| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245315 | A. Building<br>B. Wing | 08/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Seasons Healthcare | 303 Broadway Avenue South<br>Trimont, MN 56176 |

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) |
|---|---|
| F 0691<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.<br><br>47497<br><br>Based on observation, interviews, and document review the facility failed to ensure a physician order for treatment of an ostomy was appropriately documented and followed for 1 of 1 resident (R2) identified with an ostomy.<br><br>Findings include:<br><br>Review of the 7/31/24, State Agency (SA) report identified R2 had not had his ostomy bags changed for 21 days. R2 was reported to have had significant skin damage and feces on R2's abdominal area.<br><br>R2's 7/9/24, annual Minimum Data Set (MDS) assessment identified R1's cognition was moderately impaired, he had a diagnosis of colostomy (an opening for the colon through the abdomen). R2 was independent with transfers, he required extensive assist from one staff with lower body dressing, and independent after set up with hygiene.<br><br>Observation and interview on 8/19/24 at 1:58 p.m., with R2 identified he was well kempt, had a understanding of his treatment, and was able to articulate a general summary of the ostomy orders and how his skin had been damaged, and was found to be an accurate historian. He identified his ostomy appliance does not get changed often enough. When that happens, it starts to leak and the drainage from the stoma sits on the skin and gets sore. Last month the skin around his stoma was pretty bad. He recalled waiting up to a month between appliance changes. It caused the skin around the stoma to break down. It really stung, burned, and itched . It has been better lately since the wound care nurse changed the order to 3 times weekly. They still do not change it 3 times a week . they [staff]maybe change it once a week. R2 lifted his shirt to show the ostomy during the interview. The ostomy appliance in place was not dated and had several pieces of surgical tape around the edges. The adhesive edging of the appliance appeared to be lifting and no longer adhering to the skin. R2 identified it had been put on last week on Thursday around 1:30 a.m.<br><br>R2's current, undated care plan identified he had an ostomy bag to his right lower right abdominal quadrant. Nursing staff were to monitor R2 for signs or symptoms of red irritated skin around the ostomy site. Nursing was to encourage and monitor him while he changed his ostomy bag, but staff were responsible for changing the appliance that attached to his abdominal wall. R2 preferred to have his ostomy bag changed on shower days. Other days staff were to assist R2 with his ostomy change, .therefore be on Tuesdays and Saturday. There was no mention of when staff were to replace the appliance connected to R2's abdomen.<br><br>(continued on next page) |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0691<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R2's current physician (MD) order for ileostomy Bag identified the appliance was to be changed 3 times a week on Mondays, Wednesdays, and Fridays following these steps:<br><br>1. Use the adhesive remover spray to decrease pain with removal.<br><br>2. Clean skin with plain water.<br><br>3. Apply acetic acid 0.25% moistened gauze to the red skin as a compress with each pouch change.<br><br>4. Leave the compress on the skin for 10 minutes while you are gathering supplies.<br><br>5. Prepare the new pouch before you take off the old pouch.<br><br>6. Remove back of wafer, completely unwrap paste ring and stretch it to fit around the opening. Fold the white tape tabs and set aside.<br><br>7. Remove the compresses and dab skin dry.<br><br>8. Re-clean skin if soiled again.<br><br>9. Apply 50/50 miconazole 2% antifungal powder and stoma powder to the moist red skin directly around the stoma and to any rashes under the wafer. Rub in gently. Brush off extra powder. (It is okay if the powder gets on the stoma).<br><br>10. Repeat no sting barrier wipe, repeat powder. This is called the crusting technique.<br><br>11. Apply the prepared pouch to the skin by rubbing gently for 1 minute to create a seal.<br><br>12. Close the end of the pouch.<br><br>13. Remove the white tape tabs and smooth the borders down. It is okay if the tap is on the healed incision.<br><br>14. Apply barrier extenders, 1/2 on the skin and 1/2 on the wafer.