| 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 | 05/23/2024 |

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

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>42586<br><br>Based on observation, interview, and document review, the facility failed to ensure a self-administration of medications (SAM) assessment was completed to allow residents to safely administer their own medications for 2 of 2 residents (R15, R360) observed with medications at bedside.<br><br>Findings include:<br><br>R15's annual Minimum Data Set (MDS) 2/13/24, indicated R15 had severely impaired cognition, diagnosis of Alzheimer's disease, and was dependent on staff for most activities of daily living (ADL) and mobility.<br><br>R15's physician's orders dated 4/16/24, indicated Menthol-Zinc Oxide external ointment 0.44-20.6 % (Menthol-Zinc Oxide). Apply to buttocks topically every 12 hours as needed for irritation and apply to left buttock topically four times a day for skin excoriation for 5 Days.<br><br>R15's physician's orders lacked an order for self administration of medications.<br><br>R15's SAM dated 5/9/23, indicated R15 did not wish to administer her own medications.<br><br>During an observation on 5/20/24 at 1:10 p.m., R15 was sitting in her wheelchair in her room and there was a container of Hydroseptine (Menthol-Zinc Oxide) external ointment on the nightstand.<br><br>During observation and interview on 5/20/24 at 1:49 p.m., trained medication assistant (TMA)-A verified R15 had Menthol-Zinc Oxide medication in her room and stated R15 was unable to administer her own medications and it should not left in her room. TMA-A further stated in order for residents to adminster their own medications and/or keep them at bedside, they would need a doctor's order and wasn't sure if a SAM assessment needed to be completed.<br><br>During interview on 5/20/24 at 1:56 p.m., the clinical coordinator stated in order for residents to administer their own medications, they need to have a SAM assessment and a doctor's orders. The clinical coordinator further stated R15 was not able to administer her own medications and medications should not have been left in her room.<br><br>44647<br><br>R360's face sheet printed 5/22/24, indicated R360 was recently admitted .<br><br>(continued on next page) |



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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R360's diagnoses list printed 5/22/24, indicated R360 had a diagnosis of a traumatic subdural hematoma (head bleed) and Parkinson's disease (neurological disorder).<br><br>R360's provider order dated 5/15/24, indicated R360 required Carbidopa-Levodopa 25-100 milligrams (mg) three times a day for Parkinson's disease. Furthermore, R360's orders lacked a provider order to self-administer medication.<br><br>R360's medical record lacked evidence an assessment for resident self-administration of medications was completed.<br><br>An observation on 5/20/24 at 2:21 p.m., R320 was in her room laying in bed. On the bedside table was a pill cup with one and a half pills inside. R360 stated those were her Parkinson's medications and need to two hours after lunch. R320 further stated they brought them in and since it was too early to take, they left them for me to take later.<br><br>When interviewed on 5/20/24, at 2:29 p.m., licensed practical nurse (LPN)-B verified there was not a self-medication assessment completed for R360. LPN-B R320 did not eat lunch until later so when LPN-B brought in the medications R320 did not want them. LPN-B further stated the medications shouldn't have been left in the room.<br><br>During interview on 5/23/24 at 10:12 a.m., the nurse manager registered nurse (RN)-A stated in order for residents to administer their own medications, they need to have a SAM assessment and a doctor's order, and even if they have both of those things, the nurses shouldn't leave medications in their rooms/at bedside.<br><br>During an interview on 5/23/24 at 10:26 a.m., the director of nursing (DON) stated in order for residents to administer their own medications, they would need a doctor's order and an assessment. If they don't have those things, medications should not be kept at bedside because the resident may not administer it correctly (according to the orders).<br><br>A facility policy titled Resident Self-Administration of Medications dated 4/1/22, directed staff to determine if self-administration was clinically approporiate for the resident and document the findings on the Medication Self-Administration Assessment form. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39988<br><br>Based on observation, interview, and document review the facility failed to ensure a person-centered comprehensive care plan was developed for 3 of 14 residents (R103,R304, R355) reviewed.<br><br>Findings include:<br><br>R103's May 2024, admission orders identified L5 compression fracture and to wear TLSO brace when head of bed was greater than 30 degrees or when out of bed.<br><br>R103's admission Minimum Data Set (MDS) assessment identified R103's cognition was intact, he had no behaviors, used a wheelchair for mobility, he needed substantial assistance for transfers, toileting, and bed mobility. R103 was independent with eating and oral cares. R103 was incontinent of bowel and bladder. R103 was on a scheduled pain medication and had as needed pain medication available. He had history of a fall prior to admission that resulted in a fracture. He took hypoglycemic medication and opioid medication for pain. He was working with occupational and physical therapies and planned to return to the community.