

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/10/2024
NAME OF PROVIDER OR SUPPLIER  Ignite Medical Resort Blue Springs		STREET ADDRESS, CITY, STATE, ZIP CODE  20511 E Trinity Place Blue Springs, MO 64015	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46519</p> <p>Based on observation, interview, and record review, the facility failed to obtain a physician order for self-administration of medication at bedside and failed to evaluate and document the ability to self-administer medication for one sampled resident (Resident #49) out of 19 sampled residents. The facility census was 87 residents.</p> <p>Review of the facility's policy titled Self Administration of Medications and Treatments dated May 2023 showed:</p> <ul style="list-style-type: none"> <li>-Self-administration of medications and treatments were determined by physician order after determining that the resident was able to self-administer.</li> <li>-Medications and treatments for self-administration were kept in a locked drawer in the resident room.</li> <li>-All medications and treatments that were self-administered were signed out in the Medication Administration Record (MAR) or Treatment Administration Record (TAR).</li> <li>-If determined by a member of the interdisciplinary team, or if the resident requested to self-administer, it would be documented in the chart and the physician would be called for an order to self-administer.</li> <li>-A care plan was to be made for the resident who self-administered medications, and documentation should be present in the nursing notes related to the teaching related to self-administration of the medications or treatments.</li> </ul> <p>1. Review of Resident #49's face sheet showed he/she admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Unspecified Fracture of Lower End of Humerus (upper arm bone).</li> <li>-Other Specified Fracture of Left Pubis (pubic bone).</li> <li>-Cognitive Communication Deficit (problems with communication that have an underlying cause in a cognitive deficit).</li> </ul> <p>(continued on next page)</p>

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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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 8/1/24 showed the resident had moderately impaired cognition.</p> <p>Review of the resident's care plan dated 10/6/24 showed no care plan related to self-administration of any medication.</p> <p>Observation on 10/6/24 at 4:02 P.M. of the resident's room showed:</p> <ul style="list-style-type: none"> <li>-A bottle of Miconazole Nitrate 2% powder (an antifungal medication used to treat fungal or yeast infections) sitting on the resident's windowsill and not in a locked box.</li> <li>-A medication cup sitting on the resident's bedside table with one unidentified pill that had been cut into multiple different pieces.</li> <li>-A pill cutter on the bedside table.</li> </ul> <p>Review of the resident's Physician Order Sheet dated October 2024 showed:</p> <ul style="list-style-type: none"> <li>-An order for Miconazole External Nitrate Powder 2%, apply to under bilateral breasts topically as needed for redness/rash dated 10/7/24.</li> <li>-No order for the resident to be able to self-administer the Miconazole External Nitrate Powder 2%.</li> </ul> <p>Review of a Self-Administration of Medication Evaluation dated 10/7/24 showed the resident had only been evaluated on 10/7/24 for self-administration of the Miconazole Nitrate Powder 2% and not any time prior.</p> <p>Observation on 10/7/24 at 10:47 A.M. showed:</p> <ul style="list-style-type: none"> <li>-The resident still had the Miconazole Nitrate Powder 2% on his/her windowsill and not stored in a locked box.</li> <li>-The bottle was not labeled with the resident's name or any resident identifier.</li> </ul> <p>During an interview on 10/7/24 at 10:48 A.M. the resident said:</p> <ul style="list-style-type: none"> <li>-He/She had brought the bottle of Miconazole Nitrate Powder 2% upon admission and had been using it occasionally.</li> <li>-He/She was unsure if he/she had been assessed for self-administration of the Miconazole Nitrate Powder 2%.</li> </ul> <p>Observation on 10/8/24 at 8:43 A.M. of the resident's room showed:</p> <ul style="list-style-type: none"> <li>-The resident still had the bottle of Miconazole Nitrate Powder 2% on his/her windowsill, not in a locked box or labeled.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/10/24 at 9:33 A.M. Licensed Practical Nurse (LPN) D said:</p> <ul style="list-style-type: none"> <li>-Any nurse could assess for a resident to be able to self-administer medication as long as there was an order from the provider to do so.</li> <li>-He/She was unsure if there was any timeframe that the assessment needed to be completed by.</li> <li>-If he/she were to see a medication at a resident's bedside and was unsure if the resident had an order to be able to self-administer the medication, then he/she would talk about the medication with the resident, look at the orders and if the resident did not have an order for self-administration, then he/she would take the medication from the resident.</li> <li>-He/She was unsure if there was anyone at the facility who ensured completion of self-administration orders.</li> <li>-The Miconazole Nitrate Powder 2% was a medication that needed to be assessed for the ability to self-administer.</li> <li>-Self-Administration of any medication should be on the care plan.</li> </ul> <p>During an interview on 10/10/24 at 10:25 A.M. Assistant Director of Nursing (ADON) B said:</p> <ul style="list-style-type: none"> <li>-He/She could assess residents for the ability to self-administer and any of the nursing managers could do as well.</li> <li>-There needed to be an order from the provider in order to do a self-administration assessment.</li> <li>-If a resident requested to be able to administer a medication, then the facility would try and get the order and assessment completed within 24-48 hours.</li> <li>-He/She would have expected the nurses to have removed the Miconazole Nitrate Powder 2% from the room if they were unsure if the resident had an order to be able to self-administer the medication.</li> <li>-The Miconazole Nitrate Powder 2% was a medication that needed to be assessed for the ability to self-administer.</li> <li>-Self-Administration of any medication should be on the resident's care plan.</li> </ul> <p>During an interview on 10/10/24 at 11:18 A.M. the [NAME] President of Clinical Operations and the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> <li>-Any nurse was able to perform the assessment for self-administration of medication as long as there was an order from the provider.</li> <li>-Once requested, the assessment for self-administration of medication should be performed as soon as possible.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The DON reviewed order listings daily, so he/she would have been the one to ensure an order for self-administration was in place.