

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/27/2025
NAME OF PROVIDER OR SUPPLIER  St Luke Community Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  107 6th Ave S W Ronan, MT 59864	
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>52362</p> <p>Based on observation, interview, and record review, the facility failed to ensure personal privacy resulting in a resident feeling uncomfortable and imprisoned, for 1 (#4) of 19 sampled residents, and the resident requested the camera, placed by the facility, to be removed from her room, but the facility stated if it was removed, her door would need to remain open, so her privacy was not respected. Findings include:</p> <p>During an observation and interview on 3/24/25 at 3:27 p.m., a video camera was noted on resident #4's desk, facing her, as she was sitting on her bed. Resident #4 stated she did not like the video camera because sometimes she would forget it was there, Like when I am dressing.</p> <p>During an interview on 3/24/25 at 3:51 p.m., resident #4 stated she wanted to be alone because of anxiety. Resident #4 stated she used to have a private room because of her PTSD and social phobia, but that was no longer an option for her.</p> <p>During an interview on 3/25/25 at 9:02 a.m., staff member M stated the video camera was in resident #4's room for safety, Because she (resident #4) will do unsafe stuff and fall. Staff member M stated resident #4 did not have dementia and was able to call for help independently.</p> <p>During an interview on 3/25/25 at 11:34 a.m., staff member A stated the video camera was removed once, but resident #4 asked for it to be turned back on.</p> <p>During an interview on 3/25/25 at 11:43 a.m., resident #4 stated she did not want the camera, but it was her only choice. Resident #4 stated she was given the option to remove the video camera, but then she would have to always leave her door open. Resident #4 stated she wanted her door closed because it was very noisy, and it made her anxiety worse, It was the lesser of two evils.</p> <p>During an interview on 3/26/25 at 12:19 p.m., NF1 stated she was frustrated that the facility would not remove the video camera (in resident #4's room) even after repeatedly asking for it to be removed, per resident #4's request, and attending two care plan meetings with resident #4, to discuss the concern with the camera. NF1 stated she was told by the facility if they remove the camera then her door must always be open. NF1 stated she was frustrated the facility was, Not listening to me or the resident.</p> <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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 275093
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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/26/25 at 1:46 p.m., resident #4 stated she felt like she must follow the rules, or she would be treated like a child. Resident #4 stated, I hate how it (the video camera) makes me feel, like I am in a prison, like I am being controlled. NF1 stated they had been working on getting rid of the video camera for months.</p> <p>Review of the facility's policy titled, Policy and Procedure Non-Recording Video Monitoring Fall Prevention for Long-Term Care, updated 5/23/24, showed:</p> <p>.Respecting resident privacy: Video monitoring will be used in a way that does not violate residents' right to privacy .Residents will be assured that their personal privacy is respected .</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48261</p> <p>Based on observations, interviews, and record review, the facility failed to ensure staff utilized safety straps for sit-to-stand lifts, resulting in a fall with major injury, for 1 (#11); and placing residents requiring the use of the sit-to-stand lift at risk of falls, for 3 (#s 9, 20, and 23) of 4 sampled residents; and failed to ensure a resident was sufficiently assessed on an ongoing basis and monitored for the use of a Broda chair related to her fall risk and prevention, which may have led to a further decline in mobility, for 1 (#10) of 19 sampled residents. Findings include:</p> <p>1. During an interview on 3/25/25 at 4:04 p.m., staff member R stated resident #11 slid out of the sit-to-stand mechanical lift a few months ago.</p> <p>Review of resident #11's Post Fall Huddle Investigation, dated 11/25/25, reflected resident #11 fell from the sit-to-stand mechanical lift, landing on her knees, during a transfer. The report reflected, . [Resident #11] was on the Vera-Lift near the bathroom doorway so he thought that [name] must have toileted her. [Resident #11] kneeling on the lift leaning forward. [Left] arm was up and out of the sling - [Right] arm was against the bar. [sic] The Post-Fall Huddle reflected the form was not completed until the day after the fall occurred, because the CNAs involved did not report the incident to the nurse on duty. The form was incomplete and did not reflect a root cause analysis was completed to determine why the fall and misuse of the lift occurred.