| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265833 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/07/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Manor Grove, Incorporated | 711 South Kirkwood Road<br>Kirkwood, MO 63122 |

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| F 0568<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.<br><br>35394<br><br>Based on observation, interview and record review, the facility failed to reconcile the petty cash (a small amount of cash that is kept in a facility's business office to dispense to residents who have a resident trust account) on a monthly basis. The facility also failed to maintain enough funds in the resident trust to cover all residents with a resident trust for three months. The facility held funds for five residents. The census was 81 with 38 residents in certified beds.<br><br>Review of the facility's Resident Rights policy, dated 1/10/24, showed:<br><br>-Manage you money: You have the right to manage your own money or to choose someone you trust to do this for you;<br><br>-In addition, if you deposit your money with the nursing home or ask them to hold or account for your money, you must sign a written statement saying you want them to do this;<br><br>-The nursing home must allow you access to your bank accounts, cash, and other financial records;<br><br>-The nursing home must have a system that ensures full accounting for your funds and cannot combine your funds with nursing home's funds;<br><br>-The nursing home must protect your funds from any loss by providing an acceptable protection, such as buying a surety bond;<br><br>-If a resident with a fund dies, the nursing home must return the funds with a final accounting to the person or court handling the resident's estate within 30 days.<br><br>1. Review of the monthly accounts for the months of April 2023 through March 2024, showed the absence of documentation of the ending balances for petty cash.<br><br>During an interview on 5/6/24 at 12:51 P.M. and 5/7/24 at 12:12 P.M., Accounting Coordinator V said the petty cash was funded from the resident trust account.<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 0568<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation and interview on 5/7/24 at 12:16 P.M., showed Accounting Coordinator V counted the petty cash. There was a total of $150.00 in the petty cash box. Accounting Coordinator V said the petty cash was not on the reconciliation because it was petty cash. They kept a total of $200.00 in petty cash. He/She confirmed the monthly balance report contained the total amount of all resident money and the petty cash was on there. He/She wrote $4944.52 + 200 =$5144.52 on the March 2024 ending balance report. He/She said the $200 represented petty cash. It was not on the reconciliation sheet because it was cash. The reconciliation included only funds at the bank and the petty cash was separate. At the end of the month, he/she would go to the bank and balance the petty cash by adding money to get it back to $200.00. It could not be under $200.00.<br><br>2. Review of the facility's January 2024 monthly ledger report, showed:<br><br>-Ending balance report, dated 1/31/24, showed a resident trust account total of $3,350.37 for all residents;<br><br>-Monthly Bank statement balance showed an end of the month balance of $3,229.07;<br><br>-$6,270.18 was transferred from the resident trust account to another account;<br><br>-The monthly bank statement's ending balance showed the balance was $121.30 less than the ending balance report.<br><br>Review of the facility's February 2024 monthly ledger report, showed:<br><br>-Ending balance report, dated 2/29/24, showed a resident trust account total of $4,312.44 for all residents;<br><br>-Monthly bank statement balance showed an end of the month balance of $4,161.14;<br><br>-$6,270.18 was transferred from the resident trust account to another account;<br><br>-The monthly bank statement's ending balance showed the balance was $151.30 less than the ending balance report.<br><br>Review of the facility's March 2024 monthly ledger report, showed:<br><br>-Ending balance report, dated 3/31/24, showed a resident trust account total of $5,144.52 for all residents;<br><br>-Monthly bank statement balance showed an end of the month balance of $4,973.22;<br><br>-$6,300.18 was transferred from the resident trust account to another account;<br><br>-The monthly bank statement's ending balance showed the balance was $171.30 less than the ending balance report.<br><br>(continued on next page) |

