| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245632 | A. Building<br>B. Wing | 09/17/2024 |

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| St Therese of Woodbury LLC | 7555 Bailey Road<br>Woodbury, MN 55129 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0686<br><br>Level of Harm - 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** 38685<br><br>Based on observation, interview and document review the facility failed to comprehensively assess pressure ulcers and monitor for skin breakdown to prevent and/or mitigate the risk of deterioration resulting in actual harm for 2 of 3 residents when (R1) admitted with a stage 1 pressure ulcer that developed into an unstageable pressure ulcer and R2 admitted with a stage 2 pressure ulcer that developed into an unstageable pressure ulcer resulting in ongoing pain.<br><br>Findings include:<br><br>Definitions of pressure ulcers:<br><br>Pressure Ulcer/Injury (PU/PI) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. The appearance will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear.<br><br>Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes.<br><br>Stage 2 Pressure Ulcer: partial thickness skin loss with exposed dermis. Partial thickness skin loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible.<br><br>Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions).<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 |
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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Stage 3 Pressure Ulcer: 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. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI.<br><br>Unstageable pressure ulcer: Full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a stage 3 or 4 pressure ulcer will be revealed.<br><br>Eschar: dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound.<br><br>Slough: non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.<br><br>Serosanguinous drainage: a thin, watery fluid that's often slightly yellow and has a light pink tinge that can ooze from a wound as a part of the wound healing process.<br><br>R1's admission assessment dated [DATE] identified R1 had non-blanchable redness at mid-spine and buttock with blanchable redness. The assessment did not include measurements and did not identify the staging of the pressure injury identified.<br><br>R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had moderate cognitive impairment, had diagnoses of diabetes, fracture of sternum, left humerus (upper arm bone) and left patella (knee), required two person assist with toileting, transfers, and bed mobility. Further identified R1 was at risk for pressure ulcers and had one stage 1 pressure ulcer and one surgical wound. Skin ulcer/injury treatments did not identify pressure reducing devices, turning/repositioning, pressure ulcer/injury or surgical wound care.<br><br>R1's pressure ulcer Care Area Assessment (CAA) dated 8/22/24, identified R1 needed assist with bed mobility, had a pressure ulcer, and was at high risk for pressure ulcers. R1 to see therapy for strengthening to increase independence with activities of daily living (ADL)'s. Will continue to update the physician and care plan as needed.<br><br>R1's care plan revised 8/22/24 identified a focus that R1 was at risk for impaired skin integrity related to a surgical wound; no related interventions were included. An additional focus dated 8/22/24, included R1 had an ADL deficit related to subdural hematoma and multiple fractures with intervention of requiring 2 staff assist with bed mobility. R1's care plan did not identify any pressure ulcer prevention interventions.<br><br>R1's physician orders included the following:<br><br>-R1 to lie down on side while in bed due to pressure ulcer on upper back (dated 8/20/24).<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Back wound-cleanse and apply Mepilex (absorbant dressing) every 3 days and as needed (dated 8/21/24).<br><br>-Reposition every two hours and encourage to sit in chair during the day and apply Mepilex to sacrum every 72 hours for sacral wound (dated 8/22/24).<br><br>-Apply non-adherent dressing mid-spine on pressure ulcer one time per day (dated 8/23/24).<br><br>R1's Treatment Administration Record (TAR) dated August 2024 identified the aforemented physician orders and were marked as completed:<br><br>-8/20/24 to 8/28/24 R1 to lie down on side while in bed due to pressure ulcer on upper back.<br><br>-8/21/24 to 8/27/24 back wound cleanse and apply Mepilex every 3 days and as needed.<br><br>-8/22/24 to 8/28/24 reposition every two hours and encourage to sit in chair during the day and apply Mepilex to sacrum every 72 hours for sacral wound.<br><br>-8/23/24 to 8/28/24 identified to apply nonadherent dressing mid-spine on pressure ulcer one time per day.<br><br>R1's Medicare Skilled Documentation note dated 8/26/24 identified R1 had a stage 2 pressure ulcer to midback. The documentation did not include pressure ulcer characteristics to include, measurements, wound bed, drainage, peri wound, signs and symptoms of infection, pain, or a description of the treatment.<br><br>R1's certified nurse practioner (CNP) visit dated 8/27/24 identified R1 had a stage 2 pressure sore to back . unable to turn to see it due to R1's pain, will attempt to view this in the facility electronic medical record (EMR) which should have documentation. No new treatment ordered.<br><br>R1's Medicare Skilled Documentation note dated 8/28/24 identified R1 was sent to the hospital from dialysis due to low blood pressure .dressing on spine changed before leaving for dialysis.