| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235558 | A. Building<br>B. Wing | 03/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Menominee Health Services | 501 Second St, Box 246<br>Menominee, MI 49858 |

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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** 49310<br><br>Based on observation, interview, and record review, the facility failed to:<br><br>1. Accurately identify wounds as pressure injuries<br><br>2. Document accurately on wound types, and<br><br>3. Develop a care plan for pressure injuries,<br><br>for one Resident (#11) of one resident reviewed for pressure injuries.<br><br>Findings include:<br><br>All times are in Eastern Daylight Time (EDT) unless otherwise noted.<br><br>Resident #11 (R11)<br><br>R11 was admitted to the facility on [DATE] with a primary diagnosis of cerebral infarction (stroke). According to a quarterly Minimum Data Set (MDS) assessment dated [DATE], R11 was at-risk for developing pressure injuries but did not have pressure injuries. The MDS coded R11 as having diabetic foot ulcers.<br><br>On 3/10/25 at 3:45 PM, R11 was observed lying in bed with both heels lying directly on the mattress of the bed. A pair of pressure-reduction boots were observed laying in a chair in the room.<br><br>On 3/10/25 at 4:41 PM, and on 3/11/25 at 7:30 AM additional observations of R11 were made with both heels directly on the mattress and the pressure-reduction boots laying in a chair in the room .<br><br>A review of R11's Electronic Medical Record (EMR) revealed a physician's order for dressings to R11's right heel and the lateral plantar (bottom) portion of the right foot. There was no physician's order for pressure-reduction boots.<br><br>A care plan for pressure injuries was not present in R11's medical record.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An impaired skin integrity care plan was reviewed that read, in part: . [R11] has actual impairment to skin integrity, DM (diabetes mellitus)/non-pressure wounds to right heel and right lateral plantar area of foot . The care plan did not include pressure-reduction boots or directions indicating where and when pressure-reduction boots should be applied or removed.<br><br>On 3/10/25 at approximately 1:23 PM, Regional Nurse J said R11's wound assessments were in the EMR under the non-pressure assessments because R11's wounds were not pressure injuries. Regional Nurse J said R11's wounds were diabetic ulcers.<br><br>Review of the wound assessment form Non-Pressure Weekly Tracker dated 11/12/24 documented R11 developed a facility-acquired wound on the right heel on 11/9/24. The type of wound was documented as diabetic (neuropathic) ulcer. No documentation was found for the assessment of the wound when it was first identified on 11/9/24. Subsequent facility wound assessments of the right heel dated 11/26/24, 12/3/24, 12/10/24, 12/17/24, 12/24/24, 12/31/24, 1/7/25, 1/14/25, 1/21/25, 1/28/25, 2/4/25, 2/11/25, 2/18/25, 2/25/25, and 3/4/25 documented the wound on the right heel was a diabetic ulcer.<br><br>Further review of wound documentation indicated R11 developed a facility-acquired right plantar wound on 1/7/25. The type of wound was documented as diabetic (neuropathic) ulcer. Facility wound assessments on 1/14/25, 1/21/25, 1/28/25, 2/4/25, 2/11/25, 2/18/25, 2/25/25, and 3/4/25 documented the wound on the right plantar was a diabetic ulcer.<br><br>The EMR revealed R11 attended the wound clinic for the wounds on the right foot. Wound clinic documentation dated 12/5/24 documented in part .Pressure injury of right heel, stage 3 . Pressure injury of right foot, stage 3 .<br><br>Wound clinic reports for the wounds on R11's foot dated 1/16/25, 1/23/25, 1/30/25, 2/6/25, 2/13/25, 2/21/25, 2/27/25, and 3/6/25 documented the right foot wounds as: stage 3 pressure injuries (Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present).<br><br>Handwritten documentation by R11's attending physician was scanned into the EMR. Physician documentation dated 1/8/25 read, in part: . Draining wound right heel, plantar surface. Severe ulcers despite wound clinic .Stage III [3] heel, unstageable distal right lateral foot with ulceration .<br><br>The attending physician for R11 documented on 1/13/25, in part: . decubitus [pressure injury] right (illegible handwriting) and heel .<br><br>The Director of Nursing was unavailable during survey. The Administrator (NHA) said clinical questions were to be referred to RN J or RN C. The NHA said RN C was the wound nurse and Infection Preventionist.