| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265427 | A. Building<br>B. Wing | 08/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Oak Park Care Center | 6637 Berthold Avenue<br>Saint Louis, MO 63139 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681<br><br>Based on observation, interview and record review, the facility failed to ensure all residents were treated in a manner to maintain dignity when one resident's (Resident #90's) catheter bag (urine drainage bag) was visible to the hallway from the resident's room. In addition, staff fed one resident (Resident #43) while standing over the resident during a meal. The sample size was 18. The census was 85.<br><br>Review of the facility's Resident Rights policy, reviewed 4/26/23, showed:<br><br>-Policy: The facility shall treat residents with kindness, respect and dignity and ensure resident right are being followed. The resident/resident representative will be informed on their rights upon admission;<br><br>-Procedure: Employees will receive education and training on resident rights upon hire and annually;<br><br>-Resident Rights included:<br><br>-Exercise Rights;<br><br>-Respect and Dignity;<br><br>-Privacy and confidentiality.<br><br>1. Review of Resident #90's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/22/24, showed:<br><br>-Mild cognitive impairment;<br><br>-No behaviors;<br><br>-Dependent on staff for toileting and hygiene;<br><br>-Uses an indwelling urinary catheter;<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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Diagnoses included traumatic brain injury, seizures, urinary tract infection (UTI), and anxiety.<br><br>Review of the resident's care plan, initiated 7/24/24, showed:<br><br>-Focus: Requires catheterization indwelling catheter related to urinary retention;<br><br>-Goal: The resident will be/remain free from catheter-related trauma through review date;<br><br>-Interventions: The resident has an indwelling urinary catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door.<br><br>Observation on 8/8/24 at 10:48 A.M., showed the resident lay in bed on his/her back. The resident's catheter bag was halfway filled with urine and visible from the doorway upon entering the resident's room.<br><br>Observation on 8/9/24 at 5:47 A.M., showed the resident lay in bed on his/her back with his/her eyes opened. The resident's catheter bag hung on the right side of the bed, visible to the hallway. When asked if the exposed catheter bag bothered the resident, he/she nodded his/her head to indicate yes.<br><br>During an interview on 8/13/24 at 8:18 A.M., Certified Nursing Assistant (CNA) O said catheter bags should not be visible from the hallway. Catheter bags should have a privacy slip covering the bag to maintain a resident's dignity.<br><br>During an interview on 8/13/24 at 11:41 A.M., Licensed Practical Nurse (LPN) N said catheter bags should be covered and not visible from the entrance of the doorway to maintain the resident's dignity.<br><br>During an interview on 8/13/24 at 12:17 P.M., the Administrator said catheter bags should be covered and not visible from the hallway.<br><br>2. Review of Resident #43's quarterly MDS, dated [DATE], showed:<br><br>-Cognitively impaired;<br><br>-No behaviors;<br><br>-Substantial or maximal assistance with eating;<br><br>-Diagnoses included kidney disease, dementia, malnutrition, anxiety, depression, Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and asthma.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 8/8/24 at 12:18 P.M., showed the resident sat in the secured unit dining room at the table. His/Her plate of food was untouched, and the resident lay his/her head on his/her hand at the table. CNA P stood over the resident and said, try to take a bite of your food and scooped up the food on a spoon and placed it at the resident's mouth. The resident would not eat the food. CNA P sat the spoon down and assisted another resident with feeding while standing. He/She then returned to Resident #43 and attempted to spoon feed the resident a second time while standing. The resident refused to eat the food offered to him/her.<br><br>During an interview on 8/13/24 at 11:44 A.M., CNA Q said he/she should pull up a chair next to the resident to assist them in eating.<br><br>During an interview on 8/13/24 at 12:04 P.M., Registered Nurse (RN) I said staff are expected to be at eye-level when assisting residents with eating. Standing up while feeding the residents is not acceptable.<br><br>During an interview on 8/14/24 at 10:52 A.M., the Administrator and Director of Nursing (DON) said staff should be seated when feeding residents to maintain dignity.<br><br>45083 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>42247<br><br>Based on observation, interview and record review, the facility failed to follow facility policy when one resident (Resident #29) fell on the facility's transport van while returning from a doctor's appointment and staff moved the resident without a nurse physically assessing the resident or calling 911. The census was 85.