STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265549	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portageville Health Care Center	290 West State Hwy 162 Portageville, MO 63873

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48532 Based on observation, interview and record review, the facility failed to ensure staff treated residents with dignity and in a respectful manner by leaving one resident (Resident #41) out of 15 sampled residents exposed during care. The facility census was 59. Review of the facility's policy titled, Dignity and Respect, revised, 06/29/2023, showed: -Every resident has a right to be treated with dignity and respect; 1. Review of Resident #41's medical record showed: -admitted [DATE]; -Diagnoses of seizures (a sudden, uncontrolled burst of electrical activity in the brain), chronic embolism and thrombosis of deep veins of bilateral lower extremities (a blood clot that forms within the deep veins), unspecified psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), unspecified intellectual disabilities (limitations in cognitive functioning and skills, including conceptual, social and practical skills, such as language, social and self-care skills) Review of the resident's quarterly Minimal Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 03/25/24 showed: -Cognition moderately impaired; -Always incontinent of bowel; -Moderately Dependent for toileting hygiene. Observation of the resident on 06/05/24 at 11:10 A.M., showed: -The resident lay in bed; -Certified Nurse Assistant (CNA) C and CNA D entered the room to perform incontinent care; (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The CNAs did not close the curtains to the windows; -The parking lot and driveway could be seen through the window; -CNA D left the room to obtain additional supplies and the resident lay with his/her genitalia area exposed. During an interview on 06/05/24 at 2:10 P.M. Licensed Practical Nurse (LPN) B said before peri-care is started, privacy should be given by pulling the curtain within the room, pull the window curtains and close the door. During an interview on 06/05/24 at 2:15 P.M., CNA C said before performing peri-care, provide privacy by closing the curtain on the window, the curtain in the room and close the door. During an interview on 06/05/24 at 3:30 P.M. the Director of Nursing (DON) said the curtains on the window and in the room should be pulled closed before providing peri-care to any resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45872 Based on observation, interview, and record review, the facility failed to provide a safe, clean and comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 59. Review of the facility's policy titled, Safe and Homelike Environment Policy, revised 06/05/2024, showed: - In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk; - Environment refers to any environmental in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor, patio, therapy areas and activity areas; - General Considerations: Report any unresolved environmental concerns to the Administrator. 1. Observations made on 06/02/24 at 8:54 A.M., 06/03/24 at 8:46 A.M., and 06/05/24 at 8:48 A.M., of the exterior of the building, showed: - A buildup of spiderwebs, dirt and debris on the vinyl ceiling and sides located under the driveway awning; - A buildup of spiderwebs, dirt and debris on the vinyl ceiling and sides located under the entrance awning. 2. Observations made on 06/02/24 at 8:59 A.M., 06/03/24 at 8:48 A.M., and 06/05/24 at 8:56 A.M., of the main dining room showed several areas of dark scuff markings on the bottom portions of both dining room doors. 3. Observation made on 06/02/24 at 9:06 A.M., 06/03/24 at 8:59 and 06/05/24 at 12:10 PM, of the 100 hall, showed: - Several areas of peeled paint and exposed sheetrock on the walls behind a recliner near the door in room [ROOM NUMBER]; - A vent protector missing on the air conditioner/heating unit in room [ROOM NUMBER]; - A buildup of dirt and debris inside the air conditioner/heating unit in room [ROOM NUMBER]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observations made on 06/02/24 at 10:59 A.M., 06/03/24 at 8:48 A.M. and 06/05/24 at 8:56 A.M., of the 300 hall dining room, showed several straight line areas of dark scuff marks, peeled paint and exposed sheetrock on the walls by the window, under the wall-mounted television and on both sides of the entrance/exit door. 5. Observations made on 06/02/24 at 11:13 A.M., 06/03/24 at 8:57 A.M., 06/05/24 at 8:46 A.M., of the 300 hall, showed: - Floor tiles around the base of the bathroom toilet cracked and stained in room [ROOM NUMBER]; - A line of dark scuff marks, peeled paint and exposed sheetrock on the right side wall of bed 1 located in room [ROOM NUMBER]; - A line of dark scuff marks, peeled paint and exposed sheetrock on the right side wall of bed 1 near the door in room [ROOM NUMBER]; - A line of exposed sheetrock on the wall above the headboard of bed 2 located in room [ROOM NUMBER]; - Several areas of peeled paint and exposed sheetrock on the right side wall of bed 2 near the window located in room [ROOM NUMBER]; - A large area of dark scuff marks, peeled paint and exposed sheetrock behind the headboard of bed near the door located