<br><br>RN C was interviewed on 3/11/25 at 10:04 AM. When asked about R11's wounds, RN C said R11 had non-pressure, diabetic wounds on the right heel and right lateral plantar surface of the right foot. RN C said R11 was expected to have both heels floated (pillows placed under the legs to lift the heels from the mattress) because he spilled coffee on his pressure-reduction boots over the weekend, so the boots were sent to the laundry. RN C said R11 went to the wound clinic and floor nurses were responsible for reviewing documentation from the wound clinic.<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 | Dressing changes were observed being completed by RN C on 3/11/25 at 11:22 AM. R11 had a stage 3 pressure injury on the right heel measuring approximately 0.5 centimeters (cm) long and 0.3 cm wide, and a stage 3 pressure injury on the lateral right plantar measuring approximately 0.7 cm long and 0.9 cm wide.<br><br>When asked how R11's wounds were determined to be non-pressure diabetic wounds, RN C answered R11 was diabetic and went to dialysis. When asked if the wounds appeared as diabetic wounds, RN responded, I don't know how to describe them. They're not very big.<br><br>Wound clinic documentation was reviewed with RN C on 3/11/25 at 11:40 AM. RN C admitted she had not read the wound clinic reports documenting the wounds as stage 3 pressure injuries and she had been erroneously documenting them weekly as diabetic wounds. RN C said R11's attending physician said the wounds were diabetic wounds. RN C was shown R11's attending physician's documentation of 1/8/25 and 1/13/25. RN C did not provide a comment regarding the documentation. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383<br><br>Based on observation, interview, and record review, the facility failed to provide the care and services to monitor and maintain acceptable parameters of nutritional status for two residents (R11 and R22) of three residents reviewed for nutritional concerns. This deficient practice resulted in the potential for fluid imbalance for R11 and unaddressed weight loss for R22. Findings include:<br><br>All times are recorded in Eastern Daylight Time (EDT) unless otherwise noted.<br><br>Resident #11 (R11)<br><br>R11 was admitted [DATE] with diagnoses including stroke, dementia, diabetes, and dependence on renal dialysis. The diet order for R11 included a specialized renal diet with consistent carbohydrates and a 1500 ml (milliliters or cc cubic centimeters) fluid restriction per day.<br><br>On 3/12/25 at 12:30 PM, the lunch meal tray for R11 was observed. The tray contained a 240 cc coffee and a 120 cc apple juice. The supper meal ticket was observed to have planned beverages including a 240 cc coffee and a 120 cc apple juice. The total fluids planned and served by the dietary department for each lunch equaled 360 cc and for each supper equaled 360 cc.<br><br>The facility did not have an individualized plan for the allotment of the 1500 cc fluid restriction for R11. There was no guidance by the physician, nursing personnel or Registered Dietitian on the division of the fluids between the dietary department (with meals) and the nursing department (for fluids with medication pass and at bedside). The facility presented a form titled Fluid Restriction Template which indicated a plan for any residents on a 1500 cc fluid restriction was to be divided as follows 300 cc AM nursing, 200 cc PM nursing, 60 cc NOC (at night), 360 cc with breakfast, 240 cc with lunch and supper. The observed tray card plan exceeded the Fluid Restriction Template serving 360 cc at lunch and supper rather than the planned 240 cc at lunch and supper.<br><br>A progress note was entered by Registered Dietitian (RD) K on 2/28/2025 at 9:22 AM included documentation of the fluid restriction but did not coordinate the amounts and times of the fluids to be given to R11. The progress note read, Nutrition/Dietary Note . RD Note . Continues with CCHO (consistent carbohydrate) Renal diet and 1500 cc FR (fluid restriction). Continues with phos (phosphorus) binder. Meal intakes avg (average) 50-100%. It was noted that resident ate meal in dining room on 2/27/25 with improved intakes noted. Continue to encourage resident to eat meals in dining room to optimize oral intakes/nutritional status. No new nutritional concerns/recommendations. Continue to monitor and follow up as needed.