| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275159 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Beartooth Rehabilitation and Nursing LLC | 350 W Pike Ave<br>Columbus, MT 59019 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>Based on observation, interview, and record review, the facility failed to provide a clean and sanitary environment for 2 (#s 151 and 155) of 13 sampled residents. Findings include:<br><br>1. During an interview on 12/2/24 at 4:40 p.m., NF1 stated resident #151's toilet was sometimes dirty when he visited.<br><br>During an interview on 12/3/24 at 7:57 a.m., staff member B stated cleaning (of the bathroom) was done every day.<br><br>During an observation on 12/3/24 at 9:25 a.m., resident #151's toilet had brown specks splattered (apppeared to be feces) on the front part of the toilet bowl.<br><br>During an observation on 12/3/24 at 2:46 p.m., resident #151's toilet still had brown specks splattered on the front part of the toilet bowl.<br><br>During an observation on 12/4/24 at 8:01 a.m., resident #151's toilet had brown specks splattered on the front part of the toilet bowl, it did not appear to have been cleaned in the last 24 hours.<br><br>2. During an observation and interview on 12/2/24 at 12:22 p.m., resident #155 reported the facility did not clean the bathrooms enough and pointed to the toilet. The toilet in resident #155's room was observed to have what appeared to be smeared fecal material on the back portion of the toilet seat, and fecal material, splattered on the inside back wall, of the toilet bowl.<br><br>During an interview on 12/2/24 at 12:28 p.m., staff member D was notified of resident #155's soiled toilet, by the surveyor. Staff member D stated, Okay.<br><br>During an observation and interview on 12/3/24 at 1:55 p.m., resident #155 reported the toilet had not yet been cleaned from the day prior. The toilet in resident #155's room was observed to have what appeared to be smeared fecal material on the back portion of the toilet seat, and fecal material splattered on the inside back wall of the toilet bowl. The toilet appeared unchanged from the previous observation, approximately 24-hours prior.<br><br>During an interview on 12/3/24 at 3:30 p.m., staff member B stated the facility did not have a specific cleaning log or policies, but staff member B stated the resident rooms were cleaned every room, every day.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation and interview on 12/4/24 at 9:50 a.m., resident #155 reported the facility had not cleaned the bathroom in his room. The toilet in resident #155's room was observed to have what appeared to be smeared fecal material on the back portion of the toilet seat, and fecal material splattered on the inside back wall of the toilet bowl. The toilet appeared unchanged from the previous observations over the last two days.<br><br>During an interview on 12/5/24 at 9:00 a.m., staff member B stated when resident #155 was at the prior facility, he received twice daily bathroom cleaning, per his request.<br><br>Review of the facility document titled, Job Description: Housekeeper, undated, showed the following:<br><br>The primary purpose of the housekeeper is to carry out the day-to-day operations of the housekeeping/laundry department in accordance with current federal, state and local standards, guidelines and regulations governing the facility to assure that the facility is maintained in a clean, safe and sanitary manner. [sic]<br><br>A request was made on 12/3/24 at 8:00 a.m. for housekeeping cleaning logs and policies. None were received by the end of the survey period. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on observation, interview, and record review, the facility failed to implement a comprehensive, resident-centered care plan which identified residents' physical and psychosocial needs to help the residents reach their highest practicable level of well-being, and failed to identify preventative interventions, for 4 (#s 155, 156, 157 and 163) of 13 sampled residents. Findings include:<br><br>1. During an observation and interview, on 12/2/24 at 12:22 p.m., resident #155 was sitting on his bed. In reply to questions, resident #155 initially stated, Yeah, no, yeah, or Ayy. On further questioning, and providing adequate time to answer, resident #155 was able to answer some questions with occasional single word answers or yes/no responses, but he was unable to converse easily.<br><br>Review of resident #155's medical record showed a diagnosis of traumatic brain injury.<br><br>Review of resident #155's care plan did not show a focus area or interventions for a communication deficit or interventions for staff to utilize when communicating with the resident.<br><br>2. During an observation and interview, on 12/2/24 at 1:50 p.m., resident #156 was seated in a power wheelchair in his room, propped with pillows. Resident #156 stated, I've had this power chair for quite a while now. I have MS, and sitting up in this chair is pretty much all I can do.