<br><br>15. Empty pouch when 1/3 to 1/2 full of stool or gas. Okay to use wet wipes to clean the skin but must rinse the soap or cleanser out of the wipe. If you must use soap, rinse very well so the new pouch sticks.<br><br>R2's July 2024, Treatment Administration Record (TAR) identified staff put in a corresponding treatment order to change the ostomy pouch 2x per week on Tuesdays and Fridays. The TAR noted the appliance was to be changed as well. Staff recorded they had changed the ostomy pouch and appliance per the physician order, however the appliance was not observed to be dated, causing it to be impossible to confirm that it had actually been changed. There was no evidence the appliance had not been changed as the complaint noted.<br><br>(continued on next page) |

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|---|---|
| F 0691<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 8/19/24 at 4:14 p.m., with licensed practical nurse (LPN)-A removed a bin from beneath a chair on the floor in R2's room. LPN-A then placed the bin on an over-bed table without disinfecting the over-bed table first. She washed her hands and reviewed the order. LPN-A ensured R2 was in a comfortable position and put on (donned) gloves and retrieved gauze and vinegar from the bin. She was unable to locate a scissor in the bin. At that time, R2 pulled a scissor out from between a stack of papers on his nightstand and gave them to LPN-A. LPN-A then proceeded to use the scissors to cut a section of gauze without disinfecting the scissors or retrieving a new clean scissors before continuing with the dressing change. LPN-A then poured the vinegar into a cup and soaked the sterile gauze. LPN-A removed the old appliance from R2 skin and discarded that in the garbage. R2's skin directly surrounding the stoma was open, red, and appeared moist. She then picked up a package of wipes from the floor under R2's bed and with those same gloves, opened the wipes and cleansed the skin directly around the ostomy with her contaminated gloves. She placed the soaked gauze on the skin around the stoma. LPN-A then began preparing the new appliance. While LPN-A was preparing the new appliance, R2 removed the acidic acid-soaked gauze from the stoma with his bare hands (it had been on the stoma approximately 3 minutes vs the ordered 10 minutes). The stoma started leaking at that time. With his bare hands, R2 used the soaked gauze to clean the area. LPN-A turned around after approximately 4 minutes and assisted R2 with cleaning the area around the stoma with a wipe. LPN-A wiped the area around the stoma with a water-soaked piece of gauze, then applied the adhesive ring around the stoma. With her contaminated gloves, she then placed the sterile appliance on R2's skin. She attempted to attach the pouch to the appliance, however she noted it was the incorrect size. She turned away from R2 again to find the correct pouch. The stoma was leaking during this time, R2 was observed using his bare fingers to wipe the leakage from his abdomen. Several minutes later the nurse found the correct pouch and applied it to the appliance without first re-cleansing the site. She disposed of the soiled wipes, removed her contaminated gloves, and washed her hands. She assisted R2 to change the clothing that had been soiled from the leakage, removed the garbage, and left the room.<br><br>Interview on 8/20/24 at 4:00 p.m., with LPN-A identified that she did not follow the physician order and she was concerned when she realized the bin of supplies was on the floor. She agreed that she should not have used the wipes that had been laying on the floor under R2's bed and she also agreed that the physician order specifically said to rinse the detergent from the wipe before using it on the skin. She agreed she should have changed gloves between clean and dirty tasks, should not have used an unclean scissor to cut the gauze, had not ensured the vinegar soak was in place for 10 minutes, and agreed she failed to follow physician's orders to use the no-sting barrier wipe and 50/50 miconazole 2% antifungal powder and stoma powder to the moist red skin directly around the stoma as the physician directed. In regard to the appliance not having been changed (per the complaint) LPN-A stated appliances were changed and signed off by staff as having been performed. LPN-A did state it would be hard to identify if the appliances had been changed as no date as ever marked on the appliance itself to notify staff it had been changed.<br><br>(continued on next page) |