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| F 0568<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/6/24 at 12:51 P.M. and 5/7/24 at 12:12 P.M., Accounting Coordinator V said the money that was transferred from the resident trust account was transferred to the facility's corporate account. There was enough money in the resident trust account to cover all the residents who held funds. Accounting Coordinator V was asked how would they ensure they had enough money to cover the resident's balances if they wanted to close their resident trust account. He/She said it would never happen, but if there was not enough money in the account, they would give the resident cash.<br><br>3. During an interview on 5/7/20 at 12:50 P.M., the Administrator said she would expect the resident trust to be accurately reconciled every month. The Administrator believed the petty cash was company funded, but would have to check. She would expect it to be corporate money. She would expect the total balances to be correct and accurate to cover residents who had money in the trust account with the facility. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>35394<br><br>Based on interview and record review, the facility failed to check for a federal indicator (identifies when an employee who has ever held a Certified Nurse Aide (CNA) certificate has ever been found to have abused, neglected, or misappropriated resident property) through the state Nurse Aide (NA) registry prior to hiring a new employee. In addition, the facility's policy failed to direct staff to check the NA registry on all employees prior to hire for three of five employees files reviewed. The census was 81 with 38 in certified beds.<br><br>Review of the facility's undated Background Screening Investigation policy, showed:<br><br>-Policy: Facility conducts employment background screening checks, reference checks and criminal conviction investigation checks on individuals making application for employment;<br><br>-Procedure: The Staffing Coordinator, or other designee, conducts employment background checks, reference checks and criminal conviction checks on persons making application for employment with facility. Such investigations are completed prior to offer of employment;<br><br>-For any individual applying for a position as a Certified Nursing Assistant, the state nurse aide registry is contacted to determine if any findings of abuse, neglect, mistreatment of individuals, and/or theft of property have been entered into the applicant's file;<br><br>-For any licensed professional applying for a position that may involve direct contact with residents, his/her respective licensing board is contacted to determine if any sanctions have been assessed against the applicant's license;<br><br>-The policy failed to direct the facility to check the nurse aide registry on all staff.<br><br>1. Review of Dietary Aide U's employee file, showed:<br><br>-Date of hire 8/18/23;<br><br>-No documentation of the NA registry federal indicator check.<br><br>2. Review of Registered Nurse (RN) T's employee file, showed:<br><br>-Date of hire 5/2/23;<br><br>-No documentation of the NA registry federal indicator check.<br><br>3. Review of Licensed Practical Nurse (LPN) G's employee file, showed:<br><br>-Date of hire 1/30/24;<br><br>-No documentation of the NA registry federal indicator check.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. During an interview on 5/7/24 at 12:50 P.M., the Administrator confirmed the NA registry was only checked for certified nursing assistants. She would expect the NA registry to be checked for all new hires. |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observe each nurse aide's job performance and give regular training.<br><br>35394<br><br>Based on interview and record review, the facility failed to have a tracking system to ensure 10 of 10 randomly selected Certified Nurse Aides (CNAs) received the required annual 12-hour resident care training, tracked and calculated by hire date. The census was 81 with 38 residents in certified beds.<br><br>Review of the facility assessment, showed:<br><br>-Staff training and competencies: Abuse, neglect, exploitation and reporting;<br><br>-Resident rights;<br><br>-Pressure ulcer prevention;<br><br>-Medication administration;<br><br>-Dementia care and abuse prevention;<br><br>-Care for persons with cognitive impairment;<br><br>-Care for persons with mental and psychosocial disorder as well as history of trauma/Post Traumatic Stress Disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event);<br><br>-Implementing non-pharmacological interventions;<br><br>-Falls;<br><br>-Exercise and ambulation;<br><br>-Range of motion;<br><br>-Positioning residents;<br><br>-Lifting and transfers;<br><br>-Feeding assistance training;<br><br>-Required in-services done yearly for all staff;<br><br>-Nursing rounds/supervision done involving floor staff to monitor or proficiency and see to all resident needs are met.