<br><br>Review of R1's medical record did not identify a comprehensive pressure ulcer assessment to include staging, wound bed description, peri-wound, amount and type of drainage, signs and symptoms of infection or if pain was noted.<br><br>R1's hospital notes dated 8/29/24 identified R1 had an unstageable pressure injury to spine was present on admit that measured 11.0 centimeters (cm) x 3.0 cm. Wound bed had 50% eschar and 50% slough with a scant amount of serosanguinous drainage and liquifying slough. Bedside nurse reported R1 stated he was not turned all night at the nursing home. Treatment goal infection control/prevention, protection, and to remove and soften necrotic tissue. R1's coccyx had a stage 3 pressure ulcer measured 4.5 cm x 1.2 cm x 0. 3 cm. Wound bed had 50% slough and 50% epidermis with a scant amount of serosanguinous drainage.<br><br>During an interview on 9/16/24 at 8:16 a.m., nursing assistant (NA)-B stated she was there the day that R1 was sent to the hospital from dialysis, stated she got him up in his chair that morning. NA-B stated R1 had a pressure ulcer on his spine with dark spots half way up his spine.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 9/17/24 at 8:25 a.m., NA-A stated she was taking care of R1 the day they found the pressure ulcer on his coccyx and mid-spine area however, never saw what they looked like.<br><br>During an interview on 9/16/24 at 3:34 p.m., registered nurse (RN)-E stated a comprehensive skin assessment should be completed on admission; any pressure area or wounds should be measured, wound bed described, and peri wound, along with the amount and type of drainage. RN-E stated our policy was to do a comprehensive skin assessments for the first three days of admission and then weekly. If a new wound was found or had a change the family and physician should be notified. RN-E verified R1 had admitted with a stage 1 pressure injury to his back and had redness on his buttocks. RN-E stated the stage 1 pressure injury should have been measured and the care plan should have had interventions in place for prevention of worsening and to promote healing. RN-E verified he did see the unstageable pressure ulcer to R1's back on 8/28/24 and stated it should have been measured and the provider should have been notified.<br><br>During an interview on 9/16/24 at 4:12 p.m., director of nursing (DON) indicated R1's skin was not comprehensively assessed or monitored to mitigate the risks of pressure ulcer development or deterioration. DON stated all residents admitted should have comprehensive skin assessments performed, and weekly thereafter. Further stated when a wound/pressure ulcer is found, the family and physician should be notified and a comprehensive pressure ulcer assessment should include documentation of stage of pressure ulcer, wound bed characteristics, measurements, peri-wound, amount and type of drainage, signs, and symptoms of infection and if there is pain.<br><br>R2<br><br>R2's hospital After Visit Summary (AVS) dated 8/30/24, indicated R2 had a pressure ulcer to left heel with care instructions that included paint with betadine daily, leave open to air if no drainage, if drainage was noted cover with dry gauze, float heels at all times while in bed or recliner. Return to wound provider on 9/4/24.<br><br>R2's Admission Assessment note, dated 8/30/24, identified R2 had a wound next to heel on left foot, looked greenish purple, open to air.<br><br>R2's care plan dated 9/3/24, identified a focus that R2 was at risk for impaired skin integrity related to venous stasis ulcer, wound left heel and right foot with interventions to do wound cares as ordered, and ensure that a pressure reducing/relieving mattress is in place on the bed, observe for wound complications and call medical doctor (MD) with any changes.<br><br>R2's wound care provider visit dated 9/4/24 identified a stage 2 pressure ulcer to left heel, treatment to apply iodine daily. Return to wound provider on 9/18/24.<br><br>R2's order summary dated 9/4/24 identified dressing change instructions to left heel, apply iodine daily.<br><br>R2's pressure ulcer Care Area Assessment (CAA) dated 9/5/24, identified R2 needed assist with bed mobility, frequently incontinent of bowel and bladder, making R2 at higher risk for development of pressure ulcers. R2 will see therapy for strengthening to increase independence with ADL's. Staff will continue to update the physician and care plan as needed.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R2's admission MDS dated [DATE], identified R2 was cognitively intact, had a diagnosis of osteomyelitis and sepsis, required substantial to maximal assist with toileting and required intravenous (IV) medications. Further identified R2 was at risk for pressure ulcers and had no existing pressure ulcers.<br><br>R2's Skin assessment dated [DATE], did not identify a pressure ulcer on left heel.<br><br>R2's Skin assessment dated [DATE], identified a wound next to heel on left foot, looked greenish purple and left open to air.<br><br>Review of R2's medical record did not include comprehensive wound assessments and evidence of monitoring were performed to ensure ordered treatments were effective to promote healing and prevent deterioration of pressure ulcer to left heel.