves. Certified Nurse Assistant C and LPN B both proceeded to move the bed away from the wall and position Resident #64 on to her right side and lower the residents' pants, remove the brief, clean bowel material from the peri area and rectum. Observation of Resident #64's right hip dressing dated 5/12/2025. Observation on 05/14/25 at 07:41 AM with LPN B of Resident #64's Coccyx wound with heavy drainage observed and removed. Resident #64's sacral/buttock region is observed with 2 open areas. BM noted to bottom area; wash clothes used repeatedly to cleanse area. LPN then used a dressing package measure scale to measure the sacral wound at length 4.5cm x width 3.5cm open stage III to fingernail depth with under mining noted from 10 o'clock to 5 O'clock not measured. Serosanguinous bloody drainage noted as stage III pressure ulcer. Observation of a second smaller pressure wound measured at 3cm x 4cm stage III. LPN B applied wound cleanser spray, patted dry with gauze, (Did not change her gloves nor did the CNA after cleaning BM from buttock region). Nurse LPN B then open the package of Alginate treatment and ripped the alginate to size with gloves to fit wound bed area, packed the alginate into wound. Then nurse LPN B applied the foam boarder dressing to the wound. LPN B changed her gloves, but did not wash her hands or sanitize her hands, reapplied new gloves. LPN B then reached into her uniform pocket to obtain a black felt pen and dated the foam boarder dressing. Cross contamination during dressing change observation.<br><br>38471<br><br>Resident #38:<br><br>On 5/13/2025 at 2:40 PM, Resident #38 was observed resting in bed as he awaited EMS (Emergency Medical Services) to transport him to the hospital. He explained he was going to the hospital because his wounds were not healing, and he has refused to go to dialysis in four days. He is going to the hospital to get it together. He explained he understands the risks of refusing dialysis, but it is five days a week and he is lazy. As we chatted there was a heap of soiled linen to include sheets, pillow, blanket, fitted sheet and other items observed atop the recliner. The linen had multiple areas with dried red substances on it. Resident #38 was asked when his linen was changed, and he shared that it was from this morning when the staff cleaned him up. It can be noted Resident #38 is on contact precautions and upon doffing PPE (personal protection equipment), it was found there was no soap in the dispenser by the entrance to the resident's room.<br><br>Upon walking out of the room, Infection Control Nurse I was walking by. She was asked if Resident #38 was the only contact room on this unit and she reported it was. She was informed soap was not accessible in the dispenser in the residents room where staff would doff their PPE. Nurse I stated the soap should be stocked for staff/visitors to suitably wash their hands. Nurse I was also shown the pile of soiled linen atop of recliner and she agreed it should not be there.<br><br>On 5/13/2025 at approximately 3:45 PM, a review was conducted of Resident #38's medical record and it indicated he was admitted to the facility on [DATE] with diagnoses that included Diabetes, Foot drop, Alzheimer's disease, Peripheral Vascular Disease, Dementia, Anxiety Disorder, End Stage Renal Disease and Chronic Kidney Disease. Further review yielded the following:<br><br>Care Plan:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | I am at risk for MDRO infection r/t (related to): HDC skin .Contact precautions r/t possible C-Diff . initiated 5/1/2025 .<br><br>On 5/15/2025 at 1:35 PM, Infection Control Nurse I, stated the soap dispenser in Resident #38's room was full as it had recently been replaced. She explained the bag was not fully engaged with the mechanism to dispense the soap.<br><br>On 5/15/2025 at 1:40 PM, a review was conducted of Infection Control Worksheet, it showed Resident #38 was diagnosed with C. difficile, (is a bacterium that causes an infection of the colon) on 5/2/2025 and begin antibiotic therapy on 5/3/2025. |