<br><br>Review of the CNA individual in-service records, showed:<br><br>(continued on next page) |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -CNA I hired 11/5/98, with 8 hours of in-service education;<br><br>-CNA J hired 2/7/07, with 8 hours of in-service education;<br><br>-CNA K hired 6/4/08, with 34 minutes of in-service education;<br><br>-CNA L hired on 8/26/09, with 8 hours of in-service education;<br><br>-CNA M hired on 3/29/18, with 7 hours and 15 min of in-service education;<br><br>-CNA N hired on 9/30/20, with 7 hours and 45 min of in-service education;<br><br>-CNA O hired on 10/7/20, with 3 hours and 30 minutes of in-service education;<br><br>-CNA P hired on 2/8/22, with 2 hours and 45 minutes of in-service education;<br><br>-CNA Q hired on 3/22/23, with 58 minutes of in-service education;<br><br>-CNA R hired on 9/2/20, with 89 minutes of in-service education.<br><br>During an interview on 5/3/24 at 2:05 P.M., the Administrator said the previous Minimum Data Set (MDS) coordinator was responsible for education; however, he/she left two weeks ago. They are currently looking for a new educator. They are attempting to find the number of hours for the in-service training and sign in sheets with dates of the education events.<br><br>Review of the facility's in-service sign sheet, received on 5/3/24, showed no documentation of the amount of time of each in-service or education. Several staff signatures on the form, not tracked by staff.<br><br>Review of the facility's education events sheet, received on 5/3/24, showed:<br><br>-Annual Health Fair: 1.5 hours;<br><br>-911 in-service: 30 minutes;<br><br>-Dementia training: 30 minutes;<br><br>-Change in condition overview: 1 hour;<br><br>-Small group behavior tracking/log: 20 minutes;<br><br>-Professionalism in the workplace, a focus on customer service: 30 minutes;<br><br>-The facility provided no tracking documentation of the CNAs that received education or the date of the education event.<br><br>(continued on next page) |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/7/24 at 12:50 P.M., the Administrator said the staff that was responsible for tracking the hours left. She would expect there to be a system in place to track the education hours. There are three nurse managers that are now responsible for tracking the in-service education. Moving forward, the education will be tracked through payroll. The Administrator will be in charge of initiating it and nurse managers will track the clinical information. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>50366<br><br>Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 28 opportunities observed, 2 errors occurred, resulting in a 7.14% error rate (Resident #19). The census was 81 with 38 residents in certified beds.<br><br>Review of the facility's Administering Medications policy and procedure dated, 11/17/2023:<br><br>-Policy statement: medications shall be administered in a safe and timely manner, and as prescribed;<br><br>-Insulin pens containing multiple doses of insulin are for single resident use only. Changing the needle does not make it safe to use insulin pens for more than one resident;<br><br>-Insulin pens will be clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen, the Nurse will verify that the correct pen is used for that resident;<br><br>-Policy did not address priming the pen prior to resident dose administration.<br><br>Review of Manufacture How to Use Your Lantus (long-acting insulin) Pen, dated 2022:<br><br>-Perform a safety test;<br><br>-Dial a test dose of 2 units;<br><br>-Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose.<br><br>Review of Resident #19's medical record, showed:<br><br>-Diagnoses included epilepsy (seizure disorder), type 2 diabetes with polyneuropathy (nerve damage), and chronic kidney disease,<br><br>-An order, dated 3/22/2024, for Lantus Solostar injection pen (glargine, long-acting insulin) 100 units/3 milliliters (ml), administer 10 units subcutaneous (under the skin) at 8:00 A.M. daily.