<br><br>During an interview on 9/16/24 at 4:05 p.m., R2 was seated in his wheelchair and was noted to have Pressure Relief Ankle Foot Orthosis (PRAFO) boots on both lower extremities. R2 stated he had a pressure sore on his left heel, and no one has looked at that pressure sore for 8 days. R2 stated the pressure sore on his left heel was the size of a prune, it was yellowish and then it broke open. R2 further stated the staff here put iodine on it once in a while and that he will see the wound provider the day after tomorrow. R2 stated he had ongoing pain in the left heel.<br><br>During an observation and interview on 9/17/24 at 10:34 a.m., RN-A, RN-B and RN-E assisted with a dressing change to R2's left heel. R2's left leg had tubigrip on it, the tubigrip had a small amount of dried brownish drainage in the heel area. Tubigrip was removed and R2's left heel had a hard blackened area. RN-E stated the left heel was an unstageable pressure ulcer that had 90% eschar and 10% slough. Further stated there was a small amount of serosanguinous drainage noted on tubigrip and inside of PRAFO boot. RN-A stated the measurements were 5.3 cm x 4.3 cm. and the peri-wound was slightly macerated on one side. R2 stated he had level 2 to 3 pain in the left heel most of the time. R2 stated staff here looked at his left heel maybe once a week and that he has had the iodine put on his heel maybe two or three times in the last two weeks. R2 stated a girl came in his room yesterday and saw that there was drainage all over his sheets from the left heel draining and she changed his bedding for him. RN-A stated she would call the doctor to update the change in the status of the pressure ulcer.<br><br>During an interview on 9/17/24 at 11:24 a.m., DON indicated R2's left heel pressure ulcer was not comprehensively assessed or monitored to mitigate the risks of pressure ulcer development or deterioration and should have been.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Facility policy, Wound Treatment Management, dated January 2023, identified a Policy to promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse. 3. Dressing changes may be provided outside the frequency parameters in certain situations: a. Feces has seeped underneath the dressing. b. The dressing has dislodged. c. The dressing is soiled otherwise or is wet. 4. Dressings will be applied in accordance with manufacturer recommendations. 5.Treatment decisions will be based on a. Etiology of the wound: i. Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic, moisture or incontinence related skin damage. ii. Surgical. iii. Incidental (i.e. skin tear, medical adhesive related skin injury). iv. Atypical (i.e. dermatological or cancerous lesion, pyoderma, calciphylaxis). b. Characteristics of the wound: i. Pressure injury stage (or level of tissue destruction if not a pressure injury). ii. Size - including shape, depth, and presence of tunneling and/or undermining. iii. Volume and characteristics of exudate. iv. Presence of pain. v. Presence of infection or need to address bacterial bioburden. vi. Condition of the tissue in the wound bed. vii. Condition of peri-wound skin. c. Location of the wound. d. Goals and preferences of the resident/representative. 6. Guidelines for dressing selection may be utilized in obtaining physician orders (See Wound Treatment Guidelines). a. The guidelines are to be used to assist in treatment decision making. b. Due to unique needs and situations of individuals, the guidelines may not be appropriate for use in all circumstances. c. The facility will follow specific physician orders for providing wound care. 7. Treatments will be documented on the Treatment Administration Record or in the electronic health record. 8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include a. Lack of progression towards healing. b. Changes in the characteristics of the wound (see above). c. Changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Facility policy, Skin Assessment, dated January 2023, identified it is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment. Policy Explanation and Compliance Guidelines: 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. 2. Procedure: a. Wash hands. b. Explain the procedure to the resident. c. Provide privacy and adequate lighting. d. Put on gloves. e. Begin head to toe, thoroughly examining the resident's skin for conditions. Pay close attention to pressure points, bony prominences, and underneath medical devices. f. Remove any special garments or devices, if not contraindicated or ordered to remain in place. g. Remove any dressings, using clean technique, unless contraindicated or ordered to remain in place, and note findings. h. Note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers, and lesions. i. Dispose of contaminated items safely. j. Remove gloves and perform hand hygiene prior to leaving room. 3. Consider the general status of the resident's skin. a. Color. b. Temperature. c. Moisture status. d. Sensory perception. e. Skin texture/turgor. f. Perfusion. 4. Considerations for a resident with darkly pigmented skin: a. It is not always possible to identify redness on darkly pigmented skin. b. Indicators of early pressure damage: i. Localized heat ii. Edema iii. Bogginess iv. Induration v. Temperature differences of surrounding skin vi. Skin discoloration 5. Considerations for a bariatric resident: a. Perform assessment with at least one other staff member to assist with mobility and positioning of body parts. b. Approach resident in a manner that promotes dignity and respect. c. Thoroughly inspect each surface of a skin fold. d. Consider moisture and weight exerted by opposing skin and/or body parts (i.e. abdominal pannus) when determining pressure versus moisture related etiology. Pressure injuries may result from tissue pressure of high concentration of adipose tissue and may be in areas other than bony prominences. 