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| F 0691<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 8/20/24 at 12:49 p.m., with the director of nursing (DON) identified that she would expect nursing to follow the physician orders and perform appropriate infection control technique during dressing changes. She would have expected R2's ostomy supplies to be kept in a bin up in the closet in R2's room and she would not expect wipes to be stored on the floor. She identified that using a scissor for a ostomy change that may have been used by the resident for personal use was an infection control concern and would have expect the nurse to retrieve a clean scissor for the treatment. She agreed R2 had increased risk for complications due to improper infection control technique used during wound care. She noted she had not completed any training, competencies, or audits on staff to ensure nursing staff was competent with ostomy appliance changes. She also agreed not dating the appliance itself would put residents at increased risk as the TAR order did not have a specific mention for the appliance change on its own.<br><br>Interview on 8/21/24 at 9:57 a.m., with nurse practitioner (NP)-A identified R2 had expressed to her that his appliance was not being changed regularly. R2's skin around their ostomy had broken down and this could be caused by not following the order correctly, not using appropriate infection control practices, or not changing the appliance often enough. Not following the treatment could potentially lead to infection and/or cause the ostomy appliance to no longer adhere to the skin making it impossible to attach a pouch to protect the surrounding skin from fecal drainage.<br><br>Review of the 5/15/22, Ostomy/Ileostomy policy identified all residents with an ostomy/ileostomy pouch have the right to proper cleaning and changing of the pouch and cleaning of the stoma along with ensuring that the pouch is emptied to prevent leakage. If the resident experiences skin breakdown or other concerns the nurse should consult a wound care specialist for guidance. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>47497<br><br>Based on observation, interviews, and document review the facility failed to ensure 5 of 5 nursing staff registered nurses (RN)-A, RN-B, RN-C, RN-D, and 1 of 1 licensed practical nurse (LPN)-A were deemed competent to provide ostomy care for 1 of 1 resident (R2) identified with an ostomy.<br><br>Findings include:<br><br>Review of the 7/31/24, State Agency (SA) report identified R2 had not had his ostomy bags changed for 21 days. R2 was reported to have had significant skin damage and feces on R2's abdominal area.<br><br>R2's 7/9/24, annual Minimum Data Set (MDS) assessment identified R1's cognition was moderately impaired, he had a diagnosis of colostomy (an opening for the colon through the abdomen). R2 was independent with transfers, he required extensive assist from one staff with lower body dressing, and independent after set up with hygiene.<br><br>Observation and interview on 8/19/24 at 1:58 p.m., with R2 identified he was well kempt, had a understanding of his treatment, and was able to articulate a general summary of the ostomy orders and how his skin had been damaged, and was found to be an accurate historian. He identified his ostomy appliance does not get changed often enough. When that happens, it starts to leak and the drainage from the stoma sits on the skin and gets sore. Last month the skin around his stoma was pretty bad. He recalled waiting up to a month between appliance changes. It caused the skin around the stoma to break down. It really stung, burned, and itched . It has been better lately since the wound care nurse changed the order to 3 times weekly. They still do not change it 3 times a week . they [staff]maybe change it once a week. R2 lifted his shirt to show the ostomy during the interview. The ostomy appliance in place was not dated and had several pieces of surgical tape around the edges. The adhesive edging of the appliance appeared to be lifting and no longer adhering to the skin. R2 identified it had been put on last week on Thursday around 1:30 a.m.<br><br>R2's current, undated care plan identified he had an ostomy bag to his right lower right abdominal quadrant. Nursing staff were to monitor R2 for signs or symptoms of red irritated skin around the ostomy site. Nursing was to encourage and monitor him while he changed his ostomy bag, but staff were responsible for changing the appliance that attached to his abdominal wall. R2 preferred to have his ostomy bag changed on shower days. Other days staff were to assist R2 with his ostomy change, .therefore be on Tuesdays and Saturday. There was no mention of when staff were to replace the appliance connected to R2's abdomen.