<br><br>Review of the facility's Fall Management Policy, dated 2/28/23, showed:<br><br>-Definition: fall is a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object;<br><br>-Prevention/treatment: Prior to moving the resident, the charge nurse will evaluate for injury.<br><br>Review of Resident #29's annual Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 8/14/24, showed:<br><br>-Moderately impaired cognition;<br><br>-Dependent on staff for rolling left to right;<br><br>-Dependent on staff for chair/bed to chair transfer;<br><br>-Used manual wheelchair;<br><br>-Diagnoses included: diabetes and hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) or hemiparesis (slight weakness in a leg, arm, or face, it can also be paralysis on one side of the body).<br><br>Review of the resident's care plan, in use at the time of survey, showed:<br><br>-Focus: at risk for falls related to amputation, dependent on staff for transfers. On 7/4/22, found lying on left side. Complained of right hip pain;<br><br>-Goal: will not have injuries related to falls through next review;<br><br>-Interventions: Anticipate and meet my needs.<br><br>During an observation and interview on 8/12/24 at 4:30 P.M., the resident lay in bed. The resident said he/she had a fall on the van today. He/She went out for a doctor's appointment, and on the way back to the facility the pad he/she was sitting on slipped and he/she slipped out of the chair. The driver and one of the aides picked up the resident and put him/her back in the chair. The resident returned to the facility. His/Her right fourth fingernail was bleeding and they put a bandage on it.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 8/12/24 at 6:00 P.M., the Administrator said while the resident was out today at a doctor's appointment. The driver stopped at the stop sign and the resident's cushion in his/her wheelchair scooted and the resident slipped out of the wheelchair. The wheelchair did not scoot, it was secured. The resident was buckled in. Staff did not follow facility policy. They should have called a nurse to assess, or they should have called 911.<br><br>During an interview on 8/13/24 at 10:47 A.M., Transportation Specialist B said transportation Specialist A put the resident into the van and secured him/her. He/She sat in the front passenger seat. Certified Nurse Aide (CNA) K sat behind him/her and behind CNA K was the resident. On the way back to the facility, they stopped at a stop sign and he/she heard the resident say he/she was on the floor. Transportation Specialist A pulled over and he/she and CNA K tried to assist the resident back into his/her chair, but they were unable. Transportation Specialist B got out of the van to help assist the other two staff members position the resident on the mechanical lift pad and lift the resident back into the chair. The resident complained of pain in his/her right finger. The van had a first aid kit, the finger was cleaned, and a bandage was put on. The resident had no other injuries. He/She did not call the facility to notify them the resident had slipped out of his/her chair, nor did he/she call 911. He/She could not recall if anyone else called the facility.<br><br>During an interview on 8/13/24 at 12:27 P.M., Transportation Specialist A said normally the CNAs bring the residents up to the front desk and he/she will load the resident onto the van and secure the resident. The residents' wheelchairs are secured and then the residents are secured with a seat belt. The van had a shoulder strap and a waist strap. Resident #29 only used a waist strap because of his/her size. On the way back from the appointment, the van came to a stop sign and the resident slipped out of the wheelchair onto the floor. The resident slipped under the seat belt. Transportation specialist A called the Director of Nursing (DON). CNA K checked the resident. The DON asked if the resident hit his/her head. The resident would be able to tell us if he/she had hit his/her head. The resident complained of pain in his/her butt. After the DON said it was ok, all three staff used the mechanical lift pad to lift the resident up and into the wheelchair. The only injury the resident had was a chipped nail. The resident was brought back to the facility.