6. Differentiating the extent of redness a. Blanchable erythema (redness) loses its redness when a finger is pressed on the erythema for 3 seconds and released. Blanching is assessed following the removal of the finger. b. Non-blanchable erythema (redness) persists when touched. 7. Documentation of skin assessment: a. Include date and time of the assessment, your name, and position title. b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.). c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). e. Document if resident refused assessment and why. f. Document other information as indicated or appropriate. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685<br><br>Based on observation, interview, and document review the facility failed to ensure meals were served in a warm, palatable manner to promote quality of life and nutritional intake for 1 of 1 resident (R3) observed for short term stay. The facility further failed to offer an alternate meal option. This had the potential to affect all 16 of 16 residents identified to reside on the unit where the meal was served.<br><br>Findings include:<br><br>A provided line listing report, printed 9/12/24, identified all residents and their room numbers within the [NAME] unit, including R3 who resided on the TCU unit.<br><br>R3's admission Minimum Data Set (MDS) assessment dated [DATE], identified R3's cognition was intact had a diagnosis of dysphagia (difficulty swallowing) and was independent with eating, had complaints of difficulty or pain with swallowing and coughing or choking during meals or when swallowing medications and was on a mechanically altered diet.<br><br>R3's Order Summary dated 9/12/24, identified a regular diet with easy to chew texture and no bread products.<br><br>R3's care plan identified a focus dated 9/1/24, that R3 had an ADL deficit related to surgery and weakness, intervention that R3 required set up assistance with eating.<br><br>During an observation on 9/17/24 at 9:14 p.m., Food Server (FS)-A walked into R3's room and delivered R3's breakfast tray.<br><br>During an observation and interview on 9/17/24 at 9:14 a.m., R3 turned on her call light. R3 stated she just got her breakfast tray, and her eggs and turkey sausages were cold and turned her call light on to see if there was something different to eat.<br><br>During an observation on 9/17/24 at 9:36 a.m., nursing assistant (NA)-A answered R3's call light and stated to R3, Do you need something? R3 replied, my breakfast was cold could I get a sweet roll? NA-A left the room.<br><br>During an interview on 9/17/24 at 10:08 a.m. FS-A stated if someone had cold food, we would offer an alternative, we don't typically have sweet rolls. FS-A was notified that R3's breakfast was cold and R3 wanted an alternative to breakfast. FS-A did not go into R3's room to see what alternative R3 would like and was noted to continue to push the cart down the hall that was filled with the food trays she had picked up from residents rooms.<br><br>During an interview on 9/17/24 at 10:11 a.m., R3 stated she told NA-A that her food was cold, and she would like a sweet roll. R3 stated she wished she would have eaten her cold food now because she was hungry. R3 stated no one came in and asked me if I would like something different to eat.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 9/17/24 at 10:14 a.m., director of social services ([NAME])-A stated she would expect staff to offer an alternative to a meal if the resident did not like it and further stated at the very least staff should have offered to heat up R3's food if it was cold.<br><br>During an interview on 9/17/24 at 11:29 a.m., director of nursing (DON) stated the expectation if a residents food was cold, and they didn't want it to be offered another choice of food.<br><br>Dietary policy requested and not received. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| 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** 38685<br><br>Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP)-(an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.) were implemented for management of a pressure ulcer wound and a peripherally inserted central catheter (PICC) to reduce the risk of infection to others for 1 of 1 resident (R2). Further the facility failed to implement hand hygiene for 1 of 1 resident (R2) observed during incontinence care.<br><br>Findings include:<br><br>R2's order summary dated 9/2/24 identified PICC Site Maintenance: change dressing to IV site weekly and PRN (as needed) using transparent dressing. Measure upper arm circumference and external catheter length. Compare catheter length to placement record. Document abnormal findings in a progress note. 9/4/24 dressing change instructions to left heel: Iodine daily every day shift, and Dressing Change Instructions Right Foot: standard wound vac instructions 1. 3 times a week and as needed, cleanse the area with normal saline (NS) 2. Pat dry 3. Apply Cavilon (barrier cream) no sting barrier wipe to the skin surrounding the wound 4. Apply drape around incision 5. Cut the foam to fit the area of the incision 6. Cut narrow strip of foam of bridging 7. Cover foam with drape to obtain airtight seal 8. Cut opening the size of a quarter 9. Apply diction pad 10. 125 millimeters of mercury (mmhg) continuous suction.