<br><br>Review of R2's current physician (MD) order for ileostomy Bag identified the appliance was to be changed 3 times a week on Mondays, Wednesdays, and Fridays following these steps:<br><br>1. Use the adhesive remover spray to decrease pain with removal.<br><br>2. Clean skin with plain water.<br><br>3. Apply acetic acid 0.25% moistened gauze to the red skin as a compress with each pouch change.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 4. Leave the compress on the skin for 10 minutes while you are gathering supplies.<br><br>5. Prepare the new pouch before you take off the old pouch.<br><br>6. Remove back of wafer, completely unwrap paste ring and stretch it to fit around the opening. Fold the white tape tabs and set aside.<br><br>7. Remove the compresses and dab skin dry.<br><br>8. Re-clean skin if soiled again.<br><br>9. Apply 50/50 miconazole 2% antifungal powder and stoma powder to the moist red skin directly around the stoma and to any rashes under the wafer. Rub in gently. Brush off extra powder. (It is okay if the powder gets on the stoma).<br><br>10. Repeat no sting barrier wipe, repeat powder. This is called the crusting technique.<br><br>11. Apply the prepared pouch to the skin by rubbing gently for 1 minute to create a seal.<br><br>12. Close the end of the pouch.<br><br>13. Remove the white tape tabs and smooth the borders down. It is okay if the tap is on the healed incision.<br><br>14. Apply barrier extenders, 1/2 on the skin and 1/2 on the wafer.<br><br>15. Empty pouch when 1/3 to 1/2 full of stool or gas. Okay to use wet wipes to clean the skin but must rinse the soap or cleanser out of the wipe. If you must use soap, rinse very well so the new pouch sticks.<br><br>R2's July 2024, Treatment Administration Record (TAR) identified staff put in a corresponding treatment order to change the ostomy pouch 2x per week on Tuesdays and Fridays. The TAR noted the appliance was to be changed as well. Staff recorded they had changed the ostomy pouch and appliance per the physician order, however the appliance was not observed to be dated, causing it to be impossible to confirm that it had actually been changed. There was no evidence the appliance had not been changed as the complaint noted.<br><br>(continued on next page) |

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|---|---|
| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Observation on 8/19/24 at 4:14 p.m., with licensed practical nurse (LPN)-A removed a bin from beneath a chair on the floor in R2's room. LPN-A then placed the bin on an over-bed table without disinfecting the over-bed table first. She washed her hands and reviewed the order. LPN-A ensured R2 was in a comfortable position and put on (donned) gloves and retrieved gauze and vinegar from the bin. She was unable to locate a scissor in the bin. At that time, R2 pulled a scissor out from between a stack of papers on his nightstand and gave them to LPN-A. LPN-A then proceeded to use the scissors to cut a section of gauze without disinfecting the scissors or retrieving a new clean scissors before continuing with the dressing change. LPN-A then poured the vinegar into a cup and soaked the sterile gauze. LPN-A removed the old appliance from R2 skin and discarded that in the garbage. R2's skin directly surrounding the stoma was open, red, and appeared moist. She then picked up a package of wipes from the floor under R2's bed and with those same gloves, opened the wipes and cleansed the skin directly around the ostomy with her contaminated gloves. She placed the soaked gauze on the skin around the stoma. LPN-A then began preparing the new appliance. While LPN-A was preparing the new appliance, R2 removed the acidic acid-soaked gauze from the stoma with his bare hands (it had been on the stoma approximately 3 minutes vs the ordered 10 minutes). The stoma started leaking at that time. With his bare hands, R2 used the soaked gauze to clean the area. LPN-A turned around after approximately 4 minutes and assisted R2 with cleaning the area around the stoma with a wipe. LPN-A wiped the area around the stoma with a water-soaked piece of gauze, then applied the adhesive ring around the stoma. With her contaminated gloves, she then placed the sterile appliance on R2's skin. She attempted to attach the pouch to the appliance, however she noted it was the incorrect size. She turned away from R2 again to find the correct pouch. The stoma was leaking during this time, R2 was observed using his bare fingers to wipe the leakage from his abdomen. Several minutes later the nurse found the correct pouch and applied it to the appliance without first re-cleansing the site. She disposed of the soiled wipes, removed her contaminated gloves, and washed her hands. She assisted R2 to change the clothing that had been soiled from the leakage, removed the garbage, and left the room.