</p> <p>Review of resident #11's Communication Progress note, dated 11/26/24, reflected, . nurse had spoke with [Physician name] and she reported that the resident does have a fracture through her humeral neck. [sic]</p> <p>During an interview on 3/26/25 at 2:15 p.m., staff member D stated she believed the safety straps would have been beneficial in preventing resident #11 from sliding through the sit to stand lift lift. Staff member D stated a resident would not slide through the lift if they were strapped in with the chest and knee safety belts.</p> <p>During an interview on 3/27/25 at 3:40 p.m., staff member A stated the staff did not report the fall until the next day, so they did not have a post fall huddle, and no root cause was determined for the fall. The fall from the lift resulted in a substantial injury for the resident.</p> <p>2. During an observation on 3/24/25 at 12:15 p.m., staff members I and M transferred resident #9 to the toilet using the sit-to-stand lift (Vera-Lift). Both staff members I and M assisted in placing the sling on the resident, then prepared resident #9 for the transfer to the toilet. Staff member M lifted resident #9 off the toilet, with assistance of staff member I, and returned her to her recliner. The knee safety straps, or safety strap around the sling, were not utilized during either transfer, so the transfer was completed without following safety precautions for the lift use.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 3/25/25 at 3:49 p.m., staff members Q and R transferred resident #9 to the toilet using the sit-to-stand lift (Vera-Lift). Both staff members Q and R assisted in placing the sling on the resident and prepared the resident for the transfer to the toilet. Staff member R lifted resident #9 off the toilet, with assistance of staff member Q, and returned the resident to her bed. The knee safety straps, or safety strap around the sling, were not utilized during either transfer.</p> <p>During an interview on 3/25/25 at 3:55 p.m., with staff member Q and R, staff member Q stated she, . only used the safety straps when we assess the need in the moment, like if they seem weaker than usual. Staff member R stated, The staff generally do not use the safety straps unless the patient seemed weaker or resistant to cares.</p> <p>3. During an observation on 3/24/25 at 1:02 p.m., staff members H and T transferred resident #23 to the toilet using the sit-to-stand lift (Vera-Lift). Both staff members H and T assisted in placing the sling on the patient and prepared resident for transfer to the toilet. Staff member T lifted resident #23 off the toilet with the assistance of staff member H and returned her to her bed. The knee straps or safety strap around the sling were not utilized during either transfer.</p> <p>4. During an observation on 3/25/25 at 10:01 a.m., staff members G and S transferred resident #20 to the toilet using the sit-to-stand lift (Vera-Lift). Both staff members G and S assisted in placing the sling on the resident and prepared resident #20 for the transfer to the toilet. Staff member G lifted resident #20 off the toilet, with the assistance of staff member S, and returned her to her bed. Neither the knee safety straps, nor safety strap around the sling, were utilized during either transfer.</p> <p>During an interview on 3/27/25 at 10:07 a.m., staff member Y stated she would expect staff to use safety straps on the lifts, unless the resident had wounds or pain in the area where the straps cross.</p> <p>Review of the facility's policy, Long-Term Facility Fall Prevention and Management, dated 2/26/25 reflected:</p> <ul style="list-style-type: none"> <li>- . In the event of a fall or near fall, the charge nurse will initiate the Fall Report and Fall Huddle. After each fall, a thorough review and investigation will take place. This includes: <ul style="list-style-type: none"> <li>- a. Identifying contributing factors (e.g., environmental, staff actions, or resident conditions)</li> <li>- b. Reviewing whether fall prevention strategies were in place and effective.</li> </ul> </li> </ul> <p>Review of the facility's policy, Transfer P&amp;P For Vander-Lift/Vera-Lift, dated 5/6/20, reflected:</p> <ul style="list-style-type: none"> <li>- . Secure leg straps around resident's legs for safety.</li> </ul> <p>Review of the Vera-Lift II Operating Manual, provided by the facility, no date, reflected:</p> <ul style="list-style-type: none"> <li>- . Fasten the inner safety belt snugly.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/16/23, a Recertification survey was completed. F689 - Accidents and Hazards, was cited related to fall prevention, to include staff not reporting fall(s). The severity and scope for the deficiency was cited at the level of J, Immediate Jeopardy to Health and Safety of the resident(s). The facility implemented a plan of correction, to include staff training on fall prevention, identifying root causes, and staff reporting falls.