<br><br>The care plan for R11 reviewed 3/11/25 included a focus of, At risk for nutritional status change r/t (related to) diabetes, end stage renal disease - on dialysis, on diuretics, potential for weight changes, wound to right foot. The interventions included:<br><br>- Eating - independent<br><br>- Fluid restriction as ordered, 1500 ml/24 hours<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Offer large portions<br><br>- Offer protein rich snack BID (twice daily)<br><br>- Provide diet as ordered - CCHO Renal, regular texture, thin consistency.<br><br>- Record weight per facility protocol<br><br>- Review weights and notify RD, MD (physician), and responsible party of significant weight change<br><br>- See tray card for specific food preferences.<br><br>The Certified Nurse Aide (CNA) task list for amount of fluids taken was reviewed. On 2/10/25 and on 2/16/25 the fluid restriction was exceeded for R11 with 1920 cc fluids documented as given by the CNAs. These totals did not include the fluids given by the nurse with medications.<br><br>During a telephone interview on 3/11/25 at 2:07 PM, RD K: stated she had not divided the 1500 cc fluid restriction between the dietary and nursing departments. She was not aware of the amount of fluid R11 was receiving.<br><br>On 3/11/25 at 2:49 PM, Regional Registered Nurse (RN) J said there was a breakdown in the facility with this expectation. RN J added it was expected the facility nurse would coordinate with dietary and would designate the fluids between departments in the physician's fluid restriction orders. RN J said, We were certainly not doing the best documentation, and we will be focusing and working on this.<br><br>The policy Fluid Restriction dated as implemented 7/21/22 read, in part: .The food and nutrition services department and the nursing department will determine how much fluid will be provided at meals and medication passes.<br><br>Resident #22 (R22)<br><br>On 3/9/25 at 2:04 PM, R22 was observed in the dining room being fed lunch by his wife. His wife stated the resident could not always fed himself, so she assisted him. She said his (R22) hands do not always work.<br><br>On 3/10/25 at 9:15 AM, R22 was observed in the dining room being fed breakfast by staff.<br><br>The electronic medical record indicated the following recorded weights for R22:<br><br>- 11/2/24 - 216 pounds<br><br>- 11/4/24 216 pounds<br><br>- 12/1/24 - 215.5 pounds<br><br>- 12/5/24 - 215.5 pounds<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - 1/1/25 - 213 pounds<br><br>- 2/1/25 - 207 pounds<br><br>- 3/5/25 - 195.5 pounds<br><br>The Nutrition Assessment Note dated 2/20/25, noted a Current weight: 207.0 lb (pounds) . Gradual weight change present. Wt Hx (weight history) 1 mo (month) ago: 213# (pounds). There was no re-weight for the six pound weight loss from 1/2025 to 2/2025 or the 11.5 pound weight loss from 2/2025 to 3/2025.<br><br>The care plan for R22 included a focus of at risk for nutritional status change including weight changes. The goal for this focus was R22 will maintain weight. This care plan included interventions of:<br><br>- Record weight per facility protocol/MD orders and Review weights and<br><br>- Notify RD, MD, and responsible party of significant weight change.<br><br>During a telephone interview on 3/11/25 at 2:07 PM, RD K: stated there were At Risk resident meetings weekly on Wednesdays where weight loss was a part of the discussion. The RD confirmed they had written a nutrition progress note on 3/5/25 (the date of the last weight) but no recommendations to re-check the weight or any additional interventions had been made. RD K stated the expectation was weights were taken by the 7th of the month with re-weight taken if there was a five pound variance as soon as possible. RD K discussed the 12 pound weight loss recorded for R22 and stated they would not expect to wait six days to re-check the weight. RD K stated, I don't recall if we reviewed (R22) in the At Risk meeting. I notified them (the facility) on Saturday (3/8/25) for a reweigh. No follow up weight had been obtained.<br><br>The facility policy titled Weight Monitoring and dated as last Reviewed/Revised on 12/21/2022 did have a statement of Any weight change of five (5) pounds or more since the last weight assessment will be retaken for confirmation. However, there were no parameters of the timeframe for this assessment. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310<br><br>Based on observation, interview, and record review, the facility failed to update infection control policies annually and implement appropriate infection prevention and control practices for two Residents (R28 and R4) of six residents reviewed for infection control. Findings include:<br><br>All times are in Eastern Daylight Time (EDT) unless otherwise noted.