<br><br>Interview on 8/20/24 at 4:00 p.m., with LPN-A identified that she did not follow the physician order and she was concerned when she realized the bin of supplies was on the floor. She agreed that she should not have used the wipes that had been laying on the floor under R2's bed and she also agreed that the physician order specifically said to rinse the detergent from the wipe before using it on the skin. She agreed she should have changed gloves between clean and dirty tasks, should not have used an unclean scissor to cut the gauze, had not ensured the vinegar soak was in place for 10 minutes, and agreed she failed to follow physician's orders to use the no-sting barrier wipe and 50/50 miconazole 2% antifungal powder and stoma powder to the moist red skin directly around the stoma as the physician directed. In regard to the appliance not having been changed (per the complaint) LPN-A stated appliances were changed and signed off by staff as having been performed. LPN-A did state it would be hard to identify if the appliances had been changed as no date as ever marked on the appliance itself to notify staff it had been changed.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview on 8/20/24 at 12:49 p.m., with the director of nursing (DON) identified that she would expect nursing to follow the physician orders and perform appropriate infection control technique during dressing changes. She would have expected R2's ostomy supplies to be kept in a bin up in the closet in R2's room and she would not expect wipes to be stored on the floor. She identified that using a scissor for a ostomy change that may have been used by the resident for personal use was an infection control concern and would have expect the nurse to retrieve a clean scissor for the treatment. She agreed R2 had increased risk for complications due to improper infection control technique used during wound care. She noted she had not completed any training, competencies, or audits on staff to ensure nursing staff was competent with ostomy appliance changes. She also agreed not dating the appliance itself would put residents at increased risk as the TAR order did not have a specific mention for the appliance change on its own.<br><br>Interview on 8/21/24 at 9:57 a.m., with nurse practitioner (NP)-A identified R2 had expressed to her that his appliance was not being changed regularly. R2's skin around their ostomy had broken down and this could be caused by not following the order correctly, not using appropriate infection control practices, or not changing the appliance often enough. Not following the treatment could potentially lead to infection and/or cause the ostomy appliance to no longer adhere to the skin making it impossible to attach a pouch to protect the surrounding skin from fecal drainage.<br><br>There was no policy related to staff competencies provided by the end of the survey. |

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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>47497<br><br>Based on observation, interview, and document review, the facility failed to follow appropriate infection control technique and ensure appropriate storage of dressing materials during 1 of 1 dressing change for 1 of 1 resident (R2) and care of an ostomy (opening in skin where intestines empty directly into a bag).<br><br>Findings include:<br><br>Review of the 7/31/24, State Agency (SA) report identified R2 had not had his ostomy bags changed for 21 days. R2 was reported to have had significant skin damage and feces on R2's abdominal area.<br><br>R2's 7/9/24, annual Minimum Data Set (MDS) assessment identified R1's cognition was moderately impaired, he had a diagnosis of colostomy (an opening for the colon through the abdomen). R2 was independent with transfers, he required extensive assist from one staff with lower body dressing, and independent after set up with hygiene.