</p> <p>5. During observations on 3/24/25 at 12:05 p.m., 3/24/25 at 4:02 p.m., 3/25/25 at 8:19 a.m., 3/26/25 at 9:56 a.m., and on 3/27/25 at 8:58 a.m., resident #10 was reclined in a Broda chair either at the nursing station or her room.</p> <p>During an interview on 3/25/25 at 10:00 a.m., NF2 stated she was concerned resident #10's mobility was being taken away from her since a fall in 2023, and now she was 100% wheelchair bound.</p> <p>During an interview on 3/25/25 at 3:00 p.m., NF2 stated staff members A and E told her the use of the Broda chair was required for several reasons, to include the Broda chair keeps her safe from falling; and the Broda chair was harder for her mother to climb out of. NF2 stated she was upset watching her mother decline physically and mentally since she was placed in the Broda chair to prevent falls two years ago.</p> <p>During an interview on 3/26/25 at 10:14 a.m., staff member A and E stated they did not have physician orders, consents, and quarterly assessments for the use of the resident #10's Broda chair as a possible restraint.</p> <p>During an interview on 3/27/25 at 8:59 a.m., staff member L stated there was a safety component with the use of resident #10's Broda chair because she used to fall a lot. Staff member L stated she could probably sit in a wheelchair but was not sure how she could be assessed for the manual wheelchair.</p> <p>Review of the facility's policy titled, Policy and Procedure Broda chair, updated 3/25/25, showed:</p> <p>.The goal is to support residents .improved quality of life.</p> <p>.An assessment by the IDT team, including input from the resident and their family, will determine the need for a Broda chair. The Broda chair assessment will be completed quarterly and annually by the care team.</p> <p>.A physician order and consent form will be obtained .</p> <p>On 3/25/25 at 4:30 p.m., a request for patient #10's Broda chair assessments, orders, and consents was requested from the facility. No additional documentation was provided by the end of the survey.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>48261</p> <p>Based on observations, interviews, and record review, the facility failed to ensure medication error rates were under 5% for 2 (#s 17 and 24) of 9 sampled residents for medication errors. The medication errors placed residents at risk for overdose side effects of the medications, and the errors were not identified as a concern and continued over a period of time, per staff. The calculated medication error rate was 10%. Findings include:</p> <p>1. During an observation on 3/25/25 at 11:47 a.m., staff member U prepared three medications to be crushed and administered for resident #17. Staff member U placed one acetaminophen tablet, two carbidopa-levodopa tablets, and opened one capsule of gabapentin, putting all the medications in a clear bag. Staff member U then crushed them into a powder. Staff member U poured the powder in pudding and administered the pudding to resident #17. The bottle for the gabapentin reflected: DO NOT CRUSH OR CHEW, TAKE WHOLE.</p> <p>During an observation on 3/26/25 at 11:56 a.m., staff member L prepared three medications, which were crushed and administered for resident #17. Staff member L placed two acetaminophen tablets, two carbidopa-levodopa tablets, and opened one capsule of gabapentin, putting all the medications in a clear bag, and then crushed them into a powder. Staff member L poured the powder in pudding and administered the pudding to resident #17. The bottle for the gabapentin reflected: DO NOT CRUSH OR CHEW, TAKE WHOLE.</p> <p>2. During an observation on 3/25/25 at 7:37 a.m., staff member U prepared three medications to be administered crushed for resident #24. Staff member U placed two acetaminophen tablets, two Senna-S tablets and opened a Tamsulosin 0.4 mg capsule, putting all of them in a clear bag, and crushed the medications into a powder. Staff member U then poured the powder into a cup of chocolate pudding and administered the chocolate pudding to resident #24. The card for the capsule of Tamsulosin reflected: DO NOT CRUSH, SWALLOW WHOLE.</p> <p>During an interview on 3/26/25 at 11:58 a.m., staff member L stated, It's just one of those things, I'm sure the pharmacy and doctor are aware. We all have been doing it this way for a long time. When asked, staff member L stated she was not sure if there was an order for crushing medications for the residents and she assumed there would be. Staff member L deferred to staff member D to check on those orders.</p> <p>During an interview on 3/26/25 at 12:10 p.m., staff member D stated the facility did not obtain crushed medication orders for residents in the facility. Staff member D stated she was unaware gabapentin and tamsulosin packaging showed to not crush or chew the medication. Staff member D stated medications should not be crushed if the packaging showed to not crush. Staff member D stated the nurse should contact the pharmacy and doctor for other options.</p> <p>Review of the facility's policy, Medication Administration, no date, reflected:</p> <p>- . 