<br><br>R103's May 2024, administration and treatment record identified an order to update Thoraco-Lumbo-Sacral Orthosis (TLSO) spinal brace company, as R103 reported multiple areas where brace hurt to see if they could come out to assess. The record identified that staff charted 18 times from 5/10/24 through 5/22/24, that was completed. The record had no indication that the TLSO brace was to be worn when R103 was up greater than 30 degrees or out of bed. The record identified diagnoses of traumatic shock, acute kidney failure, osteoarthritis, hypertension, rhabdomyolysis, and wedge compression fracture of fifth lumbar vertebra.<br><br>R103's 5/16/24, care plan identified fifth lumbar vertebra fracture and left shoulder joint dislocation. R103 required 2 staff and extensive assistance with bed mobility. Neurosurgical restrictions were not to lift/push/pull over 5-10 pounds, no repetitive bending, twisting, or activities. Non-weight bearing to left shoulder, no active or passive range of motion to left upper extremity. R103 was to wear a sling always to left upper extremity, may remove for cares and therapy. There was no mention of the TLSO brace or when it should be worn, or how to apply the brace.<br><br>Interview on 5/20/24 at 6:11 p.m., with R103 who reported he had a back brace that he was to have on when he was up out of bed. He reported that the staff don't know how to put the brace on and that just this morning the staff had put the brace on wrong and the nurse had to fix it for me.<br><br>Interview on 5/21/24 at 12:25 p.m., with nursing assistant (NA)-B identified the nurse or therapy will give instructions on how to use a brace if a resident has one. She reported she would have to ask someone as she had never been shown how to put the TLSO brace on and she has not put the TLSO brace on R103 ever.<br><br>Interview on 5/21/24 at 12:37 p.m., with R103 who identified the staff put on his brace upside down this morning. He reported therapy even labeled the brace front and back with arrows and they still put it on upside down.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 5/21/24 at 12:52 p.m., with physical therapist (PT)-B and certified occupational therapy assistant (COTA)-D identified R103's brace was labeled, the edges are all soft, and the brace needed to be put on while R103 was laying down. PT-B reported the brace was a challenge to put on and she herself had it on wrong the first time so that was why they labeled it. COTA-D reported therapy initially trained some nursing staff, and they were to train each other from there. COTA-D revealed they had not provided any written instructions for the staff on the TLSO brace.<br><br>Interview on 5/22/24 at 7:04 a.m., with registered nurse (RN)-A nurse manager identified if a nursing assistant did not know how to apply the TLSO brace they were to ask the nurse on duty. He reported that therapy trained the staff on how to apply a brace like that. RN-A confirmed there was no instruction for when R103 was to wear the TLSO brace or how to don or doff the brace on the care plan or the staff Kardex. He stated, we must have missed placing that on the care plan he confirmed that information should be on the care plan.<br><br>Observation and interview on 5/22/24 at 7:06 a.m., with (RN)-D and (NA)-C who assisted R103 to don his TLSO brace. RN-D directed R103 to roll onto his side, he declined and stated he wanted to put the brace on while sitting on the edge of the bed. RN-D honored his wish and assisted him to sit up on the edge of the bed, while NA-C provided support from the other side of the bed. RN-D directed NA-C on how to apply the brace. NA-C reported she was unaware of any instruction on how to apply the TLSO brace and that was why RN-D was assisting. Observation of R103's room found no instruction on donning or doffing the TLSO brace and when it should be applied and when it was ok for R103 to not wear.<br><br>R103's 5/17/24, occupational therapy note identified communication had been sent out to the nursing staff to reiterate TLSO guidelines (brace needed to be donned when head of bed was greater than 30 degrees).<br><br>R103's 5/20/24, progress note identified occupational therapy was notified by floor nurse and nursing assistant about incorrect positioning on back portion of R103's brace. Education was provided on correct orientation of the brace and recommended everyone to be using the written word front and back with arrow pointing in correct orientation as a visual reminder of how to apply the TLSO brace.<br><br>Interview on 5/22/24 at 10:07 a.m., with the director of therapy identified the therapy department verbally educated nursing staff on the TLSO brace. She reported they did not have any written instruction that they provided to the nursing staff.<br><br>Interview on 5/22/24 at 1:44 p.m., with director of nursing (DON) identified her expectation was that the care plan would reflect how to care for the resident including when and how to don and doff the TLSO brace and any special instructions related to applying the TLSO brace.<br><br>42586<br><br>R304's admission Minimum Data Set (MDS) dated [DATE], indicated R304 had intact cognition and a diagnosis of Multiple Sclerosis. It further indicated R304 had lower extremity impairment, used a wheelchair, and required substantial/maximal assistance with mobility.<br><br>R304's kardex dated 5/23/24, indicated staff will follow treatment plan as prescribed by the provider and keep resident well informed of the plan of care.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During observation and interview on 5/20/24 at 2:24 p.m., R304 stated he received therapy 5 times a week but he never knew what time of day they were coming and would like to. R304's white board (in his room) lacked any indication of when therapy was coming.<br><br>During interview on 5/21/24 at 2:00 p.m., registered nurse (RN)-B stated the therapy department made the schedule the night before and then gave it to the nursing staff by midnight for the following day. Then the nursing staff were responsible for letting the residents know what time therapy was coming by writing it on the white board in each residents room.<br><br>During observation on 5/21/24 at 1:46 p.m., R304's white board indicated the date and the name of the nurse who was providing care to him that shift. It lacked any indication of the therapy schedule.<br><br>During observation on 5/22/24 at 8:48 a.m., R304's white board did not have any therapy times written on it. It had yesterday's date (5/21/24) and the name of the nurse from the previous day written on it.<br><br>During observation on 5/23/24 at 9:54 a.m., R304's white board did not have any therapy times written on it. It had yesterday's date (5/21/24) and the name of the nurse from the previous day written on it.<br><br>During an interview on 5/23/24 at 10:04 a.m., RN-C verified R304's therapy schedule was not written on the whiteboard in his room. RN-C further stated once nursing staff received the therapy schedule for the day, it was their responsibility to let the residents know what time their therapy appointments were scheduled by writing it on the white board in each residents room.<br><br>During interview on 5/23/24 at 10:12 a.m., the nurse manager RN-A stated each day therapy prints out the schedule in the morning and bring it to the nursing station. Then the nurses were responsible for letting the residents know by telling them when therapy was coming or by writing it on the white board in each resident's room.<br><br>During interview on 5/22/24 at 8:45 a.m., the physical therapist (PT)-A stated nursing was provided with the daily schedule and were then responsible for letting the residents know when therapy was coming by either telling them or writing it on the whiteboard in their room.<br><br>During an interview on 5/22/24 at 12:53 p.m., the director of therapy stated she had the schedule completed by 8:00 p.m. the night before, for the followoing day. Then either the overnight or day shift nurse was responsibloe to print the schedule and let each resident know by telling them or writing it on each residents white board.<br><br>During interview on 5/23/24 at 10:26 a.m., the administrator stated therapy was responsible for giving the nursing staff the schedule each day and then the nursing staff was responsible for letting each resident know when therapy was coming by telling them or writing it on each residents white board. They encourage the nursing staff to write it on the white board and soemtimes therapy will let the resident know but the expectation is to let the resident know when therapy is scheduled to be there.<br><br>44647<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R355's admission MDS dated [DATE], indicated R355 had sever cognitive impairment and diagnoses of a hip fracture and spine fractures.<br><br>R355's care plan dated 5/5/24, lacked indication R355 required a back brace.<br><br>R355's Kardex dated 5/5/24, lacked indication R355 required a back brace.<br><br>R355's provider order dated 5/5/24, directed staff to have brace on when elevated above 30 degrees or up and active.<br><br>An observation on 5/21/24 at 1:23 p.m., nursing assistant (NA)-B entered R355's room to assist him back to bed. R355 was sitting in the wheelchair with a black brace that went around his torso with straps over the shoulders. After NA-B was assisted back to bed, NA-B assisted R355 to remove the back brace.<br><br>When interviewed on 5/21/24 at 1:55 p.m., NA-B- stated R355 had a back brace for when R355 was out of bed. NA-B wasn't sure why the brace was needed and stated rule of thumb for back braces was for them to be on when out of bed and to be removed when residents were in bed. NA-B stated nurses need to let us know if there were different instructions. NA-B stated sometimes information was included on the Kardex, but that had to be manually entered and usually they just had the tasks to document.<br><br>When interviewed on 5/23/24 at 9:05 a.m., RN-A stated when residents were admitted with a back brace, the order would be placed and the care plan and Kardex were updated with any information or instructions. RN-A verified R255's brace instructions was missed and had not been placed on the care plan or Kardex. RN-A further verified Nas did not have access to the orders and having the brace information on the care plan and Kardex was important to ensure all staff had the information.<br><br>Review of the August 2020, Version 1, Anterior/Posterior TLSO: Guidelines, Patient and Carer Information Booklet, located at https://www.nslhd.health.nsw.gov.au/Services/Documents/SDDocs/OrthoRNSH-NS12359-E.pdf, Identified the purpose of the TLSO brace was to immobilize your spine during healing, stabilizes and restricted movement of injured area, controlled pain by restricting movement following spinal injury or surgery. The guide included how to put the brace on and take off. The guide instructions included to apply the brace while lying down by log roll onto your side with assistance. When applying the brace, the assistant was to use a scooping action and press down on the bed, and ensure the brace was even to minimize rotation/twisting when putting the brace on and off. Once the brace was in place, the person could roll back to their back. The assistant should ensure that the front piece of the brace was tucked into the back piece of the brace before fastening the Velcro straps starting with the center ones and tighten evenly side to side as firm as the person can tolerate. To remove the brace the person should be lying on their back and undo all the Velcro straps, remove the front section and then log roll to side and the assistant can remove the back section. The guide gave multiple other instruction to help with healing.<br><br>Review of 4/1/22, Comprehensive Care Plan policy identified the facility would develop a person-centered care plan for each resident to ensure the residents needs are met. The care plan should describe services that will be provided, any specialized services, discharge plan, and resident specific interventions to care for the resident. The care plan would be reviewed and revised quarterly and as needed. Qualified staff responsible for implementing interventions would be notified of their role of implementation of the interventions as identified on the care plan and when changes are made. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647<br><br>Based on observation, interview and record review the facility failed to ensure weekly wound assessments were completed to monitor wound healing and evaluate the residents response to interventions for 1 of 1 residents (R30) reviewed for non- pressure related wounds.<br><br>Findings include:<br><br>R30's admission Minimum Data Set (MDS) dated [DATE], indicated R30 was cognitively intact required dressing changes for a diabetic foot wound and had diagnoses of diabetes and a chronic right foot ulcer.<br><br>R30's skin care area assessment dated [DATE], indicated R30 had debridement of the right foot wound and had a wound vacuum dressing in place.<br><br>R30's care plan dated 4/10/24, indicated R30 had skin impairment related to diabetes and recent surgery of a right foot wound. Interventions included encouraging proper nutrition, apply lotion to dry areas and negative pressure wound therapy that included dressing changes on Monday, Wednesday, and Friday.<br><br>R30's provider order dated 5/20/24, directed staff to change the right foot negative pressure dressing every Monday, Wednesday, and Friday. R30's provider orders lacked indication R30 required wound assessment or monitoring.<br><br>R30's medical record lacked evidence of R30's right foot wound had been assessed or measurements had been obtained since admission to the facility.<br><br>R30's medical record showed R30 had appointments with a vascular provider on 5/8/24, 4/25/24, and 4/11/24, however R30's medical record lacked provider progress notes or other indication of the status of R30's wound healing.<br><br>R30's right foot wound assessments were requested however was not provided.<br><br>An observation on 5/20/24 at 1:02 p.m., R30 was sitting in the wheelchair in his room. R30's right foot had a black boot on it and had a wound vacuum dressing and machine attached to it. R30 stated the wound was slow to improve.<br><br>When interviewed on 5/22/24 at 9:28 a.m., licensed practical nurse (LPN)-A stated R30's wound was changed three times a week. LPN-A verified there were no wound assessments or measurements completed by the facility. LPN-A stated R30's wound was followed by an outside provider and the wound team only assessed residents who were not followed for wound cares by an outside provider.<br><br>When interviewed on 5/22/24 at 1:20 a.m., the Director of Nursing (DON) stated they were aware of only documentation of R30's dressing change and was not aware of any wound assessments.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | When interviewed on 5/22/24, at 2:52 p.m., the vascular clinic registered nurse (RN)-K verified R30 was followed for wound management through the vascular clinic and was seen every 2-3 weeks. RN-K stated the clinic expected measurements and assessments of R30's wound to be done at the facility to ensure there were no changes in size or signs of infection.<br><br>When interviewed on 5/23/24 at 8:53 a.m., registered nurse (RN)-A stated wound assessments were completed upon admission and weekly. More complicated wounds who were followed by an outside provider were not assessed by the facility. Treatment orders were managed by the outside provider and staff followed those orders. RN-A stated R30's dressing was changed three times a week and nurses knew to look for signs of infection and ensure the wound vacuum dressing was functioning, but measurements were not taken. RN-A acknowledged there was no documentation of how the wound appeared, measurements, signs of infection, odor, or drainage for R30's wound as this was done by the provider following for the wound.