<br><br>Observation and interview on 8/19/24 at 1:58 p.m., with R2 identified he was well kempt, had a understanding of his treatment, and was able to articulate a general summary of the ostomy orders and how his skin had been damaged, and was found to be an accurate historian. He identified his ostomy appliance does not get changed often enough. When that happens, it starts to leak and the drainage from the stoma sits on the skin and gets sore. Last month the skin around his stoma was pretty bad. He recalled waiting up to a month between appliance changes. It caused the skin around the stoma to break down. It really stung, burned, and itched . It has been better lately since the wound care nurse changed the order to 3 times weekly. They still do not change it 3 times a week . they [staff]maybe change it once a week. R2 lifted his shirt to show the ostomy during the interview. The ostomy appliance in place was not dated and had several pieces of surgical tape around the edges. The adhesive edging of the appliance appeared to be lifting and no longer adhering to the skin. R2 identified it had been put on last week on Thursday around 1:30 a.m.<br><br>R2's current, undated care plan identified he had an ostomy bag to his right lower right abdominal quadrant. Nursing staff were to monitor R2 for signs or symptoms of red irritated skin around the ostomy site. Nursing was to encourage and monitor him while he changed his ostomy bag, but staff were responsible for changing the appliance that attached to his abdominal wall. R2 preferred to have his ostomy bag changed on shower days. Other days staff were to assist R2 with his ostomy change, .therefore be on Tuesdays and Saturday. There was no mention of when staff were to replace the appliance connected to R2's abdomen.<br><br>Review of R2's current physician (MD) order for ileostomy Bag identified the appliance was to be changed 3 times a week on Mondays, Wednesdays, and Fridays following these steps:<br><br>1. Use the adhesive remover spray to decrease pain with removal.<br><br>2. Clean skin with plain water.<br><br>3. Apply acetic acid 0.25% moistened gauze to the red skin as a compress with each pouch change.<br><br>(continued on next page) |

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|---|---|---|---|
| | 245315 | A. Building<br>B. Wing | 08/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Seasons Healthcare | 303 Broadway Avenue South<br>Trimont, MN 56176 |

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 | 4. Leave the compress on the skin for 10 minutes while you are gathering supplies.<br><br>5. Prepare the new pouch before you take off the old pouch.<br><br>6. Remove back of wafer, completely unwrap paste ring and stretch it to fit around the opening. Fold the white tape tabs and set aside.<br><br>7. Remove the compresses and dab skin dry.<br><br>8. Re-clean skin if soiled again.<br><br>9. Apply 50/50 miconazole 2% antifungal powder and stoma powder to the moist red skin directly around the stoma and to any rashes under the wafer. Rub in gently. Brush off extra powder. (It is okay if the powder gets on the stoma).<br><br>10. Repeat no sting barrier wipe, repeat powder. This is called the crusting technique.<br><br>11. Apply the prepared pouch to the skin by rubbing gently for 1 minute to create a seal.<br><br>12. Close the end of the pouch.<br><br>13. Remove the white tape tabs and smooth the borders down. It is okay if the tap is on the healed incision.<br><br>14. Apply barrier extenders, 1/2 on the skin and 1/2 on the wafer.<br><br>15. Empty pouch when 1/3 to 1/2 full of stool or gas. Okay to use wet wipes to clean the skin but must rinse the soap or cleanser out of the wipe. If you must use soap, rinse very well so the new pouch sticks.<br><br>R2's July 2024, Treatment Administration Record (TAR) identified staff put in a corresponding treatment order to change the ostomy pouch 2x per week on Tuesdays and Fridays. The TAR noted the appliance was to be changed as well. Staff recorded they had changed the ostomy pouch and appliance per the physician order, however the appliance was not observed to be dated, causing it to be impossible to confirm that it had actually been changed. There was no evidence the appliance had not been changed as the complaint noted.