in room [ROOM NUMBER]; - Several areas of peeled paint and exposed sheetrock on the right side wall of bed 2 near the window located in room [ROOM NUMBER]; - Floor tiles around the base of the bathroom toilet cracked and stained in room [ROOM NUMBER]. Review of the maintenance repair log showed no documentation of areas of concern addressed. During an interview on 06/05/24 at 10:26 A.M., Housekeeper A said he/she verbally tells the Maintenance Supervisor (MS) if there are any environmental concerns such as cobwebs, scuff marks, peeled paint or exposed sheetrock. He/She has not seen any environmental concerns to report to MS recently. During an interview on 06/05/24 at 10:26 A.M., Licensed Practical Nurse (LPN) B said he/she verbally tells MS if there is an environmental concern or repair that needs to be addressed. There is a maintenance repair log at the nurses' station that staff can write down things that need repaired or addressed. He/She has not seen any environmental concerns to report to MS recently. During an interview on 06/05/24 at 10:42 A.M., the MS said staff should be filling out a maintenance repair form so the area of concern can be addressed in a timely manner. He/She would prefer staff to write down the environmental concern rather than verbally telling him. During an interview on 06/05/24 at 2:38 P.M., the Administrator said she would expect staff to fill out a maintenance form and not verbally tell MS of environmental concerns that need to be addressed in a timely manner. This will be addressed.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26904 Based on observation, interview and record review, the facility failed to ensure the baseline care plan (initial plan for delivering of care and services) included specific interventions and the resident and/or guardian received a written summary of the baseline care plan for two residents (Resident #105 and #155) out of two sampled residents. The facility was census was 59. Review of the facility's policy titled, Baseline Care Plan Policy, revised 05/18/2024, showed: - The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. - The baseline care plan will be developed within 48 hours of a resident's admission; - The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable; - Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives. - Interventions shall be initiated that address the resident's current needs. - A supervising nurse shall verify within 48 hours that a baseline care plan has been developed. - A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. - A supervising nurse or Minimum Date Set (MDS) nurse/designee is responsible for providing the written summary of the baseline care plan to the resident and representative. - The person providing the written summary of the baseline care plan shall: - Obtain a signature from the resident/representative to verify that the summary was provided. - Make a copy of the summary for the medical record. 1. Review of Resident #105's medical record, showed: - admitted to the facility on [DATE]; - Diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly, out of touch with reality, disorganized speech or behavior) and depression (a common mental disorder that can affect a person's thoughts, feelings, behavior, and sense of well-being); (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation of a written summary of the baseline care plan. During an interview on 06/04/24 at 12:40 P.M., the resident said he/she is a smoker and did not receive a copy or a written summary of the baseline care plan after being admitted to the facility. He/She said the staff did not discuss her care or orientate her to the facility. 2. Review of Resident #155's medical record, showed: - admitted to the facility on [DATE]; - Diagnoses of schizoaffective disorder (a condition characterized by abnormal thought processes and deregulated emotions), post traumatic stress disorder (PTSD - an anxiety disorder that develops in reaction to physical injury or severe mental or emotional distress), major depressive disorder (long-term loss of pleasure or interest in life) and bipolar (a mental disorder that causes unusual shifts in mood); - No documentation of a written summary of the baseline care plan. During an interview on 06/02/24 at 3:05 P.M., the resident said loud yelling and confrontational people triggered his/her PTSD. He/She does not remember any of the staff coming to his/her room and asking specific questions about personal care or current health status, but does have a guardian. He/She did not receive a copy or a written summary of the baseline care plan. During an interview on 06/05/24 at 3:00 P.M., the Director of Nursing (DON) said she and other staff had been working on the MDS's and care plans due to not having an MDS Coordinator at this time. During an interview on 06/05/24 at 3:03 P.M., The Administrator said the baseline care plans should be completed within the 48 hours of admission and knew staff had been working on the care plans. He/She thought they had been done, however, did not realize the baselines had not been given to the resident/representatives. He/She said they had several new admissions on one day and the MDS coordinator had quit and other staff had been trying to catch things up.