</p> <p>-He/She would have expected the nurses to ensure there was in order in place for the resident to self-administer the Miconazole Nitrate Powder 2% and if there had not been an order, to perform the self-administration assessment.</p> <p>-The Miconazole Nitrate Powder 2% was a medication that needed to be assess for the ability to self-administer.</p> <p>-The resident should have had a self-administration assessment completed prior to 10/7/24.</p> <p>-Self-Administration of medication should be on a resident's care plan.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 19916</p> <p>Based on observation, interview and record review, the facility failed to maintain resident rooms 118, 113, 111, 107, 103, 127, 131, 130, 138, 142, 147, 157, 161, 160, 165, 166, 170, 173, and 176 free from cobwebs (a web spun by certain spiders, often found in the corners of disused rooms) and a buildup of dust behind the beds and in the corners next to the cabinets. This practice potentially affected at least 23 residents. The facility census was 87 residents.</p> <p>Review of the facility's undated policy titled Room Cleaning process showed:</p> <p>-Section 3: Damp wipe.</p> <p>--Wipe everything you can reach.</p> <p>--Start with the door and work around the room in a circular pattern.</p> <p>--Be sure to include wall spotting, light switches, call buttons, telephones, wall moldings, dispensers, windowsills, furniture and Packaged Terminal Air Conditioner (PTAC, is a ductless, self-contained air conditioning unit that heats and cools small areas) climate control units.</p> <p>-Section 5: Dust Mop and Sweep Floor; Dust behind all furniture and doors.</p> <p>1. Observation on 10/8/24 with the Environmental (EVS) Director showed:</p> <p>-At 9:49 A.M., A buildup of dust was present behind the beds in resident room [ROOM NUMBER].</p> <p>-At 10:02 A.M., cobwebs were present behind the chairs in resident room [ROOM NUMBER].</p> <p>-At 10:11 A.M., a buildup of dust was present behind the armoire (a bigger piece of furniture, and it is more ornate than a wardrobe cabinets) in resident room [ROOM NUMBER].</p> <p>-At 10:31 A.M., a buildup of dust and cobwebs were present behind the armoire in resident room [ROOM NUMBER].</p> <p>-At 10:17 A.M., A buildup of dust was present on the frame of the bed in resident room [ROOM NUMBER].</p> <p>-At 11:37 A.M., A buildup of dust was present behind the armoire in resident room [ROOM NUMBER].</p> <p>-At 11:41 A.M., Cobwebs were present in the corner next to the bed in resident room [ROOM NUMBER].</p> <p>-At 11:47 A.M., cobwebs were present in the corner next to the armoire in resident room [ROOM NUMBER].</p> <p>-At 11:50 A.M., Cobwebs were present next to the bed in resident room [ROOM NUMBER].</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-At 12:12 P.M., Cobwebs were present next to the armoire in resident room [ROOM NUMBER].</p> <p>-At 12:22 P.M., cobwebs were present in the corner of the room next to the bed in resident room [ROOM NUMBER].</p> <p>-At 12:28 P.M., cobwebs were present in the corner of the room next to the bed in resident room [ROOM NUMBER].</p> <p>-At 12:49 P.M., cobwebs were present in the corner close to the armoire in resident room [ROOM NUMBER].</p> <p>-At 12:58 P.M., Cobwebs were present in the corner close to the armoire in resident room [ROOM NUMBER].</p> <p>-At 1:00 P.M., cobwebs were present in the corner close to the armoire in resident room [ROOM NUMBER].</p> <p>-At 1:08 A.M., cobwebs were present in the corner behind the bed in resident room [ROOM NUMBER].</p> <p>-At 1:10 P.M., the plunger (the component of the prefilled syringe that, when depressed, pushes the liquid out through the needle into a patient/resident) of a syringe (the needle was not present) was present behind the bed in resident room [ROOM NUMBER] and cobwebs were present in the room also.</p> <p>-At 1:16 P.M., cobwebs were present in the corner next to the armoire in resident room [ROOM NUMBER].</p> <p>-At 1:18 P.M., cobwebs were present in the corner next to the armoire in resident room [ROOM NUMBER].</p> <p>-At 1:23 P.M., cobwebs were present in the corner close to the armoire in resident room [ROOM NUMBER].</p> <p>-At 1:27 P.M., cobwebs were present in the corner close to the armoire in resident room [ROOM NUMBER].</p> <p>During an interview on 10/9/24 at 3:04 P.M., the Lead Housekeeper said:</p> <p>-He/she expected housekeepers to use their tools such as a dust mop to get at objects from behind or under the beds.</p> <p>-He/she expected the housekeepers to use their tools to get at the cobwebs.</p> <p>-The housekeepers were provided with dust mops.</p> <p>-He/she expected the housekeepers to move the beds if there was not a resident lying in the bed.</p> <p>-He/she always told the housekeepers to take their time and not rush through and to just be mindful of the time they take to clean the rooms.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 10/9/24 at 3:08 P.M. with the Lead Housekeeper showed cobwebs in the corner of room [ROOM NUMBER] and a live spider in those cobwebs.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51305</p> <p>Based on observation, interview, and record review, the facility failed to assess, describe and measure wounds weekly for one sampled resident (Resident #69) who had a left knee wound and right hip surgical incision out of 19 sampled residents. The census was 87 residents.</p> <p>Review of the facility's Wound Policy and Procedure dated March 2020 showed:</p> <ul style="list-style-type: none"> <li>-The facility needed to follow standard of practice for all wounds.</li> <li>-Upon admission, the wound should be assessed.</li> <li>-The wound assessment should include the location, measurement, appearance, drainage, characteristics, and appearance of wound edges.</li> <li>-The staff were to assess the wounds on a weekly basis.</li> </ul> <p>1. Review of Resident #69's Minimum Data Set (MDS-a federally mandated assessment tool required to be completed by facility staff for care planning) dated 9/11/24 showed he/she was admitted for skilled services.</p> <p>Review of the resident's admission nursing evaluation dated 9/11/24 showed:</p> <ul style="list-style-type: none"> <li>-The resident had a left front knee open area.</li> <li>-There were no measurements or description of the wound.</li> </ul> <p>Review of the resident's nursing evaluation dated 9/13/24 showed:</p> <ul style="list-style-type: none"> <li>-The resident had a left front knee open area.</li> <li>-There were no measurements or description of the wound.</li> </ul> <p>Review of the resident's Daily Skilled Evaluations dated 9/14/24 to 9/16/24 showed no measurements or descriptions of any wounds.</p> <p>Review of resident's care plan dated 9/16/24 showed:</p> <ul style="list-style-type: none"> <li>-The resident was at risk for alteration of skin integrity.</li> <li>-Note: there was no information regarding the resident's left knee wound.