<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 | Observation on 8/19/24 at 4:14 p.m., with licensed practical nurse (LPN)-A removed a bin from beneath a chair on the floor in R2's room. LPN-A then placed the bin on an over-bed table without disinfecting the over-bed table first. She washed her hands and reviewed the order. LPN-A ensured R2 was in a comfortable position and put on (donned) gloves and retrieved gauze and vinegar from the bin. She was unable to locate a scissor in the bin. At that time, R2 pulled a scissor out from between a stack of papers on his nightstand and gave them to LPN-A. LPN-A then proceeded to use the scissors to cut a section of gauze without disinfecting the scissors or retrieving a new clean scissors before continuing with the dressing change. LPN-A then poured the vinegar into a cup and soaked the sterile gauze. LPN-A removed the old appliance from R2 skin and discarded that in the garbage. R2's skin directly surrounding the stoma was open, red, and appeared moist. She then picked up a package of wipes from the floor under R2's bed and with those same gloves, opened the wipes and cleansed the skin directly around the ostomy with her contaminated gloves. She placed the soaked gauze on the skin around the stoma. LPN-A then began preparing the new appliance. While LPN-A was preparing the new appliance, R2 removed the acidic acid-soaked gauze from the stoma with his bare hands (it had been on the stoma approximately 3 minutes vs the ordered 10 minutes). The stoma started leaking at that time. With his bare hands, R2 used the soaked gauze to clean the area. LPN-A turned around after approximately 4 minutes and assisted R2 with cleaning the area around the stoma with a wipe. LPN-A wiped the area around the stoma with a water-soaked piece of gauze, then applied the adhesive ring around the stoma. With her contaminated gloves, she then placed the sterile appliance on R2's skin. She attempted to attach the pouch to the appliance, however she noted it was the incorrect size. She turned away from R2 again to find the correct pouch. The stoma was leaking during this time, R2 was observed using his bare fingers to wipe the leakage from his abdomen. Several minutes later the nurse found the correct pouch and applied it to the appliance without first re-cleansing the site. She disposed of the soiled wipes, removed her contaminated gloves, and washed her hands. She assisted R2 to change the clothing that had been soiled from the leakage, removed the garbage, and left the room.<br><br>Interview on 8/20/24 at 4:00 p.m., with LPN-A identified that she did not follow the physician order and she was concerned when she realized the bin of supplies was on the floor. She agreed that she should not have used the wipes that had been laying on the floor under R2's bed and she also agreed that the physician order specifically said to rinse the detergent from the wipe before using it on the skin. She agreed she should have changed gloves between clean and dirty tasks, should not have used an unclean scissor to cut the gauze, and should have ensured staff had not stored supplies on a bin on the floor.<br><br>Interview on 8/20/24 at 12:49 p.m., with the director of nursing (DON) identified that she would expect nursing to follow the physician orders and perform appropriate infection control technique during dressing changes. She would have expected R2's ostomy supplies to be kept in a bin up in the closet in R2's room and she would not expect wipes to be stored on the floor. She identified that using a scissor for a ostomy change that may have been used by the resident for personal use was an infection control concern and would have expect the nurse to retrieve a clean scissor for the treatment. She agreed R2 had increased risk for complications due to improper infection control technique used during wound care. She noted she had not completed any training, competencies, or audits on staff to ensure nursing staff was competent with ostomy appliance changes.<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 | Interview on 8/21/24 at 9:57 a.m., with nurse practitioner (NP)-A identified R2 had expressed to her that his appliance was not being changed regularly. R2's skin around their ostomy had broken down and this could be caused by not following the order correctly, not using appropriate infection control practices, or not changing the appliance often enough. Not following the treatment could potentially lead to infection and/or cause the ostomy appliance to no longer adhere to the skin making it impossible to attach a pouch to protect the surrounding skin from fecal drainage.<br><br>Review of the 5/15/22, Ostomy/Ileostomy policy identified all residents with an ostomy/ileostomy pouch have the right to proper cleaning and changing of the pouch and cleaning of the stoma along with ensuring that the pouch is emptied to prevent leakage. If the resident experiences skin breakdown or other concerns the nurse should consult a wound care specialist for guidance.<br><br>An infection control policy was requested and not provided by the end of the survey. |