<br><br>Observation on 5/3/24 at 7:37 at A.M., showed Licensed Practical Nurse (LPN) G set the resident's insulin to deliver 1 unit of insulin and primed the pen. He/She then set the pen to 10 units of Lantus and administered the insulin to the resident. LPN G failed to prime the insulin pen with 2 units per manufacturer's recommendation.<br><br>Observation on 5/6/24 at 7:25 A.M., showed LPN C set the insulin pen to deliver 10 units of Lantus. He/She did not prime the insulin pen before he/she administered 10 units of Lantus to the resident.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/7/24 at 9:51 A.M., with the Director of Nursing (DON), Administrator, and Assistant Director of Nursing (ADON). The DON said insulin pens should be primed with 2 units, per manufacture recommendations, prior to administering the resident's prescribed dose. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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** 40291<br><br>Based on observation and interview, the facility failed to discard outdated food and label, date, and cover food. Also, facility staff performed improper infection control practices while he/she prepared puree dishes and poured the food into plates. In addition, the facility also failed to ensure kitchen equipment was clean and in working condition. These deficient practices had the potential to affect all residents who consumed food from the facility kitchen. The census was 81 with 38 residents in certified beds.<br><br>1. Observations on [DATE] at 9:17 A.M., [DATE] at 7:15 A.M., [DATE] at 3:04 P.M., showed the following:<br><br>-Storage room:<br><br>-A large can of potato salad, with a best buy date of ,d+[DATE] and [DATE] written on the outside of the can;<br><br>-A large can of Campbells soup, with an expiration date of [DATE] and ,d+[DATE] written on the outside of the can;<br><br>-A large can of V8 original drink mix with an expiration date of [DATE];<br><br>-A large can of cherry pie filling with a best by date of ,d+[DATE];<br><br>-Cooler:<br><br>-A container of bread and butter slices without a date;<br><br>-A container of kosher dill pickle spears without a date;<br><br>-A container of slaw dressing without a date.<br><br>Observations of the freezer on [DATE] at 3:22 P.M., [DATE] at 7:15 A.M., and [DATE] at 3:04 P.M., showed the following:<br><br>-A plastic bag that contained bratwursts ripped open with a hole in it, opened and exposed to air, without a date;<br><br>-A plastic bag that contained burritos, without a date;<br><br>-A plastic bag that contained fish sticks with zip tie closure, without a date;<br><br>-An unidentified meat in plastic, without a date;<br><br>-An opened box that contained an opened package of beef patties, opened and exposed to air;<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 - Many | -An opened box that contained an opened package of Salisbury patties, opened and exposed to air;<br><br>During an interview on [DATE] at 12:07 P.M., the Dietary Manager (DM) said the shelf life for the food on the shelves is 90 days. Her method for using items on the shelves was to use the first in and first out method. If food was left over, it went into food storage containers, plastic wrap, or Ziploc bags, and then it was dated with the name on it. All staff were responsible to ensure expired food was thrown out. She also had an afternoon aide who came in at 12:00 P.M., who completed daily checks to make sure everything had been dated or thrown away if expired or not dated. Everyone in the kitchen, dietary staff, was responsible to ensure all food was properly labeled, dated, and stored. It was her expectation that all food was properly labeled, dated, stored and that all expired food was thrown out.<br><br>2. Observation on [DATE] at 10:55 A.M., showed Cook S pureed vegetables with gloves on his/her hands. He/she poured the mixture into five divided plates. Cook S then used his/her left hand to scrape the remainder of the mixture into two of the divided plates. He/She placed the food processor in the sink and rinsed it out then rinsed his/her gloves off. Cook S then went to the fryer and removed the fish and used his/her gloved hands to place more fish in the fryer. Cook S then took his/her gloves off and discarded them.<br><br>During an interview on [DATE] at 12:07 P.M., the DM said she would expect for proper infection control practices to be followed. This included using gloves, tongs, spoodles, proper handwashing, and gloves changed.