<br><br>Review of resident #156's comprehensive care plan showed the following:<br><br>Focus: The resident has potential for pressure ulcer development r/t Dehydration, Immobility, MS . Intervention: Administer medications as ordered. Monitor/document for side effects and effectiveness.<br><br>Focus: The resident has dehydration or potential fluid deficit r/t use/side effects of medication antidepressants. Intervention: Administer medications as ordered. Monitor/document for side effects and effectiveness. [sic]<br><br>Resident #156's care plan failed to show measurable, person-centered interventions, for the management and prevention of pressure wounds and dehydration related to his mobility limitations.<br><br>3. During an observation and interview on 12/2/24 at 1:50 p.m., resident #157 was seated in his wheelchair in his room. Resident #157 stated he was in his wheelchair or bed most of the time due to paraplegia. Resident #157 stated he had a pressure ulcer in the past, but it had recently healed. Resident #157 stated he had requested an air mattress (for pressure relief), and a repositioning bar, for his bed as it was difficult for him to reposition without one. The resident had not heard anything back on the mattress or repositioning bar.<br><br>During an interview on 12/2/24 at 2:30 p.m., staff member A stated she forgot about resident #157's request and would order the equipment right away.<br><br>Review of resident #157's comprehensive care plan, initiated on 9/12/24, last reviewed on 10/2/24, showed the following:<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Focus: Potential for altered skin integrity related to: hx of pressure sore to coccyx. Intervention: Administer treatments for skin impairment per physician order. Notify MD if skin impairment does not respond to current treatment regimen or resident experiences an adverse reaction. [sic]<br><br>Resident #157's care plan failed to show measurable, person-centered, interventions for the prevention of pressure ulcers to meet resident #157's physical, psychosocial, and functional needs.<br><br>4. During an observation and interview on 12/2/24 at 1:17 p.m., resident #163 was sitting in her recliner chair. A beeping sound was heard, coming from a dresser across the room. Resident #163 stated the sound was from her handheld, glucose monitoring device. Resident #163 placed the handheld device, which was for her continuous glucose monitoring device located on her arm, and then she read her glucose level which was 287. She stated the glucose level was normal for her. Resident #163 stated she had been in the facility since they opened.<br><br>Review of resident #163's electronic health record, showed her date of admission to the facility was 8/8/24, and the record included the diagnosis of Type 2 diabetes mellitus with unspecified complications.<br><br>Review of resident #163's care plan, last reviewed 11/19/24, showed no focus area for monitoring of the resident's Type 2 diabetes, goals, interventions, outcomes, or any other complications of the disease process.<br><br>During an interview on 12/4/24 at 10:08 a.m., staff member G stated she had access to resident care plans in the computer, but she relied primarily on shift report for resident care information.<br><br>During an interview on 12/4/24 at 11:40 a.m., staff member C stated she was responsible for developing the comprehensive care plans for all residents.<br><br>Review of a facility policy titled, Care Plans, Comprehensive and Revisions, dated 12/19/16, showed:<br><br>. 5. The comprehensive, person-centered care plan will:<br><br>a. Include measurable objectives and timeframes;<br><br>b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;<br><br>c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment.<br><br>d. Include the resident's goals and desired outcomes;<br><br>e. Include the resident's stated preferences;<br><br>f. Incorporate identified problem areas;<br><br>g. Incorporate risk factors associated with identified problems;<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | h. Reflect currently recognized standards of practice for problem areas and conditions. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on observation, interview, and record review, the facility failed to update resident care plans when changes to the resident's care occurred for 2 (#s 157 and 164) of 13 sampled residents. Findings include:<br><br>1. During an observation and interview on 12/2/24 at 1:40 p.m., resident #157 was sitting in his wheelchair, and a urinary catheter tubing was observed across his abdomen, and draining urine into a catheter bag, attached to the side of the chair. Resident #157 reported he previously had an indwelling catheter, but it was causing more pain and infections, therefore it was recently changed to a suprapubic catheter. Resident #157 stated the nurses changed the dressing around the catheter every day.