11. Read the label of the medication and the route of administration and check with the medication record, being sure they are the same.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- . 21. Give the drug by the method ordered. Check to be sure the drug is in the form for the method used. Check the label on the container .</p> <p>A total of 30 medication administrations were observed, with three errors, for a total of a 10% medication error rate.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 52362</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe labeling of food storage in accordance with professional standards for food service safety, placing residents at risk for consumption of expired or contaminated food and risk for food-borne illness; and failed to develop and implement policy and procedures regarding food storage and labeling. These deficient practices affected all residents receiving food services from the facility. Findings include:</p> <p>During an observation on [DATE] at 11:40 a.m., the following had incomplete or missing labels, with dates, in the kitchen and dining areas:</p> <ul style="list-style-type: none"> <li>- Blueberries (opened) in refrigerator, dated ,d+[DATE], no year noted;</li> <li>- Pickled relish (opened) in refrigerator dated ,d+[DATE], no year noted;</li> <li>- Pepperoni (opened) in freezer dated ,d+[DATE], no year noted;</li> <li>- Ricotta cheese (opened) in refrigerator dated ,d+[DATE], no year noted;</li> <li>- Caesar dressing (opened) in refrigerator dated ,d+[DATE], no year noted;</li> <li>- Sour cream (opened) in refrigerator dated ,d+[DATE], no year noted;</li> <li>- Hashbrowns (opened) in freezer with no date;</li> <li>- Honey (opened) dated ,d+[DATE], no year noted;</li> <li>- Sugar free icing (opened) in refrigerator with no date;</li> <li>- Vinegar (opened) in dry storage dated, ,d+[DATE], no year noted;</li> <li>- Bag of dried elbow pasta (unopened) labeled as received on ,d+[DATE], no year noted; with an expiration date of [DATE];</li> <li>- All opened spices in kitchen with missing/incomplete dates and/or expired included: Cream of Tartar dated [DATE], Old Bay expired [DATE];</li> <li>- Thyme, whole bay leaves, chili powder, granulated garlic, and whole oregano leaves were opened with no dates;</li> <li>- Ground basil, with an expiration date of [DATE];</li> <li>- Salt Free Dash (in dining room) dated [DATE] and expired [DATE];</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- Red and green food dye, peppermint flavor, balsamic vinegar, and caramel sauce (all opened) with no dates;</p> <p>- Worcestershire sauce (opened) dated ,d+[DATE], no year noted.</p> <p>During observation on [DATE] at 11:40 a.m., staff member F stated he had not done much with the labels on spices because, Seasonings don't expire like tea and honey; we use open dates now. Staff member F stated he did not have use-by date charts in the kitchen area for staff to use because, Our policy is five days and ninety days for everything. Staff member F stated it was easier to use the same dates for everything because there were new cooks who still need to learn. Staff member F stated pasta should be labeled with a receive-by date then the expiration date was 12 months after. Staff member F stated pickled relish was technically good for ,d+[DATE] months, but he used 90 days.</p> <p>During an interview on [DATE] at 7:28 a.m., staff member J stated she had meetings every month educating the kitchen staff on food labeling policies and procedures.</p> <p>During an interview on [DATE] at 10:42 a.m., staff member K stated it was obvious when to throw out food if it did not look good. Staff member K stated food labeling depended on the food, Like Jello is about five days, but spices I don't know, I never really tried to keep on top of those.</p> <p>During an interview on [DATE] at 8:00 a.m., staff member F stated he did not think they had a policy on received-by, opened, and use-by dates.</p> <p>During an interview on [DATE] at 8:35 a.m., staff member F presented pages 55, 57, and 61 of a document titled, Food Preparation: Purchasing, Receiving and Storage of Food Products. This document reflected the following:</p> <p>Page 55: .Dry Pasta .Aim to use within 12 months, Maximum shelf life of 24 months .Other open foods in dry storage, refrigerator and freezer should be shut/wrapped tightly and labeled and/or dated . [sic]</p> <p>Page 61: .All refrigerated ready-to-eat potentially hazardous foods (TCS Foods) prepared in house or received from suppliers must be clearly marked with the date by which the product should consumed, sold or discarded (use by date) . should be held for a maximum of 5 days .Refrigerated, ready-to-eat, NON-TCS food should be held for a maximum of 30 days .Staff will check coolers daily, checking items for dates and spoilage, discarding expired and/or spoiled foods . [sic]</p> <p>On [DATE] at 4:30 p.m., a request was made for a complete policy and procedure on food storage. This document was not received by the end of the survey.