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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 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26904 Based on observation, interview and record review, the facility failed to implement a care plan with specific interventions to meet individual needs of four residents (Residents #16, #50, #53, and #105,) out of 15 sampled residents. The facility census was 59. Review of the facility's policy titled, Comprehensive Care Plans, revised 01/19/2022, showed: - The purpose of this policy is ensure that the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. - Facility will use the Resident Assessment Instrument (RAI) User Manual 3.0 as a reference to help the Interdisciplinary Team to look at residents holistically, as individuals for whom quality of life and quality of care are mutually significant and necessary. - The care plan will be oriented toward: - Managing risk factors; - Using current standards of practice in the care planning process; - Involving resident/family/responsible party; - Assessing and planning for care sufficient to meet the care needs of new admissions; - Addressing additional care planning areas that could be considered in the facility setting. 1. Review of Resident #16's medical record showed: - admitted [DATE]; - Diagnoses of schizoaffective disorder (a condition characterized by abnormal thought processes and deregulated emotions), post traumatic stress disorder (PTSD - an anxiety disorder that develops in reaction to physical injury or severe mental or emotional distress), major depressive disorder (long-term loss of pleasure or interest in life) and bipolar (a mental disorder that causes unusual shifts in mood). Review of the resident's care plan, revised 03/22/2024, showed no individualized interventions for smoking. Observations made on 06/02/24 at 10:34 A.M. and 06/03/24 at 10:42 A.M., showed the resident sat outside in a designated smoked area smoking with staff supervision. 2. Review of Resident # 50's medical record showed: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- admitted [DATE]; - Diagnosis of Rheumatoid Arthritis (a chronic inflammatory disorder usually affecting small joints in the hands and feet), lack of coordination and hypoglycemia (a condition in which the bodies blood sugar level goes below the standard level); Review of resident's care plan, revised on 02/28/2024, showed no individualized interventions for bilateral pull bars. Observations made on 06/02/24 at 10:38 A.M. and 06/03/24 at 8:45 A.M., showed resident sitting upright in bed with both pull bars up. 3. Review of Resident #53's medical record showed: - admitted [DATE]; - Diagnoses of schizoaffective disorder, PTSD, major depressive disorder and bipolar disorder. Review of the resident's care plan, revised 02/08/2024, showed no individualized interventions for smoking. Observations made on 06/02/24 at 10:34 A.M. and 06/03/24 at 10:42 A.M., showed the resident sat outside in a designated smoked area smoking with staff supervision. 4. Review of Resident #105's medical record showed: - admitted [DATE]; - Diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly, out of touch with reality, disorganized speech or behavior) and depression (a common mental disorder that can affect a person's thoughts, feelings, behavior, and sense of well-being). Review of the resident's care plan, dated 06/02/2024, showed no individualized interventions for smoking. Observations made on 06/02/24 at 1:00 P.M. and 06/03/24 at 10:40 A.M., showed the resident sat outside in a designated smoked area smoking with staff supervision. During an interview on 06/05/24 at 3:16 P.M., the Director of Nursing (DON) said if a resident smokes then she would expect smoking to be on the care plan. During an interview on 06/05/24 at 3:18 P.M., the Administrator said she expected the care plan to reflect the resident and if they smoke then it should be on the care plan. 45872

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48532 Based on interview and record review, the facility failed to attempt a gradual dose reduction (GDR) for one resident (Resident #37) out of 15 sampled residents. This failure had the potential to keep any resident on a psychoactive medication from receiving the lowest possible dosage of medication due to not monitoring if a medication is treating the target symptom. The facility census was 59. Review of the facility's policy titled, Monthly Drug Regimen Review, revised 07/05/22, showed: -The consultant pharmacist will review the drug regimen of each Resident at least monthly and report, in writing, any irregularities; -The consultant pharmacist will provide to the director of nursing each month a written report with a statement about each resident and any irregularities found. If no irregularities were noted this shall be so noted; - Pharmacy recommendations will be documented in the resident's clinical record; -The nurse/RCC/Director of Nursing will forward the pharmacists recommendations to the attending physician within 48 hours of receiving the recommendation. The nurse/RCC/DON will document the date and time the physician was notified of the recommendation; -If the attending physician does not respond to the recommendation within 7 days, the nurse/RCC/DON will follow up with the physician's office to obtain any orders if necessary; -The attending physician will indicate if they agree or disagree with the recommendation made. If the physician does not agree with the recommendation, the physician will be asked to document the reason in the resident's clinical record. 