

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2024
NAME OF PROVIDER OR SUPPLIER  Brendan House		STREET ADDRESS, CITY, STATE, ZIP CODE  350 Conway Dr Kalispell, MT 59901	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>48261</p> <p>Based on interviews and record review, the facility failed to notify the physician and family of a significant weight loss for 1 (#19); and a severe weight loss for 1 (#52) of 22 sampled residents. Findings include:</p> <p>1. Review of resident #19's EHR weights reflected the following:</p> <ul style="list-style-type: none"> <li>- 7/6/24: 64 kg (140.8 lbs.)</li> <li>- 8/3/24: 60.9 kg (133.98 lbs.) for a 5.09% weight loss in one month, a significant weightloss.</li> </ul> <p>During an interview on 8/26/24 at 4:28 p.m., staff member S reviewed the hard copy chart and EHR of resident #19 and stated she could not locate any notifications to the physician for the weight loss. The last dietician note was dated 6/11/24. Staff member S stated resident #19 required assistance with feeding herself, including cueing, and redirection.</p> <p>During an interview on 8/27/24 at 10:15 a.m., staff member N stated resident #19 received a boost nutritional drink with meals. Staff member N stated resident #19's weight loss was mentioned in the nutrition at risk meetings, but she did not have notes to reflect a visit, or further interventions done since the weight loss. Staff member N stated the resident care managers were the ones who notify the physicians and families for changes.</p> <p>2. Review of resident #52's EHR reflected the following weights:</p> <ul style="list-style-type: none"> <li>- 2/21/24: 85.7 kg (188.54 lbs.)</li> <li>- 7/28/24: 74.2 kg (163.24 lbs.)</li> <li>- 8/21/24: 71.0 kg (156.20 lbs.) for a 17% weight loss in six months, a severe weightloss.</li> </ul> <p>During an interview on 8/26/24 at 4:28 p.m., staff member S reviewed the hard copy chart and EHR of resident #52 and stated she could not locate any notifications to the physician or family for the weight loss. Staff member S stated the last documentation in the hard copy record was dated 2/6/24. The nutrition at risk documents had been completed, but the notification to the physician and family sections were left blank.</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: 275109
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/29/24 at 9:12 a.m., with staff members A and B, staff member B stated the last notification for weight loss for resident #19 was in February (2024). Staff member B stated residents are discussed in all of the Nutrition at Risk meetings; however, the physicians were not a part of those meetings. Staff member B stated she would locate the notifications to the physician and fax them after the survey. At the end of the survey, the facility was provided a specific time in which all documentation must be submitted. The facility did not provide any further information.</p> <p>Review of the facility's policy, Weight/Nutrition at Risk, BH320, revised 01/2023, reflected:</p> <p>- .2. All significant changes in weight (5% in 30 days; 10% in 180 days), as defined in Centers of Medicare and Medicaid Services (CMS) interpretive guidelines, will be reported to the patients/resident's provider and responsible party. Consultation with a RD will be obtained as needed. [sic]</p>		

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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>Keep residents' personal and medical records private and confidential.</p> <p>41952</p> <p>Based on observation, interview, and record review, the facility failed to ensure laboratory personnel in the facility provided privacy during a blood draw, for 1 (#259) of 22 sampled residents. Findings include:</p> <p>During an observation on 8/27/24 at 8:39 a.m., resident #259 was seated at the middle table, in the open dining room, with a tablemate present, and both were eating breakfast. Three other residents were in the dining room eating breakfast. Unit staff were in the halls next to the open dining room. NF1 and NF2 approached resident #259 and stated they had a STAT order for the resident, as NF1 pulled resident #259 back from the table, and then turned her towards them. Resident #259 was confused and stated, What for, and NF1 replied, It must be for a medication you are on because it is an INR. NF1 applied the tourniquet on resident #259's left arm, and tried to place the left arm on the wheelchair arm, but NF1 did not have the right angle to do the blood draw. NF1 stated the resident's room number to NF2, as she went to grab a pillow from the room, and then placed it under resident #259's left arm. NF2 had gloves on and proceeded to draw vials of blood from #259's arm while in the dining room. No barrier was placed between resident #259's arm or the pillow. Resident #259 grimaced as the needle was placed in her arm. Resident #259's tablemate stopped eating and watched the event, and a resident at another table stopped eating, turned around and watched. NF1, who was barehanded, grabbed the garbage and used supplies from NF2, then placed the vials of blood in an open plastic bag clipped to their mobile cart. NF1 and NF2 walked back to replace the pillow and returned to their cart in the dining room. There were two open bags with two vials of blood each, hung from clips, on the cart. NF2 was still wearing gloves as she grabbed the cart. Resident #259 gave her tablemate a look of incredulity (look of disbelief) as she was checking her arm where the blood draw was done.