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35356</p> <p>Based on interview and record review, the facility failed to maintain documentation of its ongoing QAPI program efforts which demonstrated how the facility determined contributing causes of problems to determine the root-cause of identified issues; failed to establish corrective action plans which included interventions to correct the problem to establish measurable outcomes for established goals; and failed to establish measurable goals in order to determine a process on how to monitor projects to ensure expected results of the established goals. This deficient practice placed all residents receiving care at the facility at risk for missed opportunities to identify and implement improvements that could enhance patient care, increased safety risks, and operational efficiency; and the facility failed to establish a process to review and revise performance improvement projects to ensure goals would be met; and failed to determine the root-cause of a fall with major-injury which resulted in a fractured arm for 1 (#11) of 4 sampled residents for falls. This deficient practice placed residents at risk for increased falls and major injury. Findings include:</p> <p>1. During an interview on 3/25/25 at 4:04 p.m., staff member R stated resident #11 slid out of the sit-to-stand lift a few months ago.</p> <p>During an interview on 3/26/25 at 1:30 p.m., staff member D stated the performance improvement plan was started on 3/24/24, for falls, and has been ongoing through, 2/19/25. Staff member D stated there had not been additional documents to attach to the performance improvement project form. There were no interventions in plan tasks to be done, until 2/26/25.</p> <p>Review of the facility's Performance Improvement Project (PIP) Guide, dated 3/24/24, listed the key area for improvement as, reduce the number of falls per month. The root-cause was listed as, continue 5-why's and fall huddles. The section titled, Brainstorm: interventions, ideas, staff input. The plan section reflected: data collection of falls for 2024, dated 2/26/25 and comparison of 2023 and 2024, dated 2/26/25. The section titled, Study and Act Benchmarks, reflected: the progress will be measured during quarterly QAPI meetings. With the following dates: 4/23/24 - Baseline, 8/29/24 - First Measurement, 11/11/24 - Second Measurement, 2/19/25 - Final Measurement. The facility's PIP failed to determine the root-cause of a fall with major-injury for patient #11 and failed to review and revise performance improvement interventions to ensure goals were met.</p> <p>Review of resident #11's Post Fall Huddle Investigation, dated 11/25/25, reflected resident #11 fell from the sit-to-stand lift landing on her knees during a transfer. The report reflected, . [Resident #11] was on the Vera-Lift near the bathroom doorway so he thought that [name] must have toileted her. [Resident #11] kneeling on the lift leaning forward. [Left] arm was up and out of the sling-[Right] arm was against the bar. [sic] The Post-Fall Huddle reflected the form was not completed until the day after the fall occurred because the CNAs involved did not report the incident to the nurse on duty. The form was incomplete and did not reflect a root cause was completed.</p> <p>Review of resident #11's Communication Progress note, dated 11/26/24, reflected, . nurse had spoke with [Physician name] and she reported that the resident does have a fracture through her humeral neck. [sic]</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  St Luke Community Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  107 6th Ave S W Ronan, MT 59864	
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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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 3/27/25 at 3:40 p.m., staff member A stated the staff did not report the fall until the next day, so they did not have a huddle, and no root cause was determined.</p> <p>2. During an interview on 3/27/25 at 11:00 a.m., staff member A stated she was unable to explain the process the QAPI team utilized to determine the root-cause of problem-prone areas, how the facility determined which interventions would be developed to correct the problem, how the facility implemented measurable time-line driven goals, and processes for monitoring projects to ensure expected outcomes were met. Staff member A stated these areas were not documented in the facility's QAPI program.</p> <p>A review of the facility's QAPI Plan and Program for, 2024 to 2025, failed to show documentation of processes for determining the root-cause of problem-prone areas, interventions to be utilized to improve identified problems, establishment of measurable time-line driven goals, and processes for monitoring projects to ensure outcomes were met.