<br><br>3. Observations on [DATE] at 3:22 P.M., [DATE] at 7:15 A.M., and [DATE] at 3:04 P.M., of the kitchen, showed the following:<br><br>-The stove:<br><br>-Heavy caked-on stains on the stove burners;<br><br>-Heavy caked-on stains along the top and front of the stove;<br><br>-Heavy, blackened charcoal colored sticky looking matter on the bottom of the oven;<br><br>-The stand alone double oven:<br><br>-Caked-on stains on the tray racks;<br><br>-Caked-on stains on the inside on the oven doors;<br><br>-Caked on stains on the bottoms of the ovens.<br><br>During an interview on [DATE] at 12:07 P.M., the DM said obviously, the stove and ovens were not cleaned. They were supposed to be cleaned and wiped down if they got dirty. Her expectation was that all the equipment be cleaned and sanitized after each use as well as deep cleaned once a month. It was the DM's and her assistant's responsibility to ensure that the kitchen equipment was clean and sanitized. |

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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>50366<br><br>Based on observation, interview and record review, the facility failed to follow acceptable standards of practice for infection prevention and control for three residents (Residents #9, #20, and #28). The facility failed to ensure the tubing for an indwelling urinary catheter (flexible tubing used to carry urine from the bladder into a drainage bag) did not drag on the floor. The facility identified two residents as having urinary catheters. Of those two, two were included in the sample and issues were identified with one (Resident #9). In addition, the facility failed to clean shared medical equipment between resident use, for two residents observed to be transferred with a mechanical lift (Residents #20 and #28). The census was 81 with 38 residents in certified beds. The sample was 12.<br><br>1. Review of the facility's Indwelling External and Suprapubic Catheter (flexible tubing inserted through the abdomen to carry urine from the bladder) policy, not dated, showed:<br><br>-It is the facility's mission to allow residents comfort and dignity through the use of assistive technology such as catheters. We partner with physicians to ensure that quality of care;<br><br>-The policy failed to direct the staff on the proper positioning of the catheter tubing.<br><br>Review of the Resident #9's medical record, showed diagnoses included kidney disease stage three, chronic kidney disease, and fracture of the sacrum (tail bone).<br><br>Review of the resident's electronic physician order sheet (ePOS), showed:<br><br>-An order dated 8/9/23, for urinary catheter care every shift (day, evening, night);<br><br>-An order dated 8/9/23, to obtain urinary catheter output every shift (day, evening, night);<br><br>-An order dated 1/11/24, to change the urinary catheter, 16 French (diameter size of tubing) with 10 milliliter (ml) balloon (inflated to hold urine catheter in bladder), replace leg bag (urine drainage bag attached to leg), stat lock (urinary tube locking device attached to the leg), dressing to site and drainage bag on the 28th of the month.<br><br>Review of the resident's care pan, revised 4/17/24, showed:<br><br>-Urinary Incontinence Category, resident requires a urinary catheter related to urinary<br><br>-Goal; Resident will have urinary catheter care managed appropriately<br><br>-Interventions included:<br><br>-Assess the drainage (no frequency), record the amount, type, color, odor. Observe for leakage;<br><br>-Manipulate tubing as little as possible during care;<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265833 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/07/2024 |
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| NAME OF PROVIDER OR SUPPLIER Manor Grove, Incorporated | | STREET ADDRESS, CITY, STATE, ZIP CODE 711 South Kirkwood Road Kirkwood, MO 63122 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Report complications/urinary tract infection (UTI), foul odor, concentrated urine, blood in urine, obstruction, dislodgement, trauma.<br><br>Observations on 5/2/24 at 9:55 A.M., showed the resident self-propelled in a wheelchair with the urinary catheter tubing and drainage bag attached under the seat of the wheelchair and dragged on floor while the resident passed Licensed Practical Nurse (LPN) H. At 12:44 P.M., the resident sat in his/her wheelchair, the urinary catheter tubing and bag attached under the seat, and dragged on the floor while he/she passed Certified Medical Technician (CMT) D. No staff assisted the resident to reposition the catheter tubing to prevent dragging on the floor.