</li> </ul> <p>Review of the resident's interdisciplinary team (IDT) note dated 9/17/24 showed:</p> <ul style="list-style-type: none"> <li>-He/she had a wound on his/her left knee.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Daily treatment was required to his/her surgical site on his/her right hip with hip precautions.</p> <p>Review of the resident's Daily Skilled Evaluations dated 9/17/24 to 9/18/24 showed no measurements or descriptions of any wounds.</p> <p>Review of the resident's admission MDS date 9/19/24 showed:</p> <p>-The resident was severely cognitively impaired.</p> <p>-There was no information regarding the resident's wounds.</p> <p>Review of the resident's skin assessment dated [DATE] showed:</p> <p>-The resident had an open area to his/her left front knee.</p> <p>-There were no measurements or description of the wound.</p> <p>Review of the resident's Daily Skilled Evaluations dated 9/20/24 to 9/22/24 showed no measurements or description of any wounds.</p> <p>Review of the resident's care plan dated 9/22/24 showed:</p> <p>-The resident was sent to the emergency room for hip pain.</p> <p>-While in the hospital the resident was found to have a right hip fracture.</p> <p>Review of the resident's Daily Skilled Evaluations dated 9/28/24 to 9/29/24 showed:</p> <p>-The resident had a right hip stapled surgical incision with approximated (closed) edges and no signs of infection.</p> <p>-There were no measurements or description of the wound.</p> <p>-There were no measurements or description of the left knee wound.</p> <p>Review of the resident's Daily Skilled Evaluations dated 9/30/24 to 10/1/24 showed no measurements or description of any wounds.</p> <p>Review of the resident's IDT note dated 10/1/24 showed:</p> <p>-Daily treatment was required to his/her surgical site on his/her right hip.</p> <p>-No documentation regarding the resident's left knee wound.</p> <p>Review of the resident's skin assessment dated [DATE] showed:</p> <p>-A wound on his/her left knee but with no description or measurements.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-A surgical incision on his/her right hip but with no descriptions or measurements.</p> <p>Observation on 10/9/24 at 10:59 A.M. showed:</p> <p>-The resident had a right hip surgical wound with staples.</p> <p>-The right hip wound was clean, dry and intact with no signs of infection.</p> <p>-The resident's left knee had two heeled quarter size scars.</p> <p>During an interview on 10/9/24 at 1:20 P.M. Licensed Practical Nurse (LPN) A said:</p> <p>-He/she was not aware of the resident's left knee wound.</p> <p>-When a wound was identified on a resident the wound nurse would be notified.</p> <p>-The wound nurse was responsible for the assessment of all wounds.</p> <p>During an interview on 10/10/24 at 9:12 A.M. Assistant Director of Nursing (ADON) A said:</p> <p>-The nursing staff should be documenting all wounds on the weekly skin assessment.</p> <p>-The nurses can write a description and general size of the wound but do not measure the wound.</p> <p>-Upon admission the nurses were expected to assess and describe the resident's wounds.</p> <p>During an interview on 10/10/24 at 10:15 A.M. the Wound Nurse said:</p> <p>-He/she expected a full head to toe skin assessment on all residents upon admission.</p> <p>-The nurses should document a full description of the wound.</p> <p>-All skin assessments should show all resident wounds.</p> <p>During an interview on 10/10/24 at 10:30 A.M. Registered Nurse (RN) B said:</p> <p>-Upon admission the nurses were expected to assess and describe the resident's wounds.</p> <p>-He/she would document anything out of the ordinary related to the resident skin on the skin assessment.</p> <p>-He/she would describe any wounds in detail on the skin assessment.</p> <p>During an interview on 10/10/24 at 11:19 A.M.:</p> <p>-The Director of Nursing (DON) said:</p> <p>--He/she expected nursing staff to do a full detailed skin assessment at the time of admission.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>50579</p> <p>Based on observation, interview and record review, the facility failed to ensure the ordered application of splint devices were utilized to improve or maintain mobility for one sampled resident (Resident #58) with limited mobility out of 19 sampled residents. The facility census was 87 residents.</p> <p>Review of a facility policy titled Range of Motion, dated 11/2020, showed:</p> <ul style="list-style-type: none"> <li>-A resident with limited range of motion would receive services to increase range of motion and/or decrease further range of motion.</li> <li>-Residents of the facility would be provided care and services to prevent formation and progression of contractures (a condition of shortening and hardening of tendons and muscles often leading to rigidity and deformities of joints) and deformities.</li> </ul> <p>1. Review of Resident #58's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment completed by the facility) dated 8/14/24, showed the resident:</p> <ul style="list-style-type: none"> <li>-Was severely cognitively impaired.</li> <li>-Did not reject cares in the assessment period.</li> <li>-Was dependent on staff for upper body dressing.</li> <li>-Had upper extremity range of motion impairment on one side.</li> <li>-Had diagnoses of stroke and hemiplegia (inability to use one side of the body)</li> </ul> <p>Review of the resident's Physician Order Summary (POS), dated 10/9/24, showed an order for a left functional resting hand splint (a medical device that immobilizes and protects a body part from further injury) to be applied during waking hours as tolerated.</p> <p>Review of the residents Care Plan, dated 8/9/24, showed:</p> <ul style="list-style-type: none"> <li>-The resident had limitations in physical mobility.</li> <li>-An intervention of a left hand splint.</li> </ul> <p>Review of the resident's Nurse Practitioner (NP) progress note dated 9/30/24, showed NP A observed the resident during waking hours without his/her ordered hand splint.</p> <p>Observation on 10/8/24 at 11:06 A.M., the resident was in his/her wheelchair near the nurse's station without the splint device in place.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 10/9/24 at 11:07 A.M., the resident was in his/her wheelchair near the nurse's station without the splint device in place.</p> <p>During an interview on 10/9/24 at 11:26 A.M., Certified Nursing Assistant (CNA) D said:</p> <ul style="list-style-type: none"> <li>-The resident grimaced when he/she attempted to apply the splint, so he/she did not apply it.</li> <li>-The resident did not wear the splint all the time.</li> </ul> <p>During an interview on 10/9/24 at 1:16 P.M., Registered Nurse (RN) B said:</p> <ul style="list-style-type: none"> <li>-He/She was the resident's nurse for the day.</li> <li>-He/She was unaware if the resident had the splint in place or not.</li> <li>-There was not a reason the resident did not have the splint on today.</li> </ul> <p>Observation on 10/9/24 at 1:19 P.M., showed:</p> <ul style="list-style-type: none"> <li>-RN B placed the splint on the resident's left hand.</li> <li>-No grimacing or resistance was noted from the resident.</li> </ul> <p>Review of the resident's Treatment Administration Record (TAR) dated October 2024 showed documentation of splint application on 10/8/24 and 10/9/24 by the resident's staff nurse.</p> <p>During an interview on 10/10/24 at 11:25 A.M., the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> <li>-He/She would expect staff to apply ordered devices like splints.</li> <li>-He/She would not expect nurses to document application of devices if they were not applied.</li> </ul>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>46519</p> <p>Based on interview and record review, the facility failed to obtain a physician's order for one sampled resident (Resident #49) to self-perform colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon) care and failed to complete a full evaluation to self-perform the colostomy care out of 19 sampled residents. The facility census was 87 residents.</p> <p>Review of the facility's policy titled Self Administration of Medication and Treatments dated May 2023 showed:</p> <ul style="list-style-type: none"> <li>-Self-Administration of medications and treatments was determined by a physician order after determining that the resident was able to self-administer.</li> <li>-Treatments for self-administration were kept in a locked drawer in the resident's room.</li> <li>-All treatments that were self-administered were signed off in the Treatment Administration Record (TAR).</li> <li>-If it was determined by a member of the interdisciplinary team, or if the resident requested to self-administer, it would be documented in the chart and the physician would be called for an order.</li> <li>-If a treatment order was self-administered, the resident would need to perform a return demonstration of the treatment to be able to do the treatment independently.</li> <li>-A care plan would be made for the resident who self-administered medications, and documentation should be present in the nursing notes of teaching related to self-administration of the medications or treatments.</li> </ul> <p>1. Review of Resident #49's face sheet showed he/she admitted to the facility with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Colostomy Status.</li> <li>-Cognitive Communication Deficit (problems with communication that have an underlying cause in a cognitive deficit).</li> </ul> <p>Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 8/1/24 showed:</p> <ul style="list-style-type: none"> <li>-The resident had moderately impaired cognition.</li> <li>-The resident had an ostomy (an artificial opening in an organ of the body).</li> </ul> <p>Review of the resident's care plan dated 8/11/24 showed:</p> <p>(continued on next page)</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident had impaired cognitive function and/or thought processes.</p> <p>-The resident had impaired visual function.</p> <p>-The resident had an Activities of Daily Life (ADL) self-care performance deficits and limitations in physical mobility.</p> <p>-The resident had an ostomy and staff were to provide ostomy care per protocol.</p> <p>Review of an Occupational Therapy Treatment Encounter Note dated 9/10/24 showed the resident had stood over the toilet and demonstrated emptying and cleaning of his/her colostomy bag.</p> <p>Review of the resident's Physician Order Sheet dated October 2024 showed:</p> <p>-An order to change colostomy bag and appliance as needed.</p> <p>-An order to change colostomy bag and appliance every day shift every seven days.</p> <p>-An order for ostomy care as needed.</p> <p>-An order for ostomy care every shift, check appliance, and empty.</p> <p>-An order for ostomy: change wafer and bag weekly every evening shift every seven days and as needed.</p> <p>--NOTE: There was no order for the resident to self-administer his/her own ostomy treatments and no clarification on any orders related to the resident's ability to perform self-care.</p> <p>During an interview on 10/7/24 at 1:56 P.M. the resident said he/she performed his/her colostomy care by himself/herself without any assistance from staff.</p> <p>Review of the resident's Electronic Medical Record on 10/8/24 showed no nursing notes related to the assessment or ability for the resident to perform his/her own ostomy care.</p> <p>During an interview on 10/8/24 at 12:32 P.M. the resident said:</p> <p>-He/She had not been assessed for the ability to self-care for his/her ostomy.</p> <p>-No one had asked him/her to demonstrate his/her ostomy care.</p> <p>During an interview on 10/10/24 at 9:07 A.M. Occupational Therapist Registered and Licensed (OTR-L) A said:</p> <p>-Only certain parts of the self-care assessment for ostomy care would be completed by therapy staff.</p> <p>-This included the voiding/dumping of the bag and cleaning of the bag.</p> <p>(continued on next page)</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-All other aspects of the ostomy care would need to be assessed by the nursing staff.</p> <p>-He/She was unsure if the nursing staff were aware that only part of the assessment was completed by therapy staff.</p> <p>During an interview on 10/10/24 at 9:47 A.M. Licensed Practical Nurse (LPN) D said:</p> <p>-The nursing staff would be responsible for completing the assessment for the self-administration of ostomy care.</p> <p>-There was no specific timeline in which the assessment needed to be completed, just that the assessment would be completed once informed by the resident of wanting to self perform the care.</p> <p>-The orders in the POS should clarify what the resident would be responsible for and what the staff would be responsible for related to the resident's ostomy care, but a specific order for the resident to perform self-administration of his/her ostomy care was not needed.</p> <p>-He/She had watched the resident perform ostomy care but was unsure if he/she had documented a note.</p> <p>-The resident was able to self-administer his/her own ostomy care.</p> <p>-The care plan should clarify what care the resident would perform and what care the nursing staff would be responsible for.</p> <p>During an interview on 10/10/24 at 10:18 A.M. Assistant Director of Nursing (ADON) B said:</p> <p>-There was not an assessment form for nursing staff to complete when assessing for self-administration of a treatment, including ostomy care.</p> <p>-He/She would have expected the nursing staff to have completed an assessment for the resident to perform his/her own ostomy care by that point in time.</p> <p>-There should have been a note in the resident's electronic medical record that indicated the assessment had been completed.</p> <p>-The resident's care plan should have reflected the resident needed stand-by assistance when performing his/her ostomy care.</p> <p>-The resident's orders would need to be updated to include what care the resident could do by himself/herself and what care the staff would be responsible for.</p> <p>During an interview on 10/10/24 at 11:18 A.M. the [NAME] President of Clinical Operations and the Director of Nursing (DON) said:</p> <p>-Therapy or nursing staff could complete the assessment for self-administration of ostomy care.</p> <p>(continued on next page)</p>

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-They were not aware that therapy could only perform part of the assessment and were unsure if a full assessment had been completed.</p> <p>-There was no specific assessment form that was completed when assessing for self-administration of treatments, but there would need to be a note that indicated the assessment was completed.</p> <p>-They expected the nursing staff to check-in with the resident to see if any assistance was needed related to the ostomy care.</p> <p>-The resident's care plan needed to be updated to reflect that the resident could perform his/her own ostomy care.</p> <p>-The resident's current orders did not need to be updated or clarified.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21003</p> <p>Based on observation, interview and record review, the facility failed to ensure physician's orders for a Continuous Positive Airway Pressure (CPAP a form of positive airway pressure ventilation in which a constant level of pressure greater than atmospheric pressure is continuously pumped into the lungs during spontaneous breathing) machine was on their Physician's Order Sheet (POS) and care plan; and failed to ensure respiratory face masks and tubing were kept covered when not in use for two sampled residents (Resident #183 and #280) out of 19 sampled residents. The facility census was 87 residents.</p> <p>Review of the facility policy for Respiratory Supplies revised 5/2023 showed:</p> <p>-There was no policy documentation related to obtaining physician orders for a CPAP machine or storage of CPAP and oxygen supplies.</p> <p>1. Review of Resident #183's Face Sheet showed the resident was admitted on [DATE], with diagnoses including sleep apnea (a sleep disorder that causes breathing to repeatedly stop or become shallow during sleep), diabetes, high blood pressure, heart disease and emphysema (the permanent enlargement of air spaces in the lungs).</p> <p>Review of the resident's Admission Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 10/2024, showed the MDS was not completed yet (it was not due until 10/9/24).</p> <p>Review of the resident's POS dated October 2024, showed physician's orders for:</p> <p>-Continuous oxygen at 3 liters per minute (ordered 10/6/24).</p> <p>-Change oxygen tubing every night shift on Sunday and as needed (ordered 10/6/2024).</p> <p>-NOTE: The POS did not show the resident used a CPAP, did not show orders for the CPAP setting or for the duration the resident was supposed to wear it.</p> <p>Review of the resident's Care Plan dated October 2024, showed the resident had altered respiratory status/difficulty breathing and emphysema. He/She received oxygen at 3 liters daily. Interventions showed staff would:</p> <p>-Administer medication as ordered. Monitor for effectiveness and side effects.</p> <p>-Administer oxygen per physician's orders.</p> <p>-Monitor for signs and symptoms of respiratory distress and report to the physician as needed.</p> <p>-Monitor the resident's vital signs as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-NOTE: The care plan did not show the resident used a CPAP machine, when he/she was supposed to use it or how nursing staff was supposed to care for it.</p> <p>Observation on 10/6/24 at 5:04 P.M., showed the resident was sitting in his/her wheelchair dressed for the weather and watching tv in his/her room. His/Her call light was within reach and he/she was not wearing his oxygen, but showed no signs of respiratory distress. His/Her oxygen nasal cannula (a medical device that provides supplemental oxygen to a patient through two prongs that fit into the nostrils) was laying on top of his/her bed sheets, uncovered. There was also a CPAP machine that was sitting on the nightstand by his/her bed. The CPAP face mask and tubing were also laying on the resident's bedsheets uncovered. The resident's oxygen concentrator (a medical device that extracts oxygen from the air and delivers it to a patient in a more concentrated form) was sitting on the side of his/her bed and there was a plastic bag on the concentrator.</p> <p>Observation on 10/7/24 at 12:01 P.M., showed the resident was sitting in his/her recliner dressed for the weather. His/her eyes were closed and he/she seemed to be resting without signs or symptoms of distress. He/She was not wearing his/her oxygen and his/her oxygen tubing was in a plastic bag on the oxygen concentrator that was beside his/her bed. The resident's CPAP machine was sitting on the night stand beside his/her bed and the CPAP mask and tubing was laying on top of his/her bed sheets, uncovered.</p> <p>During an interview on 10/7/24 at 12:01 P.M. the resident said the nursing staff took care of his/her CPAP and oxygen tubing but he/she was able to put them on and remove them. They put his/her oxygen tubing in the bag since he/she only used it as needed. He/she said he/she wore the CPAP at night while sleeping.</p> <p>During an interview on 10/9/24 at 11:37 A.M., Certified Nursing Assistant (CNA) A said:</p> <p>-The face masks, nasal cannulas and mouthpieces for oxygen equipment should be kept covered in a plastic bag that was dated, when not in use.</p> <p>-Whenever they (nursing staff) went into the resident's room, they should check to see if the oxygen equipment was covered.</p> <p>-Sometimes residents would remove their nasal cannula or face masks and lay it down instead of placing them in the plastic bags, but when staff checked on the resident they should make sure it was put in a plastic bag.</p> <p>During an interview on 10/9/24 at 1:06 P.M., Licensed Practical Nurse (LPN) A said:</p> <p>-Oxygen equipment (nasal cannulas, face masks, tubing) should have plastic bags that they were stored in when they were not in use.</p> <p>-Anytime the nursing staff went into the resident's room, they should check because some residents removed their masks or nasal cannulas themselves and would not place them in the bags.</p> <p>-Nursing staff should place the oxygen equipment in the plastic bag anytime they saw that it was not in there.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-They have some residents that they know would not place their tubing, mask and nasal cannula in the plastic bags so they checked those residents more frequently.</p> <p>-The resident's CPAP machine tubing and face mask should be kept covered when not in use and the nursing staff also had to rinse the tubing after use.</p> <p>-There should be physician's orders for the resident's CPAP machine and the orders should be documented on the physician's order sheet and include the duration of use and care for the machine.</p> <p>-Usually the orders for the CPAP were on the discharge orders and the nurse would transcribe it to the POS upon admission.</p> <p>-If the order for the CPAP was not on the discharge orders, usually the respiratory nurse would complete an assessment and put the orders on the resident's POS.</p> <p>-He/She was unaware that the resident did not have orders for his/her CPAP machine and would follow up on resolving this.</p> <p>-The CPAP should be on the resident's care plan with interventions for care and use.</p> <p>33409</p> <p>2. Review of Resident #280's Admission Face sheet showed the resident had a diagnosis of Obstructive Sleep Apnea (a sleep disorder that keeps you from breathing normally while you sleep).</p> <p>Review of the resident's Treatment Administration Record (TAR) and Nursing Medication Administration record (MAR) dated 10/1/24 to 10/31/24 showed:</p> <p>-Did not have a detailed physician's order for use and monitoring/care of the residents CPAP machine and supplies.</p> <p>-No documentation of the monitoring of the resident's use of the CPAP machine at bedtime or as needed.</p> <p>Review of the resident POS dated 10/3/24 showed he/she had the following orders:</p> <p>-Administer supplemental oxygen as needed.</p> <p>-NOTE: There was no order found for the care and use of a CPAP machine.</p> <p>Review of the resident's Care Plan date 10/4/24 showed the resident did not have a care plan for sleep apnea to include a reason for the use and the care of C-PAP machine and mask</p> <p>Observation on 10/6/24 at 3:48 P.M., showed the resident:</p> <p>-Was in his/her room lying in bed.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Had a CPAP machine next to the bed on the dresser with a face mask draped over the machine uncovered.</p> <p>Observation on 10/7/24 at 10:14 A.M., showed the resident had a CPAP machine sitting on the dresser.</p> <p>During an interview on 10/7/24 at 10:14 A.M. the resident said he/she wore the CPAP at night.</p> <p>Review of the resident's electronic medical record on 10/7/24 at 10:40 A.M. showed the resident did not have a Physician's Order for use and care of his/her CPAP machine.</p> <p>Review of the resident's Admission MDS dated [DATE], showed he/she:</p> <p>-Was cognitively intact, able to make his/her needs and wants known.</p> <p>-Required the use of a CPAP machine.</p> <p>Observation on 10/9/24 at 11:23 A.M. showed the resident had a CPAP machine next to the bed.</p> <p>Review on 10/9/24 at 11:40 A.M., of the resident's medical record with LPN B showed:</p> <p>-LPN B could not find a physician order and care plan for the residents use and care of a CPAP machine.</p> <p>-He/she would expect to have a detailed physician order for the use of a CPAP machine and supplies.</p> <p>-He/she would expect to have a care plan with an intervention for a CPAP machine for sleep apnea.</p> <p>-the admission nurse was responsible for the transcription of initial orders and reviewed by nurse manager the next day or two of admission</p> <p>During an interview on 10/10/24 at 9:00 A.M., Registered Nurse (RN) A said he/she would expect nursing staff to have obtained and transcribed a physician order for the resident's CPAP machine upon admission.</p> <p>During an interview on 10/10/24 at 9:35 A.M., CNA C said he/she was not sure if a CPAP mask or oxygen supplies should be covered when not in use by the resident.</p> <p>During an interview on 10/10/24 at 11:18 A.M., the [NAME] President of Clinical Operation and the Director of Nursing (DON) said:</p> <p>-He/She would expect to have a detailed physician order for the use of a CPAP machine and supplies needed.</p> <p>-He/She would expect the resident to have a current, updated care plan that included the use of a CPAP machine and care/cleaning of the CPAP.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46519</p> <p>Based on observation, interview, and record review, the facility failed to ensure appropriate precautions and correct hand hygiene was completed during colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon) care of one sampled resident (Resident #7); failed to ensure enhanced barrier precautions (a set of infection control measures that use personal protective equipment (PPE-protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) to reduce the spread of multidrug-resistant organisms in nursing homes) were used when providing care for one sampled resident (Resident #182); and failed to ensure one sampled employee out of 10 sampled employees received tuberculosis (TB - a communicable disease that affects especially the lungs, that is characterized by fever, cough, difficulty in breathing, and abnormal lung tissue and function) screening timely and follow the facility policy and procedures for TB out of 19 sampled residents. The facility census was 87 residents.</p> <p>Review of the facility's policy entitled Enhanced Barrier Precautions dated March 2024 showed:</p> <ul style="list-style-type: none"> <li>-Use of Personal Protective Equipment (PPE) to include putting on gown and gloves during high-contact resident care activities, during but not limited to transferring, wound care, indwelling medical device care such as urinary catheter, changing linen and resident personal hygiene/incontinent care.</li> <li>-Continue to adhere to other infection prevention measure to including but not limited to hand hygiene, and cleaning and disinfection of medical equipment.</li> </ul> <p>Review of the facility's policy titled Hand Hygiene dated November 2018 showed:</p> <ul style="list-style-type: none"> <li>-Wash or sanitize hands when visibly dirty or contaminated, before performing cares and after performing resident cares.</li> </ul> <p>Review of the facility's policy titled Gloves dated November 2018 showed:</p> <ul style="list-style-type: none"> <li>-Gloves are worn when there was a chance of coming in contact with excretions, secretions, blood, body fluids, mucous membranes, non-intact skin or other potentially infective material.</li> <li>-Hands should be washed or hand sanitizer applied after removing gloves.</li> </ul> <p>Review of the facility's policy titled Tuberculosis (TB) Screening for Employees dated reviewed May 2023 showed:</p> <ul style="list-style-type: none"> <li>-All employees should receive baseline TB screening upon hire, using a two-step Tuberculin Skin testing (TST) .</li> <li>-TST should be read 48-72 hours after injection.</li> <li>-NOTE: The policy did not indicate a timeframe for the second step of the TB test to be completed.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Review of Resident #7's face sheet showed he/she admitted to the facility with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Spina Bifida (a congenital (present at birth) defect of the spine in which part of the spinal cord was exposed through a gap in the backbone, often causing paralysis of the lower limbs).</li> <li>-Colostomy Status (an artificial opening in an organ of the body).</li> <li>-Presence of Urogenital Implants.</li> </ul> <p>Review of the resident's undated care plan showed:</p> <ul style="list-style-type: none"> <li>-The resident had an ostomy.