<br><br>Resident #28 (R28) was admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R28 was free from infections and had no pulmonary conditions or diseases. The MDS documented R28 had received the seasonal influenza vaccination on 10/18/24.<br><br>According to a nurse's progress note in the Electronic Medical Record (EMR) dated 3/10/25 at 12:57 PM CT (Central Time), R28 experienced a cough with gray-colored sputum, chills, weakness, and decreased appetite. R28's physician ordered a Quad respiratory pathogen panel (a laboratory test for four respiratory pathogens). A nurse progress note on 3/10/25 at 2:36 PM CT documented R28 tested positive for influenza type A (a contagious viral respiratory infection that can lead to serious medical and health outcomes including death).<br><br>On 3/11/25 at 8:57 AM, R28 was observed in his room lying in bed. The door to the room was open and did not contain signage indicating R28 was in Transmission-Based Precautions (TBP - isolation) for a transmissible respiratory illness. R28 had a room mate who was occupying the other bed in the room.<br><br>The Administrator (NHA) was asked on 3/11/25 at 8:57 AM how staff and visitors were aware R28 had a contagious respiratory illness. The NHA said R28 should have a posting for isolation precautions on the door to the room. The NHA was informed the posting was not present. When asked if the facility posted signage at the entrance door to make visitors aware a contagious respiratory illness had been identified in the building and to instruct visitors on recommended infection control precautions while visiting, the NHA said they only post precautionary information at the entrance door when COVID-19 was identified in the facility.<br><br>The door to R28's room was observed open on 3/11/25 at 8:57 AM, 11:20 AM, 11:44 AM, 2:36 PM, and 4:26 PM.<br><br>Review of R28's EMR revealed no physician's order for droplet precautions (TBP for residents with known or suspected infectious pathogens transmitted by respiratory droplets). The physician ordered an antibiotic medication on 3/10/25 but there was no order for any antiviral medication. The antibiotic medication read, Give 1 tablet by mouth one time a day for influenza A .<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 - Few | On 3/11/25 at 9:36 AM, during an interview, Infection Preventionist (Registered Nurse (RN) C) said a posting should be placed at the entrance door to let visitors know a contagious respiratory illness was identified in the facility and masks were encouraged while visiting and to perform hand hygiene upon entering and exiting the facility. RN C said residents with influenza should be placed on droplet precautions. RN C confirmed signage should be posted on the door of R28's room indicating droplet precautions, a physician's order was required to put a resident in any type of TBP, and infections should be care planned. When asked why an antibiotic medication was ordered instead of an antiviral medication, RN C said she was not aware an antibiotic had been ordered but said she would contact R28's physician. RN C stated the door to the room of a resident on droplet precautions for influenza A should remain closed unless closing the door was contraindicated for a resident's safety according to the resident's care plan. RN C did not say R28 required the door to the room to be open for safety. RN C confirmed the roommate of R28 had not tested positive for any respiratory illness including influenza A. RN C acknowledged unoccupied rooms were available in the facility. When asked why R28 had not been provided one of the unoccupied rooms when influenza A was identified, RN C said that decision was not hers to make. RN C confirmed she had never seen that done in the facility and said, but it would be a best practice.<br><br>R28 did not have a care plan for influenza to direct staff on interventions to help prevent the spread of respiratory pathogens to other residents and staff. None of R28's care plans included a need to keep the door of the room open.<br><br>R28's physician was interviewed on 3/11/25 at 3:37 PM. The physician stated an antibiotic was ordered for R28 due to suspected presence of a secondary infection that was most-likely bacterial in nature. The physician confirmed antiviral therapy was not started after R28 was identified with influenza A.