<br><br>Observation on 5/6/24 at 10:18 A.M., showed the resident sat in a wheelchair in his/her room with his/her urinary catheter tubing and bag attached under the seat of the wheelchair. The resident stepped on the urinary catheter tubing and tried to untangle his/her feet from the tubing. Certified Nurse Assistant (CNA) B and CMT D walked by the resident's room. The resident was able to untangle his/her feet independently. The urinary catheter tubing and bag were attached under the wheelchair seat, positioned on the floor. At 11:43 A. M., the resident sat in the dining room in his/her wheelchair. The urinary tubing and bag were attached underneath the seat of the wheelchair and positioned on the floor. CNA F, CMT D, CNA A, and two kitchen staff were present in the dining room. At 12:19 P.M., the resident self-propelled in the wheelchair out of the dining room with the urinary catheter tubing and bag attached under the wheelchair seat, and dragged on the floor. CNA B assisted the resident out of the doorway. The resident propelled past CNA F, CMT D, LPN C, and Logistics Coordinator E. At 12:31 P.M., LPN C propelled another resident behind Resident #9 and passed Resident #9 in the hall. Resident #9's urinary catheter tubing and bag, attached under the wheelchair seat, dragged on the floor while the resident self-propelled down the hall. The resident stopped the wheelchair in the hall and CNA B and CMT D passed the resident. No staff assisted the resident to reposition the catheter tubing and bag to prevent dragging on the floor.<br><br>During interview on 5/7/24 at 9:51 A.M., with the Director of Nursing (DON), Administrator, and Assistant Director of Nursing (ADON), the DON said the facility staff shall maintain proper infection control for residents with urinary catheters by keeping tubing and urine drainage bag positioned below the bladder and off the floor.<br><br>2. Review of the facility's Equipment Cleaning and Disinfection Shared Medical Equipment policy and procedures, dated 3/7/20, showed:<br><br>-The purpose: To ensure that shared medial equipment and or electronic devices will be cleaned/disinfected to prevent the transmission of pathogens.<br><br>-The Procedure for Employees:<br><br>-After the use of any shared equipment, it should be cleaned according to the manufactures' recommendations if the manufactures' recommendations are not available, then it will be cleaned with a bleach wipe;<br><br>-All surface areas that come into contact with or have the potential of coming into contact with blood or body fluids must be wiped down after each use. The area must be allowed to air dry for a sufficient amount of time (per manufacturer guidelines) as it allows the chemical to perform the disinfected action it is intended for and to prevent the device from being used while still damp.<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 | Review of Resident #20's medical record, showed:<br><br>-Diagnosis included Alzheimer's disease, falls, inflammatory polyneuropathy (numbness or weakness of many nerves that provide feeling), and seizures;<br><br>-The resident's care plan, revised, 3/14/24, showed activities of daily living (ADLs) functional status problem, resident requires use of a Hoyer lift (full body mechanical lift) with at least two staff members for transfers.<br><br>Review of the Resident #28's medical record, showed:<br><br>-Diagnoses included hemiplegia and hemiparesis (unable to move one side of body) and stroke.<br><br>-An order dated 12/11/22, for Broda chair (medical reclining chair) for comfort;<br><br>-No order for Hoyer lift.<br><br>-The resident's care plan, revised 4/24/24, showed limited ability to transfer:<br><br>-Goal: The Resident will self-transfer with use of Hoyer lift and two staff.<br><br>-Approach Hoyer lift assistance for transferring.<br><br>Observation on 5/6/24 at 12:41 P.M., showed CNA B and CMT D retrieved the Hoyer lift from the hall and proceeded to Resident #28's room to transfer the resident from the Broda chair to bed. Directly after completing the transfer, at 12:55 P.M., CNA B and CMT D proceeded to Resident #20's room and used same Hoyer lift that had not been sanitized to transfer the resident from the Broda chair to the bed. CNA B and CMT D then returned the Hoyer lift to the hall. CNA B and CMT D did not disinfect Hoyer lift prior to, between, or after resident transfers.<br><br>During interview on 5/7/24 at 9:51 A.M., with the DON, Administrator, and ADON, the DON said it is the policy of the facility to clean all shared equipment between resident care and as needed with an antiseptic wipe. |