</p> <p>During an observation and interview on 8/28/24 at 9:50 a.m., resident #259 was teary and confused. Resident #259 stated, I don't know these people. I don't know who they were. They said they needed my blood right now.</p> <p>During an interview on 8/28/24 at 2:40 p.m., staff member X stated when laboratory staff came over to the unit they automatically went to the resident and scanned their armband before proceeding. Staff member X stated it was up to the resident if they would want to go back to their room or stay out in the common area to complete the laboratory orders. Staff member X stated if a resident was confused they would be able to tell if the resident was comfortable or not to continue in a common area. Staff member X stated she did not know what infection control training the laboratory staff received but they were aware of the facilities enhanced barrier precaution signs.</p> <p>Review of resident #259's lab results showed she had a prothrombin INR drawn on 8/27/24, by NF1 and NF2, at 8:42 a.m.</p> <p>Review of resident #259's Residents Rights and Responsibilities form, signed by her responsible party on 8/13/24, showed, .6. PRIVACY. To privacy in accommodation, medical treatment, personal care, and in visits</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>51133</p> <p>Based on interview and record review, the facility failed to report an alleged incident of abuse within the required 24 hour reporting period for 1 (#270) of 3 sampled residents for abuse. Findings include:</p> <p>A review of the Facility Reported Incident of abuse involving resident #270 showed the incident occurred on 1/17/24. The incident was not reported to the State Survey Agency until 1/19/24. The reporting delay by the staff member did not allow the facility the opportunity to ensure measures were taken for resident protection.</p> <p>A review of the facility's document, [Resident #270] Abuse Investigation 1/19/24: Incident NOC 1/17/24 shift, showed:</p> <p>1/19/24 4:00 p.m. [Resident #270] reported to [staff member KK] on 1/19/24 that she wanted to speak to me. [Staff member KK] reported it may be due to rough handling.</p> <p>During an interview on 8/28/24 at 2:37 p.m., staff member A stated administration was available on the weekends to report incidents to the State Survey Agency. Staff member A said nurses were mandatory reporters.</p> <p>A review of the facility's policy, Abuse: Definitions, Reporting, Education and Prevention, BH106, last revised 03/2023, showed:</p> <ul style="list-style-type: none"> <li>- Policy .</li> <li>- . 5. It is the responsibility of all staff members to report abuse. It is the responsibility of the [Facility Name] Director of Nursing and Administrator to ensure that this policy and procedure are followed.</li> <li>- Procedure .</li> <li>- . 7. Reporting/Response</li> <li>- . C. Any incidents of alleged abuse or injuries of unknown origin are reported to the Department of Public health and Human Quality Assurance Division Certification Bureau within 24 hours after discovery of the incident .</li> <li>- Definitions .</li> <li>- . 4. Identification</li> <li>- A. All incidents, accidents, and injuries of unknown origin, such as bruising or skin tears and resident-to-resident contacts, are identified through the 24-hour report and event reports in order to initiate an investigation. The Administrator and the Director of Nursing are also notified.</li> </ul>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>48261</p> <p>Based on interviews and record review, the facility failed to protect a vulnerable resident from potential harm during an abuse investigation, for 1 (#270) of 22 sampled residents. This practice increased the risk of other vulnerable residents receiving care from the accused staff member. Findings include:</p> <p>Review of a Facility Reported Incident, dated 1/19/24, reflected resident #270 reported she was injured by staff member MM during a brief change, and the staff were verbally spiteful just before putting her in bed, because she needed assistance. The report showed staff member MM was reassigned.</p> <p>Review of the abuse investigation notes for resident #270, dated 1/19/24, reflected the following:</p> <ul style="list-style-type: none"> <li>- Resident #270 reported the complaint to staff member OO on 1/17/24, when the incident occurred.</li> <li>- Staff member OO reported she added the incident to the alert charting.</li> <li>- Resident #270 reported the incident again on 1/19/24 to staff member KK.</li> <li>- The abuse investigation was started.