</li> <li>-The resident had a suprapubic catheter (a surgically created connection between the urinary bladder and the skin used to drain urine from the bladder).</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 9/19/24 showed the resident had an ostomy and an indwelling urinary catheter.</p> <p>Review of the resident's Physician Order Sheet (POS) dated October 2024 showed an order for the resident to be on Enhanced Barrier Precautions due to his/her ostomy and suprapubic catheter.</p> <p>Observation on 10/7/24 at 11:15 A.M. of the resident's ostomy care completed by Licensed Practical Nurse (LPN) C showed:</p> <ul style="list-style-type: none"> <li>-He/She entered the resident's room without washing/sanitizing his/her hands and without putting on a gown.</li> <li>-He/She put on gloves and removed the ostomy bag then removed his/her gloves.</li> <li>-Without washing or sanitizing his/her hands, he/she put on new gloves and cleaned the fecal matter from the resident's abdomen, leg, and surrounding the ostomy site.</li> <li>-He/She then removed his/her gloves, walked to the sink, washed his/her hands, put on new gloves, and stuffed additional gloves into his/her pocket to perform the rest of the care.</li> <li>-He/She then cut out the middle of the wafer paper and asked the resident what size the hole was normally cut too and cut the hole to the appropriate size and prepped the skin for the new appliance.</li> <li>-He/She then removed his/her gloves and without washing/sanitizing his/her hands. put on new gloves that had been in his/her pocket.</li> <li>-He/She then placed the wafer paper and new ostomy bag onto the resident.</li> <li>-He/She removed his/her gloves and without washing or sanitizing his/her hands, put on new gloves that were in his/her pocket.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Hand Hygiene should be performed:</p> <p>--Before resident care.</p> <p>--When hands were contaminated.</p> <p>--When entering/exiting resident rooms/areas.</p> <p>--In-between care tasks.</p> <p>-The LPN should have washed/sanitized his/her hands before entering the resident's room, in-between glove changes, and after exiting the resident's room.</p> <p>-Whenever gloves were taken off hand hygiene needed to be performed.</p> <p>-Gloves were not a substitute for hand hygiene.</p> <p>During an interview on 10/10/24 at 10:42 A.M. Assistant Director of Nursing (ADON) B said:</p> <p>-Enhanced Barrier Precautions were used for residents with any tubes, lines, drains, wounds, and ostomies.</p> <p>-Enhanced Barrier Precautions included wearing a gown and gloves when performing direct resident care.</p> <p>-He/She expected the nursing staff to utilize Enhanced Barrier Precautions when performing ostomy care.</p> <p>-There should be a sign posted outside of resident rooms which indicated which residents were on Enhanced Barrier Precautions.</p> <p>-Hand Hygiene was to be performed when:</p> <p>--Entering and exiting resident rooms/areas.</p> <p>--In-between resident care tasks.</p> <p>--Anytime when gloves were worn.</p> <p>-The LPN should not have put the gloves in his/her pocket during the ostomy care.</p> <p>-The LPN had not performed appropriate hand hygiene during the resident's ostomy care.</p> <p>-The LPN should have sanitized his/her hands before entering the room and in-between glove changes.</p> <p>-Gloves were not a substitute for hand hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/10/24 at 11:18 A.M. the [NAME] President of Clinical Operations and the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> <li>-They would expect staff to utilize Enhanced Barrier Precautions when performing ostomy care.</li> <li>-Hand Hygiene should be performed when: <ul style="list-style-type: none"> <li>--Entering and exiting resident rooms.</li> <li>--In-between glove changes.</li> <li>--In-between different care tasks.</li> </ul> </li> <li>-The LPN had not performed the appropriate hand hygiene during the resident's ostomy care.</li> <li>-They would have expected the LPN to have performed hand hygiene before entering the resident's room, when changing gloves, and before exiting the resident's room.</li> <li>-The LPN should not have placed the additional gloves in his/her pocket during the ostomy care.</li> <li>-Gloves were not a substitute for hand hygiene.</li> </ul> <p>21003</p> <p>2. Review of Resident #182's Face Sheet showed the resident was admitted on [DATE], with diagnoses including a left ankle wound, diabetes, malnutrition, and peripheral vascular disease (a circulatory condition that occurs when blood vessels outside of the heart and brain narrow, spasm, or become blocked).</p> <p>Review of the resident's POS dated 10/4/24 showed:</p> <ul style="list-style-type: none"> <li>-Enhanced Barrier Precautions (EBP) every shift due to his/her left lower leg wound.</li> <li>-Ciprofloxacin (an antibiotic) 750 milligrams (mg). Give 1 tablet by mouth every 12 hours for wound infection until 10/14/2024 (ordered on 10/7/2024).</li> <li>-Amoxicillin (an antibiotic) 875-125 mg Give 1 tablet by mouth every 12 hours for wound infection until 10/14/2024 (ordered 10/4/2024).</li> <li>-Treatment order to the resident's left lower extremity; Cleanse with wound cleanser, pat dry, drape wound bed with tape, apply black foam to wound bed, apply suction tubing to black foam, secure with tape, attached wound vacuum (a medical device and treatment that uses negative pressure to help wounds heal) running at 125 millimeters of mercury (mmHg-a unit of pressure that measures how high a column of mercury would rise) continuously, Change on Monday/Wednesday/Friday, and as needed for soiled/dislodged dressing (ordered 10/6/2024).</li> <li>-Enhanced Barrier Precautions every shift for lower left extremity wound (ordered 10/4/2024).</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's admission MDS showed it was in process and was not completed (due date was 10/10/24).</p> <p>Review of the resident's Physician's Note dated 10/5/24, showed the physician:</p> <ul style="list-style-type: none"> <li>-Reviewed the resident's medications, hospital and medical records, consults, care plan, labs and notes and documented the resident was in the facility for rehabilitation and had a recent hospitalization for chronic wounds, deconditioning, and evaluation of a non healing left ankle wound.</li> <li>-Per hospital records, the wound was open with purulent (containing or producing pus) drainage, foul odor, and visible tendon. The resident had vascular surgery and started him/her on antibiotics.</li> <li>-The resident was partially medically stabilized and transferred to the facility for rehabilitation.</li> <li>-The resident was otherwise stable and not in distress, though he/she did report moderate pain to the affected extremity.</li> <li>-The resident was placed on enhanced barrier infection precautions in the facility.