| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 295106 | A. Building<br>B. Wing | 06/07/2024 |

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| Trellis Centennial | 8565 W Rome Blvd<br>Las Vegas, NV 89149 |

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131<br><br>Based on observations, interviews, record reviews, and document review, the facility failed to ensure documentation accurately reflected medications and treatment services provided. Specifically: 1) a Lidocaine patch; 2) an ACE wrap (elastic bandage); 3) Heparin (blood thinner); and 4) Thrombo-Embolic Deterrent (TED) hose or compression stockings. This deficient practice could potentially have led to severe harm, including ineffective pain management, an increased risk of blood clots, and inadequate compression therapy.<br><br>Findings include:<br><br>Resident 166 (R166)<br><br>1) Lidocaine Patch<br><br>R166 was admitted on [DATE], with diagnoses including muscle spasm, bacteremia, and a history of liver transplant.<br><br>A Physician order dated 05/31/2024, documented the application of Lidocaine Patch 5 percent (%) topically daily to the affected area and removal per schedule. Apply at 9:00 AM and remove at 8:59 PM.<br><br>On 06/04/2024 at 10:18 AM, R166 indicated had been experiencing pain on the right side of the neck. Upon verification, a Lidocaine patch was in place dated 06/02/2024 with nurse's initials. R166 and the family indicated it was applied two days ago in the morning. A Licensed Practical Nurse (LPN) verified the application of the patch on R166's neck, confirming its two-day age. The LPN indicated the Lidocaine patch should have been removed at night following a 12-hour administration period. The LPN confirmed it was signed off in the MAR the Lidocaine patch was administered and removed when it was not applied as ordered or removed as scheduled.<br><br>The Medication Administration Record (MAR) documented the following:<br><br>-06/02/2024 at 8:59 PM, the Lidocaine patch was recorded as removed when it was still on.<br><br>-06/03/2024 at 9:00 AM, the Lidocaine patch was recorded as applied without replacing a new patch.<br><br>-06/03/2024 at 8:59 PM, the Lidocaine patch was recorded as removed when it was still on.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/05/2024 at 9:36 AM, another LPN indicated the Lidocaine patch was to be dated upon application and to be removed after 12 hours. The LPN indicated the MAR should have been accurately documented if the medication order was carried out, and if not, the physician would have been notified and documented.<br><br>On 06/05/2024 at 11:00 AM, the Physician Assistant (PA) indicated the Lidocaine patch was to manage the pain and should have been applied and removed timely for efficacy. The PA indicated there was no harm if the patch was not removed for more than 12 hours, but the staff were expected to follow the orders and to document accurately.<br><br>On 06/05/2024 at 2:33 PM, the Director of Nursing (DON) indicated the Lidocaine patch should have been applied and removed as ordered. The staff were expected to document accurately in the MAR or treatment administration record (TAR).<br><br>2) ACE wrap<br><br>Resident 9 (R9)<br><br>R9 was admitted on [DATE], with diagnoses including surgical amputation, diabetes mellitus, osteomyelitis, and peripheral vascular disease.<br><br>The Brief Interview of Mental status dated 05/22/2024, documented a score of 15/15, which indicated R9's cognitive status was intact.<br><br>A physician's order dated 04/18/2024, documented to apply an ACE wrap on R9's left foot amputation surgical site every shift.<br><br>On 06/04/2024 at 11:50 AM, R9 removed the non-skid socks from the left foot, revealing the toes had been amputated and were uncovered, with stitches in place. R9 indicated being a diabetic, and the toes had undergone amputation. R9 indicated the wound nurse had provided the treatment, no ACE wrap was in place.<br><br>On 06/05/2024 at 8:42 AM, R9 was seated in bed. R9 showed the swollen left foot, which had no ACE wrap in place. R9 indicated the wound nurse had previously applied the ACE wrap, but it had not been applied for more than a week. R9 expressed the ACE wrap was somehow reducing the swelling, but was wondering why it was no longer applied.<br><br>The Medication Administration Record (MAR) from 06/01/2024 through 06/04/2024, documented the ACE wrap was applied.<br><br>On 06/05/2024 at 9:36 AM, the LPN indicated the process was to verify the orders, perform the assessment, and carry out the orders and document. The LPN confirmed the MAR was signed off indicating the ACE wrap was applied.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/05/2024 at 11:07 AM, the Wound Care Treatment Nurse (WCTN) explained the ACE wrap had been ordered previously to support the dressing of the left foot surgical site, but the order was changed to leave it open to air. The WCTN confirmed the ACE wrap was an active order, but was unsure of the indication. The WCTN indicated the Licensed Nurses were responsible for the application of the ACE wrap and should not have been documented it was applied when it was not carried out.<br><br>On 06/05/2024 at 10:30 AM, the DON indicated the staff members were expected to verify the orders, implement the ACE wrap, and document what had been implemented. The staff were expected to document accurately in the MAR or TAR as the standard of practice.<br><br>40142<br><br>3) TED hose (compression stockings)<br><br>Resident 43 (R43)<br><br>R43 was admitted on [DATE], with diagnoses including hypertensive heart disease with heart failure, morbid obesity, and spondylosis of cervical region.<br><br>A physician's order dated 05/13/2024, documented thrombo-embolic deterrent (TED) hose