<br><br>Review of resident #157's nursing progress notes showed the resident was transferred to the hospital for suprapubic catheter insertion on 10/1/24, and the resident returned to the facility on the same day.<br><br>Review of resident #157's physician orders showed an order for a suprapubic catheter dressing change, once per shift, beginning on 10/1/24.<br><br>Review of resident #157's care plan, last updated on 10/2/24, failed to show the suprapubic catheter and required care and dressing changes.<br><br>During an interview on 12/4/24 at 11:40 a.m., staff member C stated the facility had not developed an interdisciplinary team yet, and therefore she was responsible for updating the care plans for all residents. Staff member C stated she would review the discharge plans after hospitalizations, and would update the care plan if needed, at that time. She stated she may not have completed them all yet.<br><br>2. During an observation on 12/2/24 at 1:32 p.m., resident #164 was lying in his lounge chair with a blanket covering his head.<br><br>During an observation and interview on 12/2/24 at 3:07 p.m., staff member G knocked on resident #164's door and requested to enter the room. Resident #164 had music turned up in volume, was lying back in his lounge chair, but sat up when staff member G spoke to him. Staff member G then exited the room. Resident #164 stated he had been tired lately, since his recent diagnosis of diabetes. He stated it had really whipped him. Resident #164 stated he returned to the facility, from the hospital, on 11/27/24, with a new diagnosis of diabetes.<br><br>Review of resident #164's comprehensive care plan, last revised 12/1/24, showed no focus area, goals, interventions, or monitoring, for his new diagnosis of diabetes.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/5/24 at 7:10 a.m., staff member E stated the care plan was used to convey information about the care for the residents. She stated nurses utilized shift report to find out about care changes to residents. Staff member E stated CNAs used written and verbal shift report to relay information about residents. Staff member E stated she was uncertain if CNAs used the care plans. She stated most information about residents was exchanged verbally. Staff member E stated if you were off work for a while, information could slip through the cracks. She stated she utilized physician orders to know how to care for residents.<br><br>During an interview on 12/5/24 at 7:53 a.m., staff member B stated an update had not been completed to resident #164's care plan to address his new diagnosis of diabetes. She stated the provider was still trying to decide if he had Type 1 or Type 2 diabetes. Staff member B stated there should have been a new problem added to the resident's care plan, and the facility could do better with care plans.<br><br>Review of a facility policy titled, Care Plans, Comprehensive and Revisions, dated 12/19/16, showed:<br><br>. 11. The Interdisciplinary Team will review and update the care plan as indicated:<br><br>a. When there has been a significant change in the resident's condition;<br><br>b. When the desired outcome is not met;<br><br>c. When the resident has been readmitted to the facility from a hospital stay; and<br><br>d. At least quarterly, in conjunction with the required MDS assessment. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on observation, interview, and record review, staff member F failed to adhere to professional standards of practice by crushing a delayed release medication not recommended to crush, for 1 (#155) of 4 sampled residents for medication administration. Findings include:<br><br>During an observation on 12/3/24 at 4:56 p.m., staff member F had removed the following medications out of the individual bubble packs for administration to resident #155:<br><br>- metFORMIN HCl Oral Tablet 1000 MG (Metformin HCl)<br><br>Give 1000 mg by mouth two times a day ., and<br><br>- Depakote Oral Tablet Delayed Release 500 MG (Divalproex Sodium)<br><br>Give 500 mg by mouth two times a day . with an order date of 11/25/24.<br><br>During an observation and interview on 12/3/24 at 4:57 p.m., staff member F crushed both metformin and Depakote for resident #155. Staff member F stated the Depakote was crushed all the time so resident #155 could swallow the medication. Staff member F stated she usually did not crush delayed or extended-release medications. Staff member F proceeded to administer the crushed medications, in pudding, to resident #155.<br><br>Review of a document provided by the facility pharmacy, from trchealthcare on 12/4/24, titled, Meds That Should Not Be Crushed, dated February 2023 - Resource #390224, showed:<br><br>- . Crushing delayed-release meds can alter the mechanism designed to protect the drug from gastric acids or prevent gastric mucosal irritation.