</li> <li>- Staff member MM was reassigned to care for other residents.</li> <li>- Interviews with staff occurred on 1/19/24 - 1/24/24.</li> <li>- Resident interviews occurred on 1/23/24.</li> <li>- The follow-up Investigation Report was completed by staff member FF on 1/24/24.</li> </ul> <p>Review of facility timecards for staff member KK reflected she worked on 1/18/24, 1/19/24, 1/21/24, and 1/22/24.</p> <p>During an interview on 8/28/24 at 1:43 p.m., staff member A stated the facility's policy was to reassign the accused staff member to other residents and start cares in pairs for the resident making the accusation during the investigation. Staff member A stated this had been the facility's practice for years, and she was not aware the accused should not care for other vulnerable residents during an investigation.</p> <p>During an interview on 8/29/24 at 9:10 a.m., staff member FF stated it was not the current practice of the facility to remove a staff member accused of abuse from resident care. Staff member FF stated it made sense but had not been implemented at the facility yet.</p> <p>Review of the facility's policy, Abuse: Definitions, Reporting, Education and Prevention, BH106, revised 03/2023, reflected the following:</p> <ul style="list-style-type: none"> <li>- . 6. Protection</li> </ul> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- A. It is the responsibility of the charge nurse to provide immediate protection to all residents who have had incidents, accidents, and injuries or unknown origin or resident to resident incidents. This may include immediate suspension of the employee .</p> <p>- B. When an employee is alleged or suspected to have committed an abusive act, the employee may be immediately suspended without pay by the charge nurse pending investigation of the allegations.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>48261</p> <p>Based on observations, interviews, and record review, the facility failed to provide therapeutic diets to optimize the nutritional status for 2, (#s 25 and 41) of 22 sampled residents. This practice had the potential to affect any resident at risk for nutritional decline and resulted in severe weight loss for 1 (#41). Findings include:</p> <p>1. During an interview on 8/27/24 at 8:43 a.m., resident #25 stated, I cannot read so have trouble getting what I want during meals, but if someone reads (the menu) the food is pretty good when I get what I want to eat. Still waiting to get food for breakfast. I keep asking all morning.</p> <p>During an observation on 8/27/24 at 9:02 a.m., resident #25 was yelling from his bed and could be heard from the hallway. Resident #25 stated, Are they gonna feed me? Staff member S exited the room. Resident #25's food tray was sitting in the dining room on the table uncovered, and untouched.</p> <p>During an observation on 8/27/24 at 9:06 a.m., staff member U entered resident #25's room and asked resident #25 why his call light was on. Resident #25 stated he wanted to eat, staff member U left the room, leaving light on, then went to another resident room.</p> <p>During an observation on 8/27/24 at 9:07 a.m., staff member U entered resident #25's room and said someone would be in soon, then turned the call light off, and left the room.</p> <p>During an observation on 8/27/24 at 9:26 a.m., resident #25's tray was still on the table in the dining room, and his call light was on in his room.</p> <p>During an interview on 8/27/24 at 9:27 a.m., resident #25 stated the staff had still not given him breakfast. Staff member E entered the room and stated resident #25 could not eat in bed, so he had to wait until after his shower, or the staff would have to feed him in bed. Staff member E stated resident #25 wanted to go to the bathroom, and by the time he went to the bathroom, it would be time for his shower.</p> <p>During an interview on 8/27/24 at 9:30 a.m., staff member S stated she was not clear on why resident #25 had not been served breakfast. Staff member S stated the staff on the unit were disorganized because she took her daughter to school on the first day, and some staff were new. Staff member S directed staff member E to toilet resident #25 and feed him before his shower.</p> <p>During an observation on 8/27/24 at 9:44 a.m., staff member B removed resident #25's tray from the dining room table and placed it in the dirty food cart.</p> <p>During an observation on 8/27/24 at 9:50 a.m., staff member LL entered resident #25's room while resident #25 was yelling, I'm ready (to get off commode). Staff member LL left the room and told staff member E and P resident #25 was ready to get off the commode.</p> <p>During an observation on 8/27/24 at 9:57 a.m., staff member LL entered resident #25's room and stated, They (CNAs) are getting [resident name] up then they will come.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/27/24 at 3:51 p.m., resident #25 stated he had two pieces of toast for breakfast at about 10:30 a.m. Resident #25 stated nothing else was offered to him for breakfast.