<br><br>During an interview on 8/13/24 at 12:53 P.M., CNA K said on the way back to the facility, the resident was saying he/she felt like he/she was sliding out of his/her wheelchair. The transportation specialist pulled over and staff checked the resident and he/she was ok. The resident again said he/she was sliding and CNA K told the resident that he/she would pull the resident up when they got back to the facility. The resident did not look like he/she was sliding. When the van stopped at the stop sign, the resident slipped out of the wheelchair. CNA K said he/she tried to break the fall, but it happened so fast. The resident broke his/her fingernail. Staff cleaned it off and put a bandage on it. He/she asked the resident to raise his/her arms and wiggle his/her toes. The resident said he/she was ok. The staff put the mechanical lift pad back under the resident and all three staff members lifted the residents back into the chair. On the way back to the facility, CNA K stood in front of the resident to hold him/her because he/she was still sliding. CNA K asked transportation specialist A to drive slowly. The incident occurred about three minutes from the facility. CNA K did not know someone had to call the facility and have the nurse come to the scene to assess the resident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 8/13/24 at 1:43 P.M. the DON said Transportation Specialist A called her on her cell phone and reported the incident. She could hear the resident saying his/her butt hurt and the CNA was asking the resident to move his/her arms. The DON asked the transportation specialist if the resident hit his/her head. The resident's finger was bleeding, a bandage was put on. The DON told the transportation specialist if the resident did not hit his/her head, to get him/her up in the chair and she would assess them when they got back to the facility. The DON would expect staff to follow the same fall policy if a resident fell off site as on-site. If the resident was off site, staff should call the DON/Assistant DON and if they were within close proximity the nurse could go to the scene and assess the resident, or they could call 911 to have them come assess the resident. She would consider close proximity as within six to seven minutes of the facility. The resident quit complaining of pain. So, the DON told the transportation specialist she would assess the resident when they got to the facility. When the resident got to the facility the resident was complaining of pain in his/her right hip and started to complain of pain in his/her left hip. CNAs cannot assess residents. The CNA was not doing an assessment. The CNA was doing a wellness check, and they are allowed to do range of motion.<br><br>During an interview on 8/14/24 at 10:52 A.M., the Administrator said ideally it is best to have the resident assessed before they are moved. The resident slid down, and someone was with him/her. The potential for injury was less. The Administrator would expect for staff to follow the facility's policies and procedures. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>45083<br><br>Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with acceptable standards of practice. The facility identified four medication carts, two nurse's carts, one treatment cart, and one medication room. Of those medication storage areas, three medication carts, one nurse's cart, and one medication room was reviewed. Issues were found in one medication cart and one nurse cart. A carton of Ensure Plus nutrition shake was opened and undated. A tube of Venelex ointment (used on the skin to cover wounds) and a tube of Betamethasone cream (used to help relieve redness, itching, swelling, or other discomforts caused by certain skin conditions) were opened, undated and unlabeled. The census was 85.<br><br>Review of the facility's Medication Storage Policy, dated 11/2018, showed:<br><br>-Policy: Medications and biologicals are stored safely, securely, and properly following the manufacture's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications;<br><br>-All medications dispensed by the pharmacy are stored in the container with the pharmacy label;<br><br>-Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from the inventory, disposed according to procedures of medication disposal;<br><br>-Drugs dispensed in the manufacture's original container will be labeled with the manufacture's expiration date;<br><br>-Certain medications, including some multi-dose preparations, may require different dating<br><br>once opened per regulations/guidelines;<br><br>-The nurse will check the expiration date of each medication before administering it;<br><br>-All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner;<br><br>-Disposal of any medications prior to the expiration dating will be required if contamination or<br><br>decomposition is apparent;<br><br>-Nursing staff should consult with the dispensing pharmacist for any questions related to medication expiration dates.<br><br>1. Observation of the nurse cart for Halls 100 and 200, on 8/9/24 at 11:10 A.M., showed ;<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Venelex ointment, opened, undated and unlabeled with resident's name;<br><br>-Betamethasone cream, opened, undated and unlabeled with resident's name.