<br><br>Review of infection prevention and control policies disclosed the policies were not updated or reviewed annually. The policy Infection Outbreak Response and Investigation was dated as last reviewed/revised on 2/26/23. The policy COVID-19 Prevention, Response and Reporting was dated as last reviewed/revised on 5/18/23. The policy Antibiotic Stewardship Program was dated as last reviewed/revised on 11/18/22.<br><br>The Centers for Disease Control (CDC) guidelines Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities (www.cdc.gov/flu/hcp/infection-control/ltc-facility-guidance.html) state, in part: . once a single laboratory-confirmed case of influenza has been identified in a resident, it is likely there are other cases among exposed persons . Implement Droplet Precautions . Droplet Precautions include: Placing ill residents in a private room. If a private room is not available, place (cohort) residents suspected of having influenza with one another . All long-term care facility residents who have confirmed or suspected influenza should receive antiviral treatment immediately. Initiation of antiviral treatment should not wait for laboratory confirmation of influenza .<br><br>The policy Influenza Exposure Control dated as implemented 9/23/24 read, in part: .Droplet Precautions shall be implemented for residents with suspected or confirmed influenza . Request to limit visitation and exclude ill persons from visiting the facility via posted notices .<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 - Few | The policy Transmission-Based (Isolation) Precautions dated as reviewed/revised on 9/24/24 read, in part: . The facility will use standard approaches, as defined by the CDC, for transmission-based precautions .When implementing transmission-based precautions, the facility will consider the following: . b. The provision of a private room as available/appropriate; c. Cohorting residents with the same pathogen . Visitors coming to visit a resident who is on transmission-based precautions or quarantine, will be informed by the facility of the potential risk of visiting and precautions necessary when visiting the resident .Signage that includes instructions for use of specific PPE (Personal Protective Equipment) will be placed in a conspicuous location outside the resident's room, wing, or facility wide . Droplet Precautions: . b. A private room is preferential, but if not available, the resident can be cohorted with a resident with the same infectious agent .<br><br>35981<br><br>Resident #4 (R4)<br><br>Review of an Admission Record revealed R4 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: malnutrition.<br><br>Review of the MDS assessment for R4, with a reference date of 1/9/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15, indicating R4 was cognitively intact.<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 - Few | On 3/9/25 at 9:00 AM., during an observation, Registered Nurse (RN) A was setting up R4's medications to administer via G-Tube (gastrointestinal tube-for nutritional feeding and medications). RN A donned Personal Protective Equipment (PPE) including a gown, gloves and a surgical mask, while outside of R2's room. R4 had a sign on his door which indicated he was on Enhanced Barrier Precautions (EBP-Contact Precautions) due to having a G-Tube in place. While RN A was setting up R4's medication wearing the gloves she had put on, she opened the laptop computer, grabbing the control mouse to access the computers Electronic Medical Record (EMR) to view R4s medication orders. RN A grabbed the medication cart keys from her pocket, unlocked the medication cart, and opened the 2nd drawer pulling R2's medication cards out. RN A proceeded to open each medication to dispense into small clear medication cups. RN A wore the same gloves to unlock the narcotic drawer pulling out a medication and placing it into the small medication cups. RN A realized the narcotic count sheets in a 3-ring binder/book was not on the medication cart. RN A then walked to nurse's station wearing the gown, gloves and mask. RN A returned to the medication cart holding the narcotic book. The book was noted to be visibly soiled and was visibly old and worn. RN A grabbed onto the tab inside for R4's narcotic medication count sheet, proceeded to grab a pen from the top of the medication cart, and signed out the medication. RN A at no time changed the gloves she had initially put on. RN A then used the same gloves to reach into the med cart, drawing up a liquid medication with a syringe and dispensing it