1. Review of Resident #37's medical record showed: -admitted [DATE]; -Diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other cognitive functions), unspecified psychosis (mental disorder causing a disconnection from reality), major depressive disorder (persistently depressed mood or loss of interest, casuing significant impairment in daily life); -An order for Olanzapine (an antipsychotic medication that treats mental disorders, including schizophrenia and bipolar disorder)10milligrams (mg) by mouth twice daily, dated 05/19/21; -An order for Quetiapine (an antipsychotic medication that treats schizophrenia, bipolar disorder, and depression) 225mg by mouth at bedtime, dated 01/25/2024; (continued on next page)

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	265549	A. Building B. Wing	06/05/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order for Carbamazepine (an anticonvulsant medication that treats seizures, nerve pain and bipolar disorder) 200mg by mouth three times daily, dated 05/19/2021; -No attempt by the physician for a GDR of the Olanzapine, Quetiapine, and Carbamazepine. Review of the resident's Pharmacist's Monthly Review Record (MRR) log, dated 01/13/2024 showed: -The GDR's requested by the pharmacist for the Olanzapine, Quetiapine, and Carbamazepine; -No documentation from the physician regarding the GDR's requested for Olanzapine, Quetiapine, and Carbamazepine. During an interview on 06/05/24 at 3:30 P.M. the Administrator said he/she would expect GDR's to be completed on psychotropic medications and a documented rational as to why a GDR was not attempted by the physician.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 48532 Based on observation, interview and record review, the facility failed to maintain an error rate of less than five percent (%) when medications were given. There were 28 opportunities with three errors made, for an error rate of 9.09%. This affected two residents (Resident #37 and #52) and had the potential to affect all residents. The facility census was 59. Review of the facility's policy titled, Medication Administration and Monitoring, revised 09/20/2023, showed: -Medications are to be given per doctors' orders; -All medications are recorded in the Electronic Medication Administration Record (EMR) immediately after the resident has taken the medications. The nurse of Certified Medication Technician (CMT) will check each medication to the EMR noting correct name of medication, correct resident name, correct dose, correct time and correct route of administration; -The nurse or CMT should note that if a medication is refused or not available. The nurse or CMT will document appropriately regarding the medication in question. Reason for the medication in question that is not given will be noted along with an explanation of the solution to the problem in progress notes of EMR. The Director of Nursing (DON) or Registered Nurse (RN) will be notified immediately regarding resident not receiving the medication. It will be the DON or RN responsibility to ensure that medication is received and that the Licensed Practical Nurse (LPN) or CMT distributes the medication to the resident; -The physician will be notified if medication is given late and the Nurses' notes will indicate why medication has a discrepancy. This will not only include medications but treatments as well. Review of the facility's policy titled, Administration of Insulin Policy, revised 05/14/2024, showed: -Procedure for administering Insulin Pens: -Gather supplies needed -perform hand hygiene -Don gloves -Verify resident identification -Check expiration date on pen -Examine the appearance of the insulin -Attach pen needle (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Prime the insulin pen; dial 2 units by turning the dose selector clockwise; with the needle pointing up, push the plunger and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears; -Set the insulin dose -Injecting the Insulin; cleanse the skin with alcohol pad; gently pinch up skin at the injection site and hold; inject the needle straight at a 90-degree angle to the skin; fully depress plunger until the dosing numbers count back to zero; while still pressing the plunger, keep the needle in the skin for up to 6-10 seconds and then remove the needle from the skin; may use bandage if needed; remove the needle from the pen by turning counterclockwise and dispose of needle in the sharps container; place the cover back onto the pen and store pen in the medication cart. -Remove gloves and perform hand hygiene -Document dosage, site and time in the medication record along with nurse signature. -Document any teaching and/or demonstrations done when planning for discharge, Review of the Novolog/aspart (fast-acting insulin injected just below the skin that helps lower mealtime blook sugar spikes) Flex Pen administration instructions, dated September 2021, showed: - Check label to make sure that the FlexPen contains the correct type of insulin; - Pull off the pen cap; - Remove paper tab from cap needle; attach needle to pen so that it is straight and secure; - Pull off outer needle cap, pull off inner needle cap and discard; - Turn the dose selector to two units; - Keep the needle upwards and press the push-button until the dose selector reads 0; - Turn the dose selector to select the number of prescribed units; - Push the needle into the skin, then press the dose button until dose selector indicates 0; - Keep the push-button fully pushed in after injection; - Leave the needle under the skin for 6 seconds and then remove it. 1. Review of Resident #37's Physician Order Sheet (POS), dated June 2024, showed: -An order for Colesevelam (a medication used to help stop diarrhea associated with irritable bowel syndrome) 625 milligrams(mg) by mouth with meals, dated 05/17/24; Review of resident's Medication Administration Record (MAR), dated June 2024 showed: (continued on next page)