<br><br>When interviewed on 5/23/24 at 10:27 a.m., the Director of Nursing (DON) expected staff to assess wounds during the treatment of any wounds that were followed by an outside provider. DON further expected to receive documentation of the outside provider's assessments of the wounds. This was important to ensure staff know when changes have occurred and providers need to be updated or understand improvement of the wound.<br><br>A facility policy titled Documentation of Wound Treatments dated 1/2023, directed staff to complete wound assessments upon admission, weekly, and as needed. Furthermore, the policy directs the following elements to be documented; type, measurements, and wound characteristics. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885<br><br>Based on observation, interview, and document review, the facility failed to ensure range of motion (ROM) exercises and a left hand splint was applied as ordered for 1 of 1 resident (R16) reviewed for range of motion.<br><br>Findings include:<br><br>R16's care area assessment (CAA) dated 9/6/23, indicated R16 refused cares one time during a seven day look back period and was usually very cooperative with cares and did not refuse. Additionally, R16's CAA indicated R16 was admitted to the facility with left sided hemiparesis (weakness) from an old stroke and required assistance with activities of daily living (ADLs) and R16 was at risk of complications of immobility such as contractures (a permanent tightening of the muscles).<br><br>R16's modified quarterly Minimum Data Set, dated dated dated [DATE], indicated intact cognition, did not reject care, had upper and lower extremity range of motion limitations on one side of the body, and was dependent on staff for upper and lower body dressing, and personal hygiene.<br><br>R16's Optional State Assessment (OSA) dated 3/7/24, indicated R16 required extensive assistance with bed mobility, transfers, and toileting.<br><br>R16's Medical Diagnosis form indicated the following diagnoses: hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non dominant side, major depressive disorder, muscle weakness, other chronic pain.<br><br>R16's care sheet indicated R16 had a left arm brace that was to be on every a.m., and off at bedtime, required daily range of motion before supper to the left arm and shoulder and further indicated to see the handouts attached to the wall in R16's room.<br><br>R16's care plan dated 8/31/24, indicated R16 had pain related to arthritis and stroke and had the following interventions: staff will assist with providing range of motion (ROM) to left arm and shoulder, printed handouts from therapy in R16's room and staff to assist to place left arm brace on every morning for comfort and remove at bedtime.<br><br>R16's care plan dated 8/31/23, indicated R16 required assist of one person with dressing, due to left sided hemiparesis.<br><br>R16's physician orders indicated the following orders:<br><br>4/16/24, and discontinued on 4/26/24, staff will assist with providing ROM to the left arm and shoulder and lower extremities. Printed handouts from therapy in the room. R16 has a visual pain chart in his room, please place on R16's lap during ROM. R16 can point to the number/pain face if pain gets too bad.<br><br>(continued on next page) |

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| | 245632 | A. Building<br>B. Wing | 05/23/2024 |

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

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 4/26/24, and discontinued on 5/22/24, staff will assist with providing ROM to left arm and shoulder. Printed handouts from therapy in R16's room. R16 has a visual pain chart in his room, please place on R16's lap during ROM. R16 can point to the number/pain face if pain gets too bad one time a day.<br><br>5/23/24, staff will assist with providing ROM to left arm and shoulder and apply left lower extremity stretching strap to AFO for 15 minutes daily. Printed handouts from therapy in room. R16 has a visual pain chart in his room, please place on my lap during ROM. R16 can point to the number/pain face if pain gets too bad one time a day.<br><br>R16's nursing assistant (NA) 30 day look back task from 4/26/24, through 5/19/24, with the intervention, Staff will assist with providing ROM to left arm/shoulder. Printed handouts from therapy in room. I have a visual pain chart in my room, please place on my lap during ROM. I can point to the number/pain face if pain gets to (sic) bad. lacked documentation ROM was completed on 5/11/24, 5/12/24, 5/14/24, 5/15/24, 5/16/24, and 5/17/24.<br><br>R16's medication administration record (MAR) and treatment administration record (TAR) dated May 2024, indicated ROM was marked as completed 21 times.<br><br>R16's Progress notes dated 4/22/24, indicated ROM to the left arm and shoulder and lower extremities were not completed because staff were not able to get to it.<br><br>During interview and observation on 5/20/24 at 12:39 p.m., R16's room had signage on the wall for ROM. R16 stated staff were supposed to help with ROM, but staff don't perform the ROM. R16 had an AFO (ankle-foot orthoses brace) on his left leg and a hand brace was located on R16's desk, was not on R16 and was out of R16's reach. R16 stated he forgot to tell staff to apply the left hand splint.<br><br>During interview and observation on 5/21/24 at 12:38 p.m., R16 stated he had not had ROM to his extremities. R16's AFO was in place on his left leg, however, the left hand brace was located on his desk and was not on R16's left hand.<br><br>During interview on 5/21/24 at 1:25 p.m., nursing assistant (NA)-D stated they looked at the care plan to know what cares a resident required. NA-D stated if a resident refused cares, they were reapproached three times before they documented a refusal and notified the nurse. NA-D further stated R16 required assist with transferring, toileting, showering and setting up meals. NA-D further stated R16 asked for the hand splint to be applied and stated sometimes he wanted it applied and sometimes he wanted to skip it. R16 asked for the splint to be applied.<br><br>During observation on 5/21/24 at 2:22 p.m., NA-D removed the left hand splint and performed ROM to the left wrist and at 2:24 p.m., NA-D left the room and did not offer to reapply the hand splint after it was removed for ROM.<br><br>During interview on 5/21/24 at 2:25 p.m., R16 stated he has to ask for the splint to be applied and stated staff did not offer to apply the left hand splint that a.m., but R16 wanted to have the hand splint placed to prevent his fingers from curling.<br><br>During interview on 5/21/24 at 2:26 p.m., family member (FM)-A stated it was infrequent that R16 received ROM every day.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During observation on 5/21/24 between 2:45 p.m., and 3:00 p.m., NA-E went into R16's room and completed ROM after R16 stated the surveyor wanted to see ROM. NA-E finished ROM at 2:54 p.m., and at 2:58 p.m., left R16's room. At 3:00 p.m., R16 still had the left hand splint located on the bed.<br><br>During interview and observation on 5/21/24 at 3:23 p.m., R16's left hand splint was still located on the bed and R16 stated he wanted it to be applied.<br><br>During interview on 5/21/24 at 3:35 p.m., registered nurse (RN)-E stated they looked to the care plan to know what kind of cares a resident required. If a resident refused cares they reapproached and if a resident continued to refuse, a refusal was documented in the electronic medical record. RN-E stated R16's hand and leg brace was used because R16 had weakness and the hand splint was used to prevent R16's fingers from digging into his skin and expected the left arm brace to be on in the a.m., and expected staff follow the care plan and staff should explain why R16 needed the hand splint and offer the splint because some residents may not remember to ask for it. RN-E further stated R16 at times was forgetful. RN-E further stated R16 was able to report if he did not receive ROM and further stated sometimes staff overlooked the care plan.<br><br>During interview on 5/21/24 at 3:25 p.m., NA-E stated he looked at the care plan to know what cares a resident required. NA-E stated R16 did not refuse cares, and verified R16's brace was located on the bed and verified the left hand brace should be on in the a.m., and off at bedtime.<br><br>During interview on 5/22/24 at 1:41 p.m., licensed practical nurse (LPN) clinical coordinator (CC)-A stated she expected staff to follow the care plan and care sheet, and stated R16 sometimes wanted to leave the left hand splint off for a while after ROM, but expected staff to offer to apply the left hand brace. CC-A further stated it was reported to her that R16 had not always received ROM and has had many conversations with staff and stated the NA's reported they did not have time to complete the ROM. CC-A further stated R16's cares were time consuming. CC-A stated she tried to isolate if it was just one person not performing ROM, but it did not seem to be the case. CC-A stated R16 had a stroke and had paralysis and pain and did not want R16 to become contracted and needed the support of the braces to have the highest quality of life and decreased pain.<br><br>During interview on 5/23/24 at 9:52 a.m., physical therapist assistant (PTA)-E stated physical therapy (PT) set up ROM for R16 who had hemiplegia and hemiparesis after a stroke that affected his left non dominant side. PT saw R16 on 5/6/24, 5/8/24, and 5/13/24. PTA-E stated she hoped staff would complete ROM to maintain R16's optimal ROM in order to carry out his activities of daily living (ADLs) and remain pain free and expected staff to donn the left hand splint because it was important to maintain his ROM.<br><br>During interview on 5/23/24 at 10:26 a.m., the director of nursing (DON) stated she expected staff follow instructions with applying splints and completing ROM and expected staff to follow the care plan and care sheets.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A policy, Prevention of Decline in Range of Motion, dated 4/1/22, indicated the facility in collaboration with the medical director, director of nurses and as appropriate, physical, occupational consultant shall establish and utilize a systematic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventive care. The facility will provide treatment and care in accordance with professional standards of practice. This includes, but is not limited to appropriate services, appropriate equipment such as braces or splints. A nurse with responsibility for the resident will monitor for consistent implementation of the care plan interventions. Refusals of care or problems associated with range of motion exercises will be documented in the medical record. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586<br><br>Based on observation, interview, and document review the facility failed to ensure residents oxygen was adminstered according to doctor's orders for 1 of 1 resident (R305) reviewed for respiratory therapy.<br><br>Findings include:<br><br>R305's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition and a diagnosis of chronic obstuctive pulmonary disease (COPD).<br><br>R305's physician's order lacked a doctor's order for oxygen.<br><br>R305's care plan dated 5/15/24, indicated R305 had difficulty breathing at times due to COPD with an intervention of continuous oxygen via nasal cannula set at 2 lpm.<br><br>During observation and interview on 5/20/24 at 2:49 p.m., R305 was sitting in her room with continuous oxygen via nasal cannula. She stated her oxygen was supposed to be set at 2.0 liters per minute (LPM) but surveyor observed it was set at 2.5 LPM. R305 stated she had not been short of breath.<br><br>During interview on 5/21/24 at 1:32 p.m., registered nurse (RN)-B verified R305 had a physician's order for oxygen in her hard chart/paper chart but it had never been put in the computer or medication administration record (MAR) and should have been. RN-B further verified the physicians order indicated oxygen 2.0 LPM via nasal cannula continuous-no weaning due to chronic obstructive pulmunary disease (COPD), every shift. RN-B stated the nurses would not have known how many LPM of oxygen R305 should have or if they should be attempting to wean her off of it since the orders were not in the MAR. Nurses were responsible for checking the LPM of oxygen the resident was being administered each shift.<br><br>During an observation and interview on 5/22/24 at approximately 9:30 p.m.,the nurse manager RN-A verified R305's oxygen was set at 2.5 LPM and it should have been set at 2.0 LPM. RN-A stated the expectation was for the nurses to be checking the lpm each shift.<br><br>During observation and interview on 5/23/24 at 9:52 a.m., licensed practical nurse (LPN)-C verified R305's oxygen was set at 2.5 LPM and stated it should have been set at 2.0 LPM. If a resident was short of breath and required oxygen to be increased, the process would be to increase the oxygen, notify the doctor, and document it in the progress notes.<br><br>During interview on 5/23/24 at 10:26 a.m., the director of nursing (DON) stated the nurses were responsible for checking the lpm of oxygen the resident was receiving was correct when compared with the physician's orders and it should be checked each shift. She further stated if the lpm of oxygen needed to be changed, the nurse should reach out to the physician and document it. If a resident was receiving the wrong amount of oxygen, some of the adverse effects could be shortness of breath and/or low oxygen saturations.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A facility policy regarding oxygen administration was requested and received, however it did not address checking the LPM of oxygen each shift. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>44647<br><br>Based on observation, interview and record review the facility failed to ensure 1 of 1 residents (R360) colonized with a multidrug resistant organism (MRDO) was placed on enhanced barrier precautions (EBP). This had the potential to impact all residents who reside in the facility. Furthermore, the facility failed to ensure proper hand hygiene and glove use was utilized for 1 of 1 residents (R360) observed during personal cares.<br><br>Findings include:<br><br>R360's face sheet printed 5/22/24, indicated R360 was recently admitted and had a diagnosis of a traumatic subdural hematoma (head bleed).<br><br>R360's care plan dated 5/15/24, indicated R360 required assist of one for toileting and had occasional incontinence.<br><br>R360's nursing and provider orders reviewed on 5/20/24, lacked indication R360 required EBP.<br><br>R360's hospital history and physical dated 5/12/24, indicated R360 had recurrent urinary tract infections (UTI) and UTI due to the MDRO extended-spectrum-beta lactamase (ESBL).<br><br>R359's face sheet printed 5/22/24, indicated R359 was recently admitted and had a diagnosis of dementia.<br><br>R359's care plan dated 5/15/24, indicated R359 was assist of one for toileting and used the toilet.<br><br>An observation on 5/20/24 at 2:22 p.m., R360's room was entered. Upon entering the main room door there were two doors straight ahead to then access R360's room and R359's room. To the left side was a bathroom shared by R360 and R359. R360's main room door and inside door had no sign or cart indicating EBP was required.<br><br>When interviewed on 5/22/24 at 8:33 a.m., R360 stated staff had not been wearing gowns or gloves when providing care. R360 stated she was able to use the bathroom and wore a brief as she did not always make it in time. R360 verified staff assisted her in changing her brief when needed. R360 further stated they had a history of frequent UTIs and had a bacteria in her system that apparently could be transferred by coming in contact with their urine.