<br><br>During an interview on 8/9/24 at approximately 10:00 A.M., Certified Medication Technician (CMT) J said the opened containers of medications should be dated once opened. Undated medications should be discarded.<br><br>2. Review of Ensure Plus nutrition shake manufacturer's instruction, showed once a bottle of Ensure and drinks have been opened, it should be used or refrigerated within four hours. The remaining product should be used or discarded after 48 hours.<br><br>Observation and interview on 8/12/24 at 10:24 A.M., showed the CMT medication cart for Hall 200, had a carton of Ensure Plus shake 8 ounce, opened, undated and unlabeled. The carton was half full, not refrigerated or iced and was placed in the medication cart drawer. CMT J said he/she was not aware when the shake was opened.<br><br>3. During an interview on 8/14/24 at 10:52 A.M., the Administrator and Director of Nursing (DON) said they expected the staff to follow the facility's Medication Storage Policy. The staff should always date and label the medications after opening. The Ensure Plus nutrition shake 8 oz was supposed to be for one resident and one-time use only. If a resident was unable to finish the one carton, it should be discarded. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36151<br><br>Based on observation, interview and record review, the facility failed to store food in a safe and sanitary manner to prevent potential cross-contamination and failed to label and date food items. This had the potential to affect all residents who consumed food from the facility kitchen, The facility had a census of 85.<br><br>Review of the facility Food Storage Policy, dated [DATE], revised on [DATE], showed:<br><br>-Policy: Ensure food storage and safety practices are maintained and monitored and comply with Federal and State regulations governing food storage and safety;<br><br>-Responsibility: Dietary Aide, Dietary Cook, & Dietary Manager;<br><br>-Dating of leftovers shall be as follows:<br><br>-Multiple ingredients shall be used the same day of preparation then discarded;<br><br>-Other potentially hazardous leftovers shall be labeled with an expiration date of three (3) days;<br><br>-Leftovers which are not expired but change appearance or lose quality shall be discarded immediately;<br><br>-Foods shall be stored in an organized manner and shall be maintained in their original containers unless they are considered a leftover. All leftovers shall be labeled and dated with an expiration date of no more than three days.<br><br>1. Observation of the kitchen on [DATE] at 10:22 A.M., showed:<br><br>-Inside the dry storage area, two bags of cheesecake mix inside Ziplocked bags, with partial contents spilled inside the bottom of the Ziplocked bag, opened, and undated;<br><br>-A bag of yellow corn bread in Ziplocked bag, opened, and undated;<br><br>-A 25 pound bag of fish breading, rolled shut/partially opened, and undated;<br><br>-A large bag of white rice inside a plastic tub, opened, uncovered and undated;<br><br>-A large bag of all-purpose flour inside a plastic tub, opened, uncovered and undated.<br><br>Observation of the kitchen on [DATE] at 12:00 P.M., showed:<br><br>-Inside the dry storage area:<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Two bags of cheesecake mix inside ziplocked bags, with partial contents spilled inside the bottom of the Ziplocked bag, opened, and undated;<br><br>-A bag of yellow corn bread in Ziplocked bag, opened and undated;<br><br>-A 25 pound bag of fish breading, rolled shut/partially opened, and undated;<br><br>-A large bag of white rice inside a plastic tub, opened, uncovered and undated;<br><br>-A large bag of all-purpose flour inside a plastic tub, opened, uncovered and undated;<br><br>-Inside the walk in refrigerator;<br><br>-Three small Ziplocked bags of orange slices, undated;<br><br>-One small Ziplocked bag of apple slices, undated;<br><br>-Five paper bagged sack lunches, undated;<br><br>-One large plastic bag of lettuce, opened/partially uncovered, undated.<br><br>2. Observation and interview on [DATE] at 11:00 A.M., showed the inside the walk-in refrigerator, 8 paper sack lunches on a tray, undated. The dietary manager said the lunches are for people who go to dialysis, the bags contain a deli sandwich, juice, chips, and fruit.<br><br>Observation of the kitchen on [DATE] at 5:00 P.M., showed;<br><br>-Seven paper sack lunches on a tray, undated;<br><br>-Six Ziplocked bags of orange slices, undated;<br><br>-One Ziplocked bag of apple slices, undated.<br><br>3. During an interview on [DATE] at 10:00 A.M., the Dietary Manager said she expected staff to date and label opened food prior to placing the food in the refrigerator, and to cover and/or wrap opened packaging and ensure the package is dated after opening.<br><br>4. During an interview on [DATE] at 11:10 A.M., the administrator said she expected staff to ensure opened food is covered, labeled, and dated. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42247<br><br>45083<br><br>Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program when staff failed to wear appropriate personal protective equipment (PPE), in accordance with the facility's policy, during high-contact activities with residents on enhanced barrier precautions (EBP, precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO, microorganisms that are resistant to one or more classes of antimicrobial agents) for three residents (Residents #57, #29 and #82). Furthermore, the facility failed to follow their incontinent care policy when staff provided perineal area care (cleansing between the legs and buttocks area) to Resident #82. In addition, the facility failed to follow accepted infection control and prevention to implement their water management program to prevent the spread of waterborne pathogens, such as legionella (a bacteria that causes legionnaire's disease which is a severe form of pneumonia or lung inflammation). This failure had the potential to affect all residents in the facility. The sample was 18. The census was 85.<br><br>Review of the facility's Enhanced Barrier Precautions (EBP) Policy, dated 5/15/24, showed:<br><br>-Procedure:<br><br>-Examples of high-contact resident care activities requiring gown and glove use for EBP:<br><br>-Transferring;<br><br>-Providing Hygiene;<br><br>-Changing Briefs or Toileting;<br><br>-Device Care; Enteral Tube (pertaining to the gastrointestinal tract);<br><br>-Steps:<br><br>-Post signage in the resident room with information on use of EBP and required PPE (e.g., gown and gloves). EBP signage should include information on high contact resident care activities that require the use of gown and gloves.<br><br>Review of the facility's Incontinent Care Policy, dated 7/21/22, showed:<br><br>-Policy:<br><br>-The facility will provide incontinent care as directed in the plan of care. incontinent care will include a skin evaluation of the resident; promoting hygiene and skin prevention with infection/irritation;<br><br>-Responsibility:<br><br>(continued on next page) |

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|---|---|---|---|
| | 265427 | A. Building<br>B. Wing | 08/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Oak Park Care Center | 6637 Berthold Avenue<br>Saint Louis, MO 63139 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Nursing Assistant, Licensed Nurses, Nursing Administration, ICP and Director of Nursing;<br><br>-Procedure:<br><br>-Gather supplies;<br><br>-Identify resident and explain procedure;<br><br>-Provide privacy; close door/blinds, pull privacy curtain;<br><br>-if resident refuses incontinent care; inform charge nurse/supervisor;<br><br>-Place equipment on clean surface within reach;<br><br>-Perform hand hygiene and apply gloves;<br><br>-Assist with positioning resident in a safe/comfortable position, avoid overexposing the body;<br><br>-Remove soiled brief/underpad by rolling the brief/underpad;<br><br>-Cleanse perineal area with a perineal cleanser;<br><br>-Females: separate labia, cleanse one side and then the other, cleanse center of the labia wiping towards the rectal area;<br><br>-Cleanse perineal area from front to back, cleanse thighs, rectal area and buttocks;<br><br>-Males: retract foreskin if uncircumcised, cleanse the penile tip using a circular motion starting with the urethra working outward;<br><br>-Cleanse penile shaft, scrotum, rectal area, thighs & buttocks;<br><br>-Use a clean surface area of the cloth for each wipe;<br><br>-Use multiple cloths, if necessary, to maintain infection control;<br><br>-Remove soiled gloves, perform hand hygiene and apply clean gloves;<br><br>-If necessary, apply protective ointment;<br><br>-Remove gloves, perform hand hygiene and apply clean gloves, apply clean brief and clothing;<br><br>-Discard contaminated items in a plastic liner;<br><br>-Remove gloves and perform hand hygiene;<br><br>-Reposition resident in a safe/comfortable position (bed in low position unless contraindicated);<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 | -Place call light within reach of the resident;<br><br>-Residents with indwelling catheters; refer to catheter care policy;<br><br>-Report abnormal findings to the charge nurse/supervisor of discharge, bleeding, odor or skin changes.<br><br>Review of the facility's Legionella Water Management Program Policy, dated 11/23, showed:<br><br>-The Facility is committed to the prevention, detection and control of water-borne contaminants including Legionella;<br><br>-The water management program includes the following elements:<br><br>-Detailed description and diagram of the water system in the facility, including the following:<br><br>-Receiving;<br><br>-Cold water distribution;<br><br>-Heating;<br><br>-Hot water distribution;<br><br>-Waste.