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The medication administered at 7:34 A.M. on 06/04/2024. During an observation on 06/04/24 at 8:45 A.M., Certified Medication Technician (CMT) I administered Colesevelam. During an interview on 06/04/24 at 8:46 A.M., the resident said his/her medication was supposed to be given before meals. During an interview on 06/04/24 at 1:05 P.M., CMT I said he/she charted the medication was given and night shift forgot to chart it. During an interview on 06/04/24 at 2:55 P.M., the Director of Nursing (DON), said he/she would expect staff to not chart a medication has been given if it has not. During an interview on 06/04/24 at 2:55 P.M., Administrator said he/she would expect medications to be charted when administered. 2. Review of Resident #52's POS, dated June 2024, showed: -An order for Novolog insulin pen 100 units per milliliter (ml) subcutaneous (an injection just below the skin) with meals and before bedtime per a sliding scale of blood sugar if 50-150=0 units, 151-200=4 units, 201-250=6 units, 251-300=8 units, 301-350=10 units, 351-400=12 units, dated 01/28/24. Observation of Resident #52's medication administration on 06/04/24 at 11:07 A.M., showed: - LPN J administered 8 units of Novolog subcutaneously per order of the sliding scale for a blood sugar of 263 with the resident's Novolog Kwik Pen; - LPN J did not prime the Novolog Kwik Pen per the manufacturer's instructions prior to the administration to the resident. - LPN J did not hold the Novolog Kwik Pen in place for 6-10 seconds per the manufacturer ' s instructions and facility policy. During an interview on 06/04/24 at 2:55 P.M., the Director of Nursing (DON), said he/she would expect nurses and CMT's to prime the insulin pen prior to administration and hold the needle in place for a minimum of 5 seconds to ensure the insulin has been absorbed.

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	265549	A. Building B. Wing	06/05/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48532 Based on observation, interview and record review, the facility failed to maintain proper infection control practices during incontinent care for one resident (Resident #38) out of four sampled residents and one resident (Resident #44) outside the sample. The facility failed to maintain proper infection control practices during a wound care treatment for one resident (Resident #26) out of two sampled residents. The facility census was 59. Review of the facility's policy titled, Handwashing/Hand Hygiene, dated 06/29/23, showed: - The use of gloves does not replace handwashing; - Hands are to be washed before and after gloving; - A waterless antiseptic solution may be used as an adjunct to routine handwashing; - Appropriate ten to fifteen second handwashing must be performed under the following conditions: -whenever hands are obviously soiled; -before performing invasive procedures; -before preparing or handling medications; -after having prolonged contact with a resident; -after handling used dressings, specimen containers, contaminated tissues, linens, etc.; -after contact with blood, body fluids, secretions, excretions, mucous membranes or broken skin; -after handling items potentially contaminated with a resident's blood, body fluids, excretions; -after removing gloves. Review of the facility's policy titled, Standard Precautions- Infection Control, dated 05/14/2024, showed: - All staff are to assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services; - Standard Precautions refer to the infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status, this includes hand hygiene; - Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of antiseptic hand rub; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- During the delivery of resident care services, avoid unnecessary touching of surfaces in close proximity to the resident to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces; - Perform hand hygiene in accordance with the facility's hand hygiene policy. Review of the facility's policy titled, Wound Dressing Change, dated 05/18/2024, showed: - It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. - Each wound will be treated individually; - When multiple wounds are being dressed, the dressings will be changed in order of the least contaminated to most contaminated. - Wash hands and put on clean gloves; - Loosen the tape and remove the existing dressing; - Remove gloves, pulling inside out over the dressing, the discard into an appropriate receptacle; - Wash hands and put on clean gloves; - Cleanse the wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound; - Dress the wound as ordered; - Discard disposable items and gloves into appropriate receptacle and wash hands. 