</p> <p>A review of the facility's policy and procedure titled, Quality Assurance Performance Improvement Plan, with a review of date of 11/22/24, showed:</p> <ul style="list-style-type: none"> <li>. An important aspect of our PIPs is a plan to determine the effectiveness of our performance improvement activities and whether the improvement is sustained.</li> <li>. The responsibilities for the PIP teams will be to determine what information is needed for the PIP and how to obtain the information . The team will develop an action plan using the organizations usual format. When determining and implementing interventions, [Plan-Do-Study-Act] cycles will be used .</li> <li>. Our facility uses a systematic approach to determine when in-depth analysis is needed to fully understand identified problems, causes of the problems, and implications of a change. To get at the underlining cause of issues, we bring teams together to identify the root cause and contributing factors.</li> <li>. To prevent future events and promote sustained improvement our organization develops actions to address the identified root cause and/or contributing factors of an issue/event that will affect change at the systems level. We use Plan-Do-Study-Act cycles to test actions and recognize and address unintended consequences of planned changes.</li> <li>. To ensure the planned changes/interventions are implemented and effective in making and sustaining improvements, our organization chooses to conduct ongoing periodic measures and review.</li> </ul>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>35356</p> <p>Based on observation, interview and record review, the facility failed to ensure staff changed gloves and performed hand hygiene when moving from a contaminated task to a clean task during the provision of ADL care for 2 (#s 9 and 11); failed to maintain a clean gait belt for 1 (#14) of 19 sampled residents; and failed to maintain a soiled/dirty area separate from the clean equipment and supplies; and failed to maintain cleanable surfaces in the laundry room. These deficient practices increased the risk of infection for all residents receiving services in the facility. Findings include:</p> <p>1. Hand Hygiene and Glove Changes</p> <p>a. During an observation on 3/25/25 at 9:15 a.m., staff member G cleaned resident #11 of BM. With the same gloved hands used to wipe the resident of BM, staff member G opened a clean brief and laid it out to be placed on the resident. Staff member G then opened the package of wet wipes and grabbed out several more wipes and continued to cleanse the resident of BM. Staff member G did not change her gloves or cleanse her hands between completing the soiled care to when she placed the clean brief on resident #11.</p> <p>During an interview on 3/25/25 at 9:30 a.m., staff member G stated it was the expectation to change gloves and disinfect hands when transitioning between a contaminated task and a clean task.</p> <p>b. During an observation on 3/25/25 at 10:01 a.m., staff members G and S were preparing resident #9 to be toileted with the Vera-lift. Staff member G attached the lift belt to resident #9 and to the lift. Staff member S ran the lift, and both assisted resident #9 to the bathroom. Staff members G and S each assisted on opposite sides of resident #9, removing the dirty brief and guiding resident #9 to the toilet. Staff member G exited the bathroom and began scratching her face above her eye with the dirty glove on. Staff member S exited the bathroom and pulled out a brief and the wipes from the closet with her dirty gloves. Both staff members G and S re-entered the bathroom and put on a new brief and pantyliner in place with their soiled gloves on. Staff member S began to raise the Vera-lift and staff member G began to clean resident #9's peri-area. Staff member G and S did not change their gloves or cleanse their hands between completing the soiled care to when they placed the clean brief on resident #9 and touched face with soiled glove.</p> <p>c. During an observation and interview on 3/25/25 at 3:49 p.m., staff members Q and R prepared resident #9 for transfer to the toilet with the Vera-lift. They transferred resident #9 to the toilet, with one on each side of the resident and assisted each other in the removal of the soiled brief. Staff member Q exited the bathroom, with her dirty gloves still on, and removed a clean brief and wipes from the closet stock and returned to the bathroom. Staff member R grabbed new gloves from the box on the wall while wearing her contaminated gloves. Staff member Q raised resident #9 up from the toilet, using the Vera-Lift, while staff member R cleansed resident #9's peri-area. Staff member Q began to pull up the brief she and staff member R placed on resident #9. Staff member R took her gloves off, and took resident #9 to her recliner, using the Vera-Lift. Staff member R did not complete hand hygiene after degloving. Staff member R stated she forgot to complete hand hygiene and then was overthinking it because her hand sanitizer was in her pocket. Staff member Q and R did not change their gloves or cleanse their hands between completing the soiled care to when they placed the clean brief on resident #9.