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An observation on 5/22/24 at 12:56 p.m., R360's main room door and inside room door had no sign or cart indicating EBP was required. NA-A entered R360's room without performing hand hygiene. R360 was sitting on their bed and asked NA-A for assistance to the bathroom. After placing a transfer belt on R360 and obtaining R360's walker, NA-A assisted R360 to walk into the bathroom. Once R360 was standing in front of the toilet, NA-A obtained gloves that were near the bathroom sink. NA-A attempted to don gloves but could not fit them over their hands. NA-A stated, these are too small and not my size. Without gloves, NA-A then assisted R360 in lowering their pants and wet brief. R360 then sat down on the toilet. Without hand hygiene, NA-A left R360's room to a supply closet down the hall and obtained a box of gloves. NA-A then re-entered R360's room and without performing hand hygiene donned gloves but no gown. NA-A removed the wet brief and placed in the bathroom garbage. Without glove exchange or hand hygiene NA-A removed R360's pants from around their ankles and hung them on the walker. NA-A then obtained a clean brief and assisted R360 to first place the brief around their lower legs and followed with the pants. NA-A then removed gloves performed hand hygiene and exited R360's room. At 1:04 p.m., NA-A entered R360's bathroom, performed hand hygiene and donned gloves but no gown. R360 was assisted to stand with the walker and NA-A then obtained wipes to provide perianal care for R360. Without glove exchange or hand hygiene, NA-A assisted R360 in pulling up the brief and pants. R360 was assisted over to the sink to wash hands. NA-A then took the garbage with the wet brief and tied it closed removed and placed on the bathroom floor. Still without hand hygiene or glove exchange, NA-A assisted R360 back to sit on their bed. NA-A moved R360's wheelchair out of the way, adjusted R360's pillows and removed R360's transfer belt before assisting with R360's legs to lay down in bed. Still without hand hygiene or glove removal, NA-A moved the walker out of the way, placed a bed railing in the up position and moved R360's bedside table near the bed. NA-A then took R360's cell phone and handed it to them and placed the call light within reach. NA-A then removed gloves and performed hand hygiene before obtaining tied garbage and exiting R360's room.<br><br>When interviewed on 5/22/24 at 1:14 p.m., NA-A any resident who was in EBP would have a sign and cart outside of their room. NA-A verified R360 had no sign and was not on EBP. NA-A stated hand hygiene needed to be completed when entering and exiting a resident room and verified they had not performed hand hygiene with each entrance and exit of R360's room. NA-A further stated gloves should have been worn before assisting with R360's brief however the correct size was not in R360's bathroom. NA-A verified they had not exchanged gloves after providing personal cares for R360 as there was only urine incontinence. NA-A stated it was dependent on the situation when or if glove removal was needed during personal cares. If the gloves were not soiled during the cares, they did not need to be exchanged. NA-A further stated since R360's brief was only wet and had no bowel movement, it was ok to use the same gloves for all assistance until leaving the room. NA-A further stated if there was bowel movement then the gloves would be exchanged.<br><br>When interviewed on 5/22/24 at 2:02 p.m., the infection preventionist (IP) stated upon admission, the information sent from the hospital was reviewed to determine if EBP was needed. The admission coordinator looked at discharge orders, diagnosis, history and physical. Any resident with a drain, catheter, wounds or colonized MDRO required EBP. IP verified R360's hospital history and physical indicated R360 had history of urinary tract infection due to ESBL. IP stated this was a miss and R360 should have been placed on EBP due the history of ESBL. IP further verified R360 should not be sharing a bathroom with R359. IP also expected staff to perform hand hygiene upon entrance and exit of resident rooms. Gloves were also required when assisting residents with toileting and personal cares. Furthermore, gloves were expected to be removed and hand hygiene performed after perianal cares or handling soiled briefs and before moving on to other resident cares. IP stated ensuring EBP and proper hand hygiene was required to minimize the risk of bacteria to be spread.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | When interviewed on 5/23/24 at 10:37 a.m., the Director of Nursing (DON) expected resident MDRO status to be reviewed during the admission process and EBP initiated upon resident arrival. DON further stated staff were expected to exchange gloves and perform hand hygiene after assisting with personal cares or when assisting with any soiled items and before moving to other cares.<br><br>A facility policy titled Enhanced Barrier Precautions dated 10/2022, directed staff to initiate EBP for colonization of any MDRO's including ESBL. The policy further directed staff to use a gown and gloves when providing high contact resident care activities including dressing, transferring, changing briefs and assisting with toileting.<br><br>A facility policy titled Hand Hygiene revised 9/2023, directed staff to perform hand hygiene before performing resident care procedures and after handling items potentiall contaminated with body fluids, secretions or excretions. |