</li> </ul> <p>Review of the resident's Care Plan dated 10/6/24, showed the resident was at risk for alteration in skin integrity, was admitted with a wound to his/her left lower extremity and received antibiotic therapy for a wound infection. Interventions showed staff were to:</p> <ul style="list-style-type: none"> <li>-Apply barrier cream per facility protocol to help protect skin from excess moisture.</li> <li>-Encourage/assist with turning and repositioning every 2-3 hours.</li> <li>-Provide skin/wound treatments as ordered.</li> <li>-Monitor/document/report as needed adverse reactions to antibiotic therapy.</li> <li>-Report pertinent lab results to the physician.</li> </ul> <p>-NOTE: The care plan did not show the resident was on enhanced barrier precautions, the reason why enhanced barrier precautions were initiated and how nursing staff was to initiate infection control procedures with the resident.</p> <p>Observation on 10/7/24 at 12:12 P.M., showed there was an Enhanced Barrier Precaution sign outside of the resident's room that instructed staff on what they needed to do prior to entering the resident's room, to include sanitizing/washing hands, putting on PPE (a gown and gloves). A box of gloves and gowns were on the resident's door. There was hand sanitizer on the wall upon entrance to the resident's room. The following occurred:</p> <ul style="list-style-type: none"> <li>-LPN A entered the resident's room without sanitizing or washing his/her hands, pulled up a chair and sat down to speak with the resident. He/She then left the resident's room without washing or sanitizing his/her hands.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The CNA's did not apply personal protective equipment, including a gown, before having direct contact with the resident during a mechanical lift transfer of the resident.</p> <p>During an interview on 10/9/24 at 11:37 A.M., CNA A said:</p> <p>-Nursing staff should wash or sanitize their hands before entering the resident's room and upon leaving, whenever hands were visibly soiled and after cleaning the resident or performing a dirty task.</p> <p>-If the resident was on enhanced barrier precautions, and the nursing staff was going to provide resident care, they should also put on a gown and gloves and then remove the gown and gloves after performing cares, and sanitize or wash their hands prior to leaving the resident's room.</p> <p>During an interview on 10/9/24 at 1:06 P.M., LPN B said:</p> <p>-They usually would know before the resident came in that they would need enhanced barrier precautions. Once they determined the resident was going to be on enhanced barrier precautions, they put the sign on the resident's door and personal protective equipment, gloves and gowns, on the door or in a box by the residents door.</p> <p>-The protocol for staff was to put on the gown and then enter the room wash/sanitize their hands and put on gloves since the hand sanitizer was on there wall upon entering the resident's room.</p> <p>-Prior to leaving the resident's room they were to remove their gown, gloves and then sanitize their hands.</p> <p>-They would need to put on PPE with any cares they provided to the resident.</p> <p>-Staff should wash and or sanitize their hands when entering and exiting the resident's room, with any cares and between cares.</p> <p>-Staff should complete the dirty task and then sanitize/wash their hands before completing a clean task.</p> <p>During an interview on 10/10/24 at 9:08 A.M., CNA E said:</p> <p>-For residents on enhanced barrier precautions he/she would use the required PPE, to include a gown and gloves.</p> <p>-He/she would complete hand hygiene before and after direct contact with the resident, including during a transfer of a resident.</p> <p>During an interview on 10/10/24 at 9:35 A.M., CNA C said:</p> <p>-If a resident was on enhanced barrier precautions, the nursing staff should wear a mask, gown, and gloves, when having direct contact with the resident, to include transferring the resident from wheelchair to bed.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/she was not aware Resident #182 was on enhanced barrier precautions.</p> <p>-He/she did not place PPE on when they transferred the resident to his/her bed.</p> <p>During an interview on 10/10/24 at 11:08 A.M., RN B said</p> <p>-On 10/7/24, he/she was aware the CNA C and CNA E did not put on the required PPE needed with direct care or contact with Resident #182.</p> <p>-CNA C and CNA E should have applied gowns and gloves when providing direct contact with Resident #182, who was on enhanced barrier precautions for wounds.</p> <p>During an interview on 10/10/24 at 11:18 A.M., the DON and [NAME] President of Clinical Operations said:</p> <p>-He/she would expect care staff to wash or sanitize their hands upon entering and exiting the resident's room, between each glove change and from a dirty to clean process.</p> <p>-Resident's on enhanced barrier precautions would require gowns and gloves to be worn with any high contact activities with the resident, to include transferring from chair to bed, resident's personal hygiene care, therapy treatments (any care contact with the resident).</p> <p>-He/she would expect facility staff to be aware of signage on the resident's door for those on enhanced barrier precautions or any other isolation protocols.</p> <p>-The sign outside the door would inform staff of the type of PPE required and when it needed to be used.</p> <p>-He/she would expect all staff, who enter a room with enhanced barrier precautions and planned to provide direct high contact care for the resident, to use PPE, to include gown and gloves. If there was potential of body fluids splashing, then he/she would expect face mask/shield to be worn.</p> <p>-Resident #182 was on enhanced barrier precautions for wounds. He/she would expect staff to wear PPE with any high direct contact with the resident for care or treatment.</p> <p>3. Review of Dietary Aide A's employee record showed:</p> <p>-Dietary Aide A was hired on 7/1/23.</p> <p>-His/Her 1st step TB screening was completed on 10/30/23 and was read on 11/1/23 with negative results.</p> <p>-His/Her second step TB screening was completed on 11/14/23 and was read on 1/16/23 with negative results.</p> <p>-There was no documentation showing the resident had a previous TB test completed prior to hire or upon hire.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Dietary Aide A was no longer employed at the facility.</p> <p>During an interview on 10/10/24 at 11:18 A.M., the DON and [NAME] President of Clinical Operations said:</p> <ul style="list-style-type: none"> <li>-Employee TB tests should be done prior to orientation and then again in two weeks.</li> <li>-Facility licensed nursing staff were responsible for completion of employee TB testing.</li> <li>-Human resource staff also monitored for completion of new employee TB testing.</li> <li>-Employee A's initial TB testing was not completed in the required time frame, during orientation and two weeks after first step TB testing was completed.</li> </ul>		