</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 - Many</p>	<p>During an interview on 3/26/25 at 11:30 a.m., staff member A stated it was the expectation for staff to wash their hands and change gloves between clean and dirty care.</p> <p>On 3/26/25 at 5:00 p.m., a request for the facility's policy and procedure for hand hygiene was requested. The document was not provided by the end of the survey.</p> <p>During an interview on 3/27/25 at 8:33 a.m., staff member D stated there was not a policy specific to the hand washing, but the staff had the hand washing training with return demonstration.</p> <p>48261</p> <p>2. Gait Belt Disinfection</p> <p>During an observation and interview on 3/25/25 at 7:48 a.m., staff member G offered to assist resident #1 to walk from the dining room to her room for her exercise program. Resident #1 stood up from her wheelchair and staff member G removed the gait belt from around her own waist and placed the same gait belt around resident #1's waist. Staff member G walked resident #1 to her room, removed the gait belt from resident #1, and placed the gait belt back on her own waist. Staff member G stated the facility issued them a gait belt to be used on all residents throughout the day and then the CNAs each sanitize their own gait belts at the end of their shifts.</p> <p>On 3/26/25 at 5:00 p.m., a request for the facility's policy and procedure for gait belt disinfection was requested. The document was not provided by the end of the survey.</p> <p>During an interview on 3/27/25 at 11:03 a.m., staff member D stated the facility did not have a policy related to cleaning of the gate belts, but she would expect the staff to clean the gate belts after every use.</p> <p>3. Dirty Linen and Laundry Room</p> <p>a. During an observation and interview on 3/26/25 at 12:35 p.m., of the shower room on unit 300, there were three bins inside the door for dirty linens and trash. Next to those bins was a clean shower bed, a tub, and clean Vera-lifts/Vander-Lifts. Upon immediate entrance of the room, across from the trash and dirty laundry bins, was two clean linen racks full of linens. The shower area had multiple cracks in the flooring, creating an uncleanable surface. Staff member W stated the facility was planning to do a remodel soon and create a separate space for the dirty linens and trash.</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 - Many</p>	<p>During an observation and interview on 3/26/25 at 12:45 p.m., of the shower room on unit 200, there were three bins immediately upon entry of the shower room to the right for dirty linens and trash. Above the bins was wooden cabinets with clean linens and peri care supplies and briefs. In front of the dirty linen bins and trash bin was the clean Vera-lifts/Vander-Lifts, two tubs, and a dirty linen bin. Down the right wall along the floor was a crack through the tile running the length of the wall. To the left of the door was a clean linen cabinet with briefs blocking the access to the sink. Across from the cabinet, was a shower area. Between the shower area and the tub area was a half wall with broken tiles, with missing pieces, creating an uncleanable surface and an injury hazard. Staff member W stated the dirty linen bins were placed in the shower room for convenience for staff. Staff member W stated there was also a dirty utility room two doors down the hall. Staff member W stated the facility was aware of the shower room being used to store both clean and dirty linens and trash but thought the remodel would have been done sooner. Staff member W stated they recently had an Infection Control Assessment and Response (ICAR) evaluation completed which determined the shower room was inappropriately being used as a dirty and clean utility.</p> <p>During an observation and interview on 3/24/25 at 1:10 p.m., the shower room had a strong odor of bowel movements and trash. Staff member AA stated, I clean the shower room once a day. It usually smells pretty bad from the trash. The CNAs are supposed to take it out, but they don't.</p> <p>b. During an observation and interview on 3/26/25 at 12:50 p.m., in the dirty laundry area on the left side of the wall along the washing machines the paint on the wall was bubbling, had multiple holes and damage to the wall. The wall was not a cleanable surface. The Formica along the sorting countertop had chips and breaks creating an uncleanable surface. Inside the clean laundry area, there was chipped and broken Formica on the counter tops for the sink and the folding counter, creating an uncleanable surface. There was a missing tile on the left side of the dryer duct which was allowed dust and debris to enter the clean folding area.</p> <p>During an interview on 3/27/25 at 11:10 a.m., staff member B and O stated they had an opportunity to observe the laundry room and shower rooms. Staff member O stated, The laundry room was pretty bad.</p>		