<br><br>- . Medications That Should Not Be Crushed<br><br>- . Generic Name Divalproex<br><br>- Brand Name Depakote (US), Depakote ER (US) .<br><br>Review of resident #155's physician order summary, dated 12/4/24, showed the following existing order, dated 11/25/24:<br><br>- May crush/alter medications as necessary unless otherwise specified or contraindicated. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on observation, interview, and record review, the facility failed to ensure a dependent resident was getting turned frequently enough to prevent skin breakdown, for 1 (#154) of 13 sampled residents, and the resident was identified to have new skin redness to the coccyx and perineum. Findings include:<br><br>Review of resident #154's EHR showed an admission date of 11/27/24.<br><br>Review of resident #154's EHR showed a medical diagnosis of Amyotrophic Lateral Sclerosis (ALS).<br><br>Review of resident #154's EHR showed an assessment, titled Admit/Readmit Screener, dated 11/27/24. In this assessment, resident #154's skin integrity was addressed, and no coccyx or buttock redness was documented:<br><br>. color: normal .<br><br>temperature . warm .<br><br>turgor . normal .<br><br>skin assessment . Right knee (front) Abrasion, Left knee (front) Abrasion.<br><br>Review of resident #154's EHR showed a nursing note, dated 11/27/24, included: some redness noted to coccyx and perineum. [sic]<br><br>During an interview on 12/2/24 at 1:36 p.m., resident #154 stated she had pain to her coccyx and buttock area. Resident #154 was positioned in the middle of the recliner with a pillow directly beneath her buttocks. The long end of the pillow was positioned horizontal to the back of the recliner. Resident #154 stated she preferred to stay in her recliner instead of the bed because the bed was very uncomfortable.<br><br>During an interview on 12/4/24 at 8:22 a.m., resident #154 stated staff did not routinely go into her room to position her. Resident #154 stated she would push the call button every two to three hours to have staff rotate her. Resident #154 was seated on top of a pillow, positioned horizontally, toward the back of the recliner.<br><br>During an interview and observation on 12/4/24 at 11:17 a.m., staff member E stated there was blanchable redness to resident #154's buttock area. The pillow located below resident #154's buttock was in the same position as previously observed that morning.<br><br>During an observation on 12/4/24 at 12:54 p.m., resident #154 was positioned in the same position as previously observed. The pillow had not moved in its position.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation and interview on 12/5/24 at 9:50 a.m., resident #154 was in the same position, on the pillow, as previously observed the day prior. Resident #154 was not rotated side to side and the pillow was not positioned in any different way to displace pressure on resident #154's coccyx or buttock area. Resident #154 stated the pillow was always placed in the same position, where the long end of the pillow was horizontal, to the back of the recliner. Resident #154 stated the pillow was never in a different position. Resident #154 stated she would have anxiety when being positioned and get nervous, but never refused being repositioned.<br><br>Review of resident #154's baseline care plan, initiated 12/1/24, showed:<br><br>- .Monitor/document/report PRN any s/sx of immobility: contractures forming or worsening, thrombus formation, skin-breakdown, fall related injury .<br><br>-The resident has an ADL self-care performance deficit r/t Amytrophic Lateral Sclerosis .<br><br>-The resident requires substantial assistance by 2 staff to turn and reposition in bed as necessary .<br><br>-The resident requires substantial assistance by 1 staff to dress .<br><br>-The resident is totally dependent on 1 staff for personal hygiene and oral care .<br><br>-The resident is dependent by 2 staff for toileting . [sic]<br><br>Review of resident #154's EHR showed frequent turning was not addressed as a physician's order or in the care plan to prevent the skin breakdown.<br><br>Review of resident #154's EHR failed to show notes documenting frequent turning or repositioning. |

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|---|---|
| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, interview, and record review, the facility failed to ensure BiPAP parameter orders were in place for 1 (#154) of 3 sampled residents with respiratory concerns. Findings include:<br><br>During an interview and observation on 12/2/24 at 1:31 p.m., resident #154 stated she was unsure if she had oxygen bled into her BiPAP. No oxygen tank was located in resident #154's room.<br><br>During an interview on 12/4/24 at 12:54 p.m., staff member E stated the BiPAP machine did not have any oxygen bled into the system for resident #154.<br><br>Review of resident #154's EHR showed no physician's order was placed for the BiPAP parameters. BiPAP parameters consist of: oxygen delivery (FiO2), distending pressure to help recruit alveoli (EPAP), high pressure to augment the patient's normal breath (IPAP), and respiration rate.<br><br>During an interview on 12/4/24 at 1:10 p.m., staff member H stated they were unable to find the oxygen parameter order for resident #154's BiPAP. Staff member H stated not knowing the orders could be dangerous if there was a power outage or if the parameters were changed on accident.<br><br>During an interview on 12/4/24 at 1:22 p.m., staff member C stated they would find the initial physician's BiPAP order for resident #154 from [Clinic Name]. Staff member C stated the facility staff would be able to ask the resident what the parameter settings were, if the settings were ever changed.<br><br>Review of a facility provided document, titled [Clinic Name], dated 11/27/24, showed the physician's order for resident #154's BiPAP: SNF Oxygen Therapy: 2 liters per minute per Nasal Cannula during the day if needed for sats greater than 90%, BIPAP at hs with bleed in for sats greater than 90% (has been on 25% inspired oxygen with BIPAP here at hs) .<br><br>During an interview on 12/4/24 at 2:05 p.m., staff member C stated hs in resident #154's physician order from [Clinic Name] meant home settings. Staff member C stated the parameters did not need to be entered into PCC if they were home settings.<br><br>During an interview on 12/4/24 at 2:33 p.m., staff member E stated hs meant hour of sleep to them. Staff member E read the order from [Clinic Name], dated 11/27/24, for resident #154 and stated hs would mean at night in this order.<br><br>Review of resident #154's baseline care plan did not show resident #154's BiPAP parameters, and did not address resident #154's frequent anxiety and concern for air hunger due to her ALS diagnosis. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275159 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Beartooth Rehabilitation and Nursing LLC | 350 W Pike Ave<br>Columbus, MT 59019 |

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|---|---|
| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>Based on interview and record review, the facility failed to ensure prn psychotropic medications were limited to 14 days, for 1 (#156) of 13 sampled residents. Findings include:<br><br>During an interview on 12/2/24 at 1:40 p.m., resident #156 stated he sometimes took diazepam for anxiety and mood.<br><br>During an interview on 12/4/24 at 3:30 p.m., staff member B stated she was not sure why the prn diazepam did not have a stop date, and stated, I will get a stop date put on it today.<br><br>Review of resident #156's physician orders showed an order on 10/2/24 for diazepam, 5mg, every eight hours, prn, without a stop date noted. Resident #156's MARs for October 2024 and November 2024, showed he received prn diazepam on 23 occasions in October 2024, and 23 occasions in November 2024. The order for prn diazepam remained active as of 12/4/24.<br><br>Review of resident #156's medical record failed to show an initial evaluation or re-evaluation of the resident's need for diazepam on a prn basis. The review of resident #156's medical record showed the diazepam was ordered and used on an prn basis over a 2-month period with no 14-day stop date in accordance with federal regulations. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>5. During an interview on 12/3/24 at 4:14 p.m., staff member D stated they did not know if the washing machine killed any pathogens present on clothing by heat, chemical, or both. Staff member D stated they would push the button associated with the type of materials, and this was the extent of information they knew concerning the washing machine. Staff member D stated staff member A might know those sorts of questions. Staff member D stated the residents clothing was kept away from their body, but no protective gown was worn to prevent the transmission of pathogens.<br><br>Review of a facility document, titled Housekeeping/Laundry Competency Checklist, dated 11/22/24, showed: . Laundry: Review shift routine including . following correct infection control principles .<br><br>During an interview on 12/5/24 at 10:20 a.m., staff member A stated, I didn't even think of that, when asked why staff member D did not have a gown on in the laundry room.<br><br>Review of a facility provided policy, titled Infection Prevention and Control Program, dated 7/2016, showed:<br><br>- Policy Statement: 1. The infection prevention and control program (IPCP) is a facility wide effort involving all disciplines and individuals .<br><br>- 7. Prevention of Infection: . 