</p> <p>Review of resident #25's EHR weights indicate resident #25's weights fluctuate related to his diagnosis of Congestive Heart Failure and on-going lower extremity edema.</p> <p>2. During an observation and interview on 8/27/24 at 9:16 a.m., resident #41 had a open package of cookies on his bedside table, with three cookies gone. Staff member E stated, He's on a puree diet only, he hates it, so he won't eat it. The kitchen always sends puree, so he just eats cookies. Resident #41's breakfast plate was on his bedside table, with approximately two bites gone of the scrambled eggs, which had gravy on them. The meal ticket on the tray reflected the resident was on a soft diet. Resident #25 stated he . won't eat it, it's wet mush.</p> <p>Review of resident #41's EHR weights reflected the following:</p> <ul style="list-style-type: none"> <li>- 5/28/2024: 99.80 kg (219.5 lbs.)</li> <li>- 8/14/2024: 81.69 kg (179.7 lbs.) which is a -18.13 % weight loss in three months. This is a severe weight loss.</li> </ul> <p>During an interview on 8/28/24 at 10:16 a.m., with staff members A, B, and N, staff member N stated she had changed #41's diet to Benecal protein shakes per his preference, but she had not discussed food preferences with the soft diet to learn what foods resident #25 would likely eat, or specifically why he is not eating the foods brought to him. Staff member B stated #41's wife would bring in many snacks, fast food, and sweets.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>41952</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received tube feedings as ordered, for 2 (#s 36 and 77) of 22 sampled residents. Findings include:</p> <p>1. During an observation on 8/27/24 at 8:35 a.m., resident #77 was lying in bed, next to the tube feeding pump, which was alarming with the words Feeding complete, across the screen. The tube feeding bag was observed to be over half full.</p> <p>During an observation on 8/27/24 at 11:25 a.m., resident #77's tube feeding pump was alarming. Resident #77 was in bed, and stated, It drives me nuts (the alarm). The tube feeding pump showed, Error flow clog in line downstream of pump, across the screen.</p> <p>During an interview on 8/27/24 at 4:19 p.m., staff member Y stated resident #77's pump alarming, earlier in the day, was because the door on the pump, where the tubing came out, was open after it was changed. Staff member Y stated he did not realize if the pump door was open it did not hold the tubing in place to flow, so it alarmed. After the other staff let him know of the alarm, he closed the door and restarted the pump. The pump was running without any problem since that time.</p> <p>During an interview on 8/28/24 at 10:39 a.m., staff member N stated she checked on residents with tube feedings daily, and residents with tube feeding's were always on the nutrition at risk list. She would get notified of any concerns such as gastrointestinal issues, or if an incorrect tube feed was given, through alerts her supervisor would forward to her. Staff member N stated there had been times residents with current tube feedings were provided the wrong tube feeding than what was ordered. Staff member N stated she would message the nurse who gave the wrong tube feeding, if known, and remind them of the order and supplies to use. Staff member N stated the kitchen had bulk supplies, and the unit ordered tube feeds from the kitchen for the residents and kept them in the medication storage room. Staff member N stated that unless there was an issue of intolerance or major difference in nutrients, she did not get involved more with an event of the wrong tube feeding being given. Staff member N stated nursing would be managing the administration error of the tube feedings.</p> <p>During an observation and interview on 8/28/24 at 2:26 p.m., staff member X stated the unit now had bins with labels for the different tube feedings on the unit, as there were three currently. She demonstrated how the nurses were to check with the order pulled up on the mobile cart, and then grabbed Isosource 1.5 for resident #77. Staff member X stated she let the current feed run dry and had just turned the alarm and pump off to change out a new tube feeding. Staff member X stated the alarming for resident #77's pump was now part of her environment and did not bother the resident. Staff member X stated the tube feed times for resident #77 varied because of the tube feeding, bolus of fiber and medications given, and if the resident wanted to get up or lay down flat. Staff member X stated if there was an issue with the tube feeding for a resident she would stop the tube feed, contact the provider for a directive and assess the resident.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/29/24 at 8:55 a.m., staff member Z stated resident #36 had an updated order to five times a day bolus feed versus resident #77 with a continuous feed. Staff member Z stated the nurses were training resident #36's family how to do the tube feeding for her. Staff member Z stated he had used the type of tube feeding pumps of the residents for a long time, but had not had any training on tube feeding in years.</p> <p>During an interview on 8/29/24 at 9:10 a.m., staff member FF stated there had been issues with tube feedings for residents. It was an area they were working on correcting. Staff member FF stated the incorrect tube feedings for residents #77 and #36 were treated like a medication error, for not following the orders. Staff member FF stated when the nurse who administered the wrong tube feedings was able to be identified he would educate them on the proper tube feeding orders. Staff member FF stated the facility management thought it was because the supplies looked so similar, but then a nurse grabbed the wrong bag after they were all labeled. Staff member FF stated new hires have to do a competency on tube feedings, if there is a resident in the facility at the time who was tube fed. There had not been any other training's on tube feeding for staff, but a training that was needed due to the errors occurring.</p> <p>Review of resident #77's hard copy EHR showed a note on 8/14/24, This RN observed the Pt taking in Fibersource HN through her tube feed instead of Isosource 1.5. No adverse effects observed. Please advise. On 8/16/24 a response from a provider showed, Will review .</p> <p>Review of resident #77's current diet orders showed, Tube Feeding Diet, Isosource 1.5 cal by gastric tube with a goal rate of 60 ml per hour.</p> <p>2. Review of resident #36's hard copy EHR showed:</p> <p>- 8/23/24, This RN accidentally gave an additional dose/bolus of Fibersource HN on 8/22/24 @ approximately 2300 (11:00 p.m.) No adverse effects observed. Please advise. Midas conducted. Will continue to monitor . (Was approximately 300 ml).</p> <p>- 8/24/24, Pt was found to have received the wrong tube feed - Isosource 1.5 rather than Fibersource HN. [No] adverse effects noted so far.</p> <p>Review of resident #36's current diet orders showed, Tube Feeding Diet, Fibersource HN, bolus feeding 250 ml bolus five times a day with flush before and after feeds.</p> <p>Review of an email thread about tube feedings, provided by the facility, showed:</p> <p>- Starting on 8/8/24 tube feeding errors were identified and a discussion of corrective options and reasons for the errors began.</p> <p>- A screen shot of the Glacier pod tube feeding supplies on 8/23/24 were labeled with the residents orders and in bins to separate the different types.</p> <p>- Emails sent to two nurses who made errors in giving the wrong tube feedings to residents #77 and #36 were also in the provided information.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Brendan House		STREET ADDRESS, CITY, STATE, ZIP CODE  350 Conway Dr Kalispell, MT 59901	

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F 0693  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Review of the Glacier pod, August 2024, events, showed errors for #77 on 8/14/24, and for #36 on 8/22/24 and 8/24/24, however it did not show what was done to prevent future tube feeding errors.

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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>48261</p> <p>Based on observations, interviews, and record review, the facility staff failed to wear hair restraints or wear them properly during food preparations to prevent hair from entering the food, which increased the risk of hair falling in the food served to the residents. Findings include:</p> <p>During an observation on 8/26/24 at 3:15 p.m., staff member H was preparing drinks at the prep table with her hairnet only covering a hair bun on top of her head. The hairnet did not cover her bangs, or her hair below the bun. Staff member I had no beard net, but had a full beard, and was working on the cook line. Staff member J was prepping fruit bowls with her hairnet on but it was only covering the top third of her hair. Staff member K was prepping fish with her hairnet on but it was only covering the top one-third of her hair. Staff member K's long bangs hung down to her eyebrows and were not covered. The sides and back of her hair was not covered.</p> <p>During an interview on 8/26/24 at 3:30 p.m., staff member L stated staff members H, I, J, and K were not in compliance with the facility's hair restraint policy, and she would be re-educating them immediately.</p> <p>During an observation on 8/27/24 at 1:03 p.m., staff member GG was standing on the cook line with his beard net hanging off one ear and not covering his full beard. Staff member BB was on the prep line making a tray with her hairnet not covering her hair hanging down. Staff member HH was standing at the prep line talking to other staff members with hair not covered fully by a hairnet. Staff member II was moving clean dishes to the serving line with her ponytail hanging outside of the hairnet. Staff member JJ walked thru the prep line in the kitchen wearing her hat with loose bun dangling out the back down to her shirt. Staff member JJ stated, I was told I didn't have to wear a hairnet for sloppy buns, only if hair is fully down.</p> <p>During an interview on 8/27/24 at 1:23 p.m., staff member L stated, Education was done (with kitchen staff), and they should all have their hair fully restrained.</p> <p>During an observation on 8/28/24 at 8:12 a.m., staff member I had no beard net on while standing on the cook-line. Staff member EE had no hairnet on while on the cook-line. NF4 and NF5 arrived in the kitchen with a new oven and rolled the oven through the cook-line without hair restraints. Staff member M was pushing a cart through the cook line with no hairnet covering the bottom half of her head, with her hair hanging down, unrestrained.</p> <p>Review of the facility's Uniform Policy, revised 05/19, reflected:</p> <p>. Vi) Shall wear hair covering that will cover all hair, hair needs to be contained in hair covering or above collar, this may be a hairnet, Logo caps or bonnet.</p> <p>. Vv) .Beards or mustaches longer than 1/2 inch will require a beard covering while in the kitchen or service areas.</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>48261</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper staff hand hygiene was used during meal service in a common dining room; failed to ensure proper hand hygiene was used when delivering meal trays to resident rooms, for 6 (#s 16, 25, 46, 52, 61, and 70); and failed to ensure laboratory personnel followed infection control practices during a blood draw for 1 (#259) of 22 sampled residents. Findings include:</p> <p>1. During an observation on 8/28/24 at 7:32 a.m., staff member E took resident #61's meal tray to his room, started to set up resident #61 in bed by adjusting the pillows, changing the bed position with the remote, and removing personal items on the bed. Staff member E left the room to get a clothing protector from the cabinet in the dining room. No hand hygiene was performed by staff member E as she exited the room. Staff member E went to the nutrition room, made a cup of coffee for resident #61, stocked cups, and then returned to resident #61's room to set up the meal tray. Staff member E placed the food protector on resident #61, and opened and buttered the waffles. Staff member E left the room without completing hand hygiene, went to the food service line, grabbed resident #70 a fruit bowl, stopped at the dining room cabinet for sugar packets, and returned to the residents' room. Staff member E placed the fruit bowl on resident #70's tray and determined he also needed sugar, wiped her hands on her scrub bottoms, and returned to the dining room cabinet for the sugar substitute packets. Staff member E again wiped her hands on her scrubs, returned to the resident's room, gave resident #70 his sugar packets, and then returned to resident #61 to add sugar to his food. Staff member E then left the resident's room without completing hand hygiene, then returned to the food serve line and began prepping food items for the next resident tray. Staff member E entered the room of the next resident without completing hand hygiene.</p> <p>During an observation on 8/28/24 at 7: 34 a.m. staff member U entered the room of resident #70, setup his tray and exited the room without completing hand hygiene. Staff member U returned to the food service line and began prepping items for the next resident tray.</p> <p>During an observation on 8/28/24 at 7:50 a.m., staff member Q took resident #16's tray to his room, started setting up his tray and bed. Resident #16 asked for salt and staff member Q exited the room without completing hand hygiene, went to the nutrition room for salt, returned to the room and assisted with tray set up. When staff member Q left the room, she did not complete hand hygiene and returned to the food service line and began prepping items for the next resident tray.</p> <p>During an observation on 8/28/24 at 7:53 a.m., staff member E entered resident #52's room and placed the meal tray on his bedside table. Staff member E began getting resident #52 ready to pull up in bed, and stated she was waiting for another CNA to assist with positioning resident #52. Staff member E lowered the bed down flat, adjusted the pad under resident #52's buttocks, adjusted his blankets, and moved clean linens from the chair to the sink. Staff member V arrived, put on gloves, and assisted with sliding resident #52 up in bed, then left. Staff member E set up the meal tray and began to feed resident #52, then stopped and left the room. Staff member E went to get butter and sugar from the dining room cabinet without completing hand hygiene. Staff member E returned to the resident's room and re-started the setup of resident #52's tray with butter and sugar, then started feeding the 1 to 1 feeding again.</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 observation on 8/28/24 at 8:28 a.m., staff member F entered resident #46's room carrying a breakfast tray. Staff member F was in resident #46's room for four minutes assisting the resident with positioning and setup for the meal. Staff member F exited the room at 8:32 a.m. without performing hand hygiene and walked to the nourishment room door. Staff member F entered the code on the locked door, walked into the nourishment room, obtained a drink for resident #46, and returned to the resident's room. No handwashing or hand sanitizing was performed until 8:37 a.m., after staff member F left resident #46's room for the final time, and then returned to the dining room.