into the small med cup. RN A finished with the setup of R4's medications, grabbed the cups and a water cup, and entered R4's room. RN A then proceeded with the same gloves on to lift R4's shirt up to expose the G-Tube. RN A then grabbed her stethoscope from around her neck, placed the ear pieces into her ears and without cleaning it, she placed the end of it on R4s upper quadrant of his stomach to check placement of the G-Tube. RN A then put the stethoscope back around her neck. RN A took the opening of the G-Tube, uncapped it, pulling back on syringe she had inserted into it to check for residual (stomach contents). Once RN A pulled the syringe out of the opening of the G-Tube, liquid (stomach content) leaked out of the syringe onto R4s upper pant leg. RN A then began to administer R4's medication via his G-Tube. RN A at no time, changed her gloves or performed hand hygiene during this process. After administering R4's medication RN A cleaned up the supplies and placed them in a container in R4's room for future use. RN A then exited R4's room after taking her gloves, gown and mask off. RN A took her stethoscope from around her neck and hung it on the end of the medication cart. RN A did not sanitize the stethoscope nor use an appropriate amount of hand sanitizer to cover her entire hands, nor did RN A wash her hands with soap and water.<br><br>In an interview on 3/10/25 at 10:10 AM., RN A reported R4 was in Enhanced Barrier Precautions (EBP) because of the feeding/G-tube. After being asked what the protocol was for EBP use for a resident on Contact Precautions-EBP and overall infection control measures, RN A reported she should have ensured she did not have PPE on while walking in hallway to the nurses' station, nor should she have used the same gloves as long as she did. RN A reported she should have taken her gloves off while setting up the medications, using hand sanitizer along the way. RN A reported that was not properly donning/doffing PPE per policy or proper infection control techniques. RN A reported she wasn't thinking about it when she was setting up the medications for R4, she was just trying to get through her medication pass.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235558 | A. Building<br>B. Wing | 03/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Menominee Health Services | 501 Second St, Box 246<br>Menominee, MI 49858 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a facility Policy and Procedure titled Transmission-Based (Isolation) Precautions with a revision date of 9/24/2024 revealed: Policy: It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. For training and quick referencing purposes, a summary of precautions is contained at the end of this policy Definitions: Airborne precautions refer to actions taken to prevent or minimize the transmission of infectious agents/organisms that remain infectious over long distances when suspended in the air . Droplet precautions refer to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Transmission-based precautions (a.k.a. Isolation Precautions) refer to actions (precautions) implemented in addition to standard precautions that are based upon the means of transmission (airborne, contact and droplet) in order to prevent or control infections .10. Contact Precautions- a. Intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or the resident's environment. b. Make decisions regarding private room on case-by-case basis, balancing infection risks to other residents, the presence of risk factors that increase the likelihood of transmission, and the potential adverse psychological impact on the infected or colonized resident. c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g. VRE (Vancomycin Resistant Enterococcus [bacteria difficult to treat with antibiotics]), C. difficile (Clostridium difficile [infection of the bowel]), noroviruses (respiratory viral infections) and other intestinal tract pathogens, RSV (Respiratory Syncitial Virus [respiratory virus]). e. Residents experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, should be placed on contact precautions even before a specific organism has been identified. f. Contact precautions will be used for residents infected or colonized with MDROs (Multi-drug resistant organisms) in the following situations: i. When a resident has wounds, secretions, or excretions that are unable to be covered or contained; and ii. On units or in facilities where, despite attempts to control the spread of the MDRO, ongoing transmission is occurring . |