6. Always following standard precautions and implementing appropriate isolation or upgraded precautions when necessary; and 7. Following established general and disease-specific guidelines such as those of the Center for Disease Control . [sic]<br><br>2. During an observation on 12/2/24 at 1:31 p.m., staff member F was completing a care (200mL free water flush) through a PEG tube for resident #154. Staff member F was not wearing a gown. Resident #154's room did not have an EBP sign on the door and did not have EBP supplies inside or outside of the room at this time.<br><br>During an observation on 12/4/24 at 8:22 a.m., resident #154's room had a sign for EBP, and an EBP cart, outside of the room.<br><br>During an interview on 12/4/24 at 9:27 a.m., staff member E stated the staff were educated today (12/4/24) on EBP and also educated on EBP upon hire. Staff member E stated a gown and gloves were required for EBP.<br><br>3. During an observation and interview on 12/3/24 at 3:12 p.m., staff member G was observed in resident #156's room, assisting the resident to the bathroom and emptying the catheter bag. Staff member G was wearing gloves, but was not wearing a gown. On exit from the room, staff member G stated she did not need to wear a gown for resident #156's cares, and no one in the facility currently required any PPE for their care. Staff member G stated she was not familiar with enhanced barrier precautions, and stated, Do you mean like when we are in outbreak? No signage or a PPE cart were observed in or near resident #156's room for EBPs.<br><br>4. During an interview on 12/3/24 at 4:02 p.m., resident #157 stated the staff have never worn gowns for his catheter or personal care.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 12/3/24 at 4:22 p.m., staff member B stated the facility had not been performing enhanced barrier precautions, and were completing the training today.<br><br>Review of a facility document, titled, Enhanced Barrier Precautions, version 1.1, revised 4/1/24, showed:<br><br>. 5. In addition the use of standard precautions, staff should wear gloves and a gown during high-contact resident care activities that provided opportunities for transfer of MDROs to staff hands and clothing. Examples of high-contact resident activities include:<br><br>a. Dressing<br><br>b. Bathing/showering<br><br>c. Transferring<br><br>d. Providing hygiene<br><br>e. Changing linens<br><br>f. Changing briefs or assisting with toileting<br><br>g. Device care or use; central line, urinary catheter, feeding tube, tracheostomy/ventilator<br><br>h. Wound care: any skin opening requiring a dressing with the exception of shorter-lasting wounds as described above . [sic]<br><br>Based on observation, interview, and record review, the facility failed to ensure staff member H adhered to proper infection prevention and control practices during medication administration for 1 (#157) of 4 sampled residents for medication administration; failed to ensure enhanced barrier precautions were implemented and followed, for 3 (#s 154, 156, and 157) of 13 sampled residents; and failed to follow proper infection control practices were used when transferring dirty and clean laundry. Findings include:<br><br>1. During an observation on 12/4/24 at 7:34 a.m., staff member H, who was a licensed nurse training with staff member E, entered resident #157's room to administer medications. After entering resident #157's room, staff member H laid down the following medications onto the top of a clothing dresser:<br><br>- Fluticasone Propionate Nasal Suspension 50 mcg,<br><br>- Novolog Injection Solution 100 Units/ml - 30 U, and<br><br>- Combivent Respimat Inhalation Aerosol Solution 20-100 mcg.<br><br>Staff member H did not clean the top surface of the clothing dresser or lay down any form of protective barrier prior to placing the items on the dresser.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 12/4/24 at 7:36 a.m., staff member H administered resident #157's oral medications, then donned gloves to administer the injection of insulin. Staff member H did not wash or sanitize her hands prior to donning the clean gloves. Staff member H continued with the remaining medication administration with resident #157.<br><br>During an interview on 12/4/24 at 2:50 p.m., staff member E who was training staff member H stated she was providing oversight and shadowing her (staff member H) on medication administration that morning. Staff member H was unavailable for interview. Staff member E stated the process for lying down any medication in a resident's room was to wipe the area clean and place a barrier between the medication, and the resident's dresser or any surface in the room. Staff member E stated (staff) hands were to be sanitized or washed before and after donning and doffing gloves.<br><br>Review of the facility's policy titled, Administering Medications, last revised December 2012, showed:<br><br>- .22. Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. |