</p> <p>During an observation on 8/28/24 at 12:37 p.m., staff member E entered resident 25's room and placed a food protector on the resident. Staff member E then adjusted him in bed, put on gloves from her pocket without performing hand hygiene, put food condiments on his burger, cut the burger in half, took her gloves off, placed the meal tray on his pillow in his lap, and left the room without completing hand hygiene. Staff member E returned to the food service line and began prepping meal items for the next resident tray.</p> <p>48268</p> <p>2. During an observation of the dining room breakfast meal service, on 8/28/24 at 8:22 a.m., staff member G carried a breakfast tray from the steam table into a resident room. Staff member G returned to the steam table for the next meal tray, was observed brushing her forehead and hair with her hand, and then carried a meal tray to another resident in the dining room. Staff member G peeled the resident's banana, removed the food covers, handled the resident's utensils, and touched the resident's right arm and wheelchair handle. Staff member G then returned to the steam table two additional times to pick up and deliver trays to different residents in the dining room. Staff member G was observed touching the tables, the residents' hands, and their utensils. Staff member G did not perform hand hygiene at any time during the dining room observation period.</p> <p>During the same observation of breakfast meal service on 8/28/24 at 8:22 a.m., staff member E was observed wearing the same pair of gloves while assisting multiple residents with meal service. Staff member E was observed touching one resident, their wheelchair, meal tray, food, and utensils, and then assisting other residents with their meal trays. Staff member E did not change gloves or perform hand hygiene between assisting residents in the dining room.</p> <p>During an interview on 8/28/24 at 1:50 p.m., staff member A stated staff should be performing hand hygiene at every point of contact with residents.</p> <p>Review of a facility policy titled, Hand Hygiene, IPC104, revised 5/2022, showed the following:</p> <ul style="list-style-type: none"> <li>- . 1. When to perform hand hygiene .</li> <li>- . B. Immediately after each episode of direct patient contact/care</li> <li>- . D. Immediately after contact with objects and equipment in the immediate patient environment or other activities that could result in hands becoming contaminated.</li> <li>- E. Immediately after removal of gloves, including between the exchange of dirty to clean gloves.</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 CDC.gov document, titled, Clinical Safety: Hand Hygiene for Healthcare Workers, accessed on 8/28/24, included the following information:</p> <p>Hand hygiene should be performed:</p> <ul style="list-style-type: none"> <li>- . Immediately before touching a patient,</li> <li>- . after touching a patient or patient's surroundings .</li> </ul> <p>- When healthcare providers do not perform hand hygiene 100% of the time, they put themselves and their patients at risk for serious infections.</p> <p>41952</p> <p>3. During an observation on 8/27/24 at 8:39 a.m., resident #259 was seated at the middle table of the open dining room with a tablemate, both were eating breakfast. NF1 and NF2 approached resident #259 and stated they had a STAT order for her. NF1 tied off resident #259's left arm and grabbed a pillow from her room and then placed it under resident #259's left arm. NF2 was gloved and proceeded to draw vials of blood in the dining room. No barrier was placed between resident#259's arm or the pillow. NF1 barehanded, grabbed the garbage and used supplies from NF2 and placed the vials of blood in an open plastic bag clipped to their mobile cart. NF1 and NF2 walked back to replace the pillow and returned to their cart in the dining room where two open bags with two vials of blood each hung from clips. NF2 was still wearing gloves as she grabbed the cart.</p> <p>During an interview on 8/29/24 at 8:45 a.m., staff member Z stated the laboratory staff followed the precautions signs when they had them on the resident doors but did not know of any specific infection control training they received.</p> <p>During an interview on 8/29/24 at 9:07 a.m., staff member FF stated the laboratory staff cart had all the supplies such as chucks as a barrier in case of the resident bleeding but could use the units supplies if needed. Staff member FF did not know what training the laboratory staff received but they did follow the precautions signs on resident doors when entering them.</p> <p>Review of resident #259's laboratory results showed she had a prothrombin INR drawn on 8/27/24 by NF1 and NF2 at 8:42 a.m.</p>		