1. Observation on 06/04/2024 at 11:14 A.M., of incontinent care for Resident #38, showed: - A hoyer lift was used to transfer resident from chair to bed; - Certified Nurse Assistant (CNA) C and CNA K performed incontinent care; - CNA C removed the resident's soiled brief, cleaned the resident's front perineal area, did not remove gloves, failed to perform hand hygiene and failed to apply clean gloves; - CNA C cleaned the resident's buttocks and rectal area, did not remove gloves, did not perform hand hygiene and did not apply clean gloves; - CNA C did not change gloves and did not perform hand hygiene before applying a clean brief to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/05/24 at 2:10 P.M., LPN B said when providing peri-care, staff should change gloves and perform hand hygiene between removing dirty linens and brief and applying anything that is clean. During an interview on 06/05/24 2:12 P.M., CNA C said that he/she would change dirty gloves, perform hand hygiene and don clean gloves before putting anything clean on the resident. 2. Observation on 06/04/2024 at 4:00 P.M., of wound care for Resident #26, showed: - Licensed Practical Nurse (LPN) H did not perform hand hygiene, then put on gloves and gown; - The resident sat in his/her wheelchair in his/her room; - LPN H removed the soiled bandage from the resident's right lower leg (by using a pair of surgical scissors); - LPN H did not clean the scissors; - The resident's lower leg showed two small open areas to the front of the calf area and two open areas to the back of the calf area; - LPN H removed the gloves, did not perform hand hygiene, and put on new gloves; - LPN H applied wound cleanser to a four by four piece of gauze and cleaned the resident's leg from knee downward to his/her foot from one wound to another, retrieved a clean four by four gauze, applied wound cleanser and cleaned the resident's leg from the knee downward to his foot several times repetitively; - LPN H removed the gloves, did not perform hand hygiene, and put on new gloves; - LPN H wearing the soiled gloves, opened the package, and applied Xerofoam petroleum (a fine mesh gauze occlusive dressing with petrolatum and 3% of deodorizing agent with anti-microbial properties) at the top of the resident's leg (knee area working his/her way down the leg) placing Xerofoam on the resident's leg; - LPN H cut a Xerofoam petroleum dressing in half with the dressing inside the package with the same scissors; - LPN H applied wound cleanser to a four by four piece of gauze and cleaned an open area to the right side of the resident's foot; - LPN H cut calcium alginate (an absorbent non-adhesive dressing) with the same scissors, and placed on the open wound. - LPN H wrapped the resident's lower leg and foot with kling (an absorbent gauze that stretches and conforms to the body shape and clings to itself as it wrapped). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LPN H did not clean each open area with a single gauze, using the same gauze down the leg on all wounds, failed to wash hands in between glove changing, and clean the scissors. During an interview on 06/05/24 at 2:03 P.M., LPN B said the wounds should be cleaned individually and not to cross contaminate with one wound to the other. He/She said the scissors should have been cleaned after removing the dressing and after cutting the Xeroform dressing packet. During an interview on 06/05/24 at 3:10 P.M., the Director of Nursing said the highest wound on the leg should have been cleansed first, dressed and move on down the leg. She said the gauze should not have touched the leg all the way down on all areas. The DON said the scissors should have cleaned prior to starting the wound treatment, after the soiled dressing was removed, after cutting the packaging of dressing. The gloves should be removed and hands washed before putting on new gloves. 3. Observation on 06/05/2024 at 11:37 A.M. of incontinent care for Resident #44 showed: - Certified Nurse Aide (CNA) F performed hand hygiene and put on gloves, CNA G failed to perform hand hygiene and put on gloves; - The resident lay in bed on his/her back; - CNA G removed the resident's urine soaked pull up; - CNA G cleaned the resident's front perineal area, - CNA F rolled the resident to his/her right side; - CNA G cleaned the resident's buttocks, hips, and rectal area; - CNA F and CNA G wearing the same soiled gloves, rolled the resident to his/her back and placed a clean pull up on the resident; - CNA G repositioned the resident's bed linens, clipped the resident's call light to the linens within reach; - CNA G gathered trash and dirty linens, removed his/her gloves and left the resident's room. During an interview on 06/05/24 at 2:06 P.M., CNA G said his/her hands should have been washed prior to placing gloves on to care for the resident and he/she should have removed his/her gloves after they became dirty. CNA G said the gloves should have been removed before touching anything else in the resident's room. During an interview on 06/05/24 at 3:25 P.M., the DON said staff should always wash their hands before applying gloves, and between dirty and clean tasks. She said staff should always wash their hands before exiting the resident's rooms.