<br><br>1. Review of Resident #57's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 5/20/24, showed:<br><br>-Short and long-term memory problem;<br><br>-Diagnoses included atrial fibrillation (a-fib, irregular heart rhythm), heart failure and dementia;<br><br>-Feeding tube (gastrostomy tube (g-tube), a tube placed through the abdomen into the stomach to provide nutrition, hydration and medication).<br><br>Observation on 8/12/24 at 12:01 P.M., showed a sign on the door that the resident was on EBP. The resident was lying in bed. Licensed Practical Nurse (LPN) N administered medication to the resident via feeding tube. LPN N failed to apply a gown during the process.<br><br>2. Review of Resident #29's medical record, showed:<br><br>-Moderately impaired cognition;<br><br>-Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) wound to the sacrum (triangular bone located above the coccyx).<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 | Observation on 8/12/24 at 10:00 A.M., showed a sign on the door that the resident was on EBP. The resident was lying in bed. Certified Nurse Aide (CNA) C and CNA E put gloves on, unfastened the resident's brief and provided perineal care and rolled the resident side to side to place a clean brief on the resident. Staff failed to wear a gown while providing personal care.<br><br>3. Review of Resident #82's quarterly MDS, dated [DATE], showed:<br><br>-Cognitively impaired;<br><br>-Dependent to staff on toileting hygiene, shower or bath, upper and lower body dressing;<br><br>-Frequently incontinent of both bladder and bowel;<br><br>-Diagnoses included stroke, anemia, high blood pressure, kidney failure, diabetes, aphasia (a language disorder that affects a person's ability to communicate), hemiplegia (muscle weakness or partial paralysis on one side of the body);<br><br>-Feeding tube.<br><br>Observation on 8/13/24 at 10:22 A.M., showed a sign on the door that the resident was on EBP. CNA L provided perineal care to the resident. The resident was lying in bed. CNA L applied gloves and failed to apply a gown. He/She obtained a bath towel, placed one end on the sink with running water while the other end was hanging out of the sink. He/She then applied soap and squeezed some liquid out. He/She removed the resident's brief, wiped the perineal area up and down and side to side with the wet end of the towel. He/She then dried the area with the other end of the towel. He/She placed the dirty towel in the plastic bag which he/she laid on the floor. He/She turned the resident on his/her back and picked up the dirty towel from the plastic bag and started wiping the resident's buttocks and anal area, then dried with the same dirty towel. He/She applied a clean brief and put on the resident's pants. CNA L failed to replace gloves and performed hand hygiene in between handling clean and dirty.<br><br>4. During an interview on 8/13/24 at 12:04 P.M., Registered Nurse (RN) I said staff should wear gowns and gloves while providing care to residents in EBP rooms. Staff may use wash cloths or disposable wipes in providing perineal care to residents. He/She expected staff to use clean wash cloths or wipes for each area to and never to re-use dirty wash cloths or towels. He/She expected staff to properly follow the perineal area care procedures found in the facility's policy.<br><br>5. During an interview on 8/14/24 at 8:30 A.M., CNA F said he/she knew which residents were on EBP because the resident would have a red pillow on their bed, and they would have a caddy on the door with PPE in it. Staff should wear PPE if a resident has a wound.<br><br>6. During an interview on 8/14/24 at 8:40 A.M., Licensed Practical Nurse (LPN) G said staff know which residents require PPE because the facility has a list of residents who are on EBP, and the residents have a caddy on their door. PPE is worn while providing dressing changes, personal care and transfers. Staff do not need to wear PPE for residents with a g-tubes.<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 | 7. During an interview on 8/14/24 at 9:10 A.M., the Assistant Director of Nursing (ADON) said all staff have been in-serviced on EBP and if they do not know, they should ask the nurse. Staff should wear PPE when they provide direct patient care.<br><br>8. During an interview on 8/14/24 at 9:20 A.M., RN I, who was also the Infection Control Preventionist (ICP), said residents who have g-tubes, and wounds require EBP, and staff should wear PPE while providing direct care. The ICP expected staff to follow the facility's policy.<br><br>9. During an interview on 8/14/24 at 10:52 A.M., the Administrator and the Director of Nursing (DON) said they expected staff to wear PPE per the facility's policy. They said staff are expected to follow the facility's proper procedures in providing perineal care to prevent the spread of infection. In addition, the Administrator said she did not have a detailed description or a diagram of the facility's water system. She expected the facility to have all the components of their policy. |