<br><br>R2's care plan dated 9/3/24 identified a focus of PICC line for IV antibiotics with an intervention for staff to implement and adhere to EBP while resident has device in place. An additional focus dated 9/3/24 of R2 was at risk for impaired skin integrity related to venous stasis ulcer, wound left heel and right foot with interventions to do wound cares as ordered, and ensure that a pressure reducing/relieving mattress is in place on the bed, observe for wound complications and call medical doctor (MD) with any changes.<br><br>R2's admission Minimum Data Set (MDS) dated [DATE] identified R2 was cognitively intact, had a diagnosis of osteomyelitis and sepsis, required substantial to maximal assist with toileting and required IV medications.<br><br>During an observation on 9/17/24 at 8:49 a.m., upon entrance to R2's room on the inside of the door an orange paper sign was taped to the inside of R2's door, and a white cart with drawers was to the right entrance of the room. Two red colored, STOP signs noted at the top on either side. Signage read: ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following activities. Dressing, Bathing/Showering, Transferring, Changing linens, Providing Hygiene, Changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. The sign also had color pictures of hand cleanser, gloves, and gown.<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 |
|---|---|---|---|
| | 245632 | A. Building<br>B. Wing | 09/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 9/17/24 at 8:51 a.m., nursing assistant (NA)-A and nurse practitioner (NP)-A were on either side of R2's bed rolling him to the side while changing his wet brief, NA-A and NP-A had gloves on but did not have a gown on. After changing R2's brief, NA-A with the same gloves got a pillow and put it behind R2's head, then NA-A and NP-A boosted R2 up in bed. NA-A went to R2's bathroom and removed her gloves and did not perform hand hygiene. R2 asked NA-A for his dentures in the top drawer of his nightstand, NA-A put a new pair of gloves on, rinsed the dentures in the sink and handed R2 his dentures. R2 put his dentures in his mouth. NA-A removed her gloves and threw them in the trash in R2's bathroom, picked up the trash bag, tied it in a knot and walked out of R2's room without performing hand hygiene.<br><br>During interview on 9/17/24 at 8:55 a.m., NA-A stated she thought you only had to use EBP with wound care and verified she did not wash her hands after removing her dirty gloves and stated she should have.<br><br>During an interview on 9/17/24 at 11:20 a.m., registered nurse (RN)-B stated anyone with a PICC line, surgical wound or pressure ulcer all staff should be using EBP's with toileting assist to help prevent the spread of infection. EBP would include the use of gowns and gloves. All staff should be performing hand hygiene before and after resident cares.<br><br>During an interview on 9/17/24 at 11:24 a.m., director of nursing (DON) stated anyone with a PICC line, surgical wound or pressure ulcer all staff should be using EBP's with toileting assist to help prevent the spread of infection. EBP would include the use of gowns and gloves. All residents with EBP have a sign clearly posted on the door of their room and staff should be looking for that and following the policy for EBP to help prevent the spread of infection. All staff should be utilizing hand hygiene before and after resident cares.<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 | Facility policy, Enhance Barrier Precautions, dated July 2024 identified it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug resistant organisms. Definitions: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and gloves use during high contact resident activities. Policy explanation and Compliance Guidelines: 1. Prompt recognition of need: a. all staff receive training on enhance barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. B. all staff receive training on high-risk activities and common organisms that require enhanced barrier precautions. C. the facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which resident require the use of EBP prior to providing high contact care activities. 2. Initiation of Enhance Barrier Precautions: a. the facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC but may be considered epidemiologically important. b. an order for enhanced barrier precautions will be obtained for residents with any of the following: i. wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO .3. Implementation of Enhance Barrier precautions: a. make gowns and gloves immediately near or outside of the residents room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the residents room. c. ensures alcohol-based hand rub in every resident room ideally both inside and outside the room. d. position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to the exit of the room or before providing care to another resident in the same room. e. The infection preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. F. provide education to residents and visitors .4. High-contact resident care activities include a. dressing .d. providing hygiene .f. changing briefs or assisting with toileting .10. Enhance barrier precautions should be used for the duration of the affected residents stay in the facility until the resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.<br><br>Facility policy, Hand Hygiene, dated September 2023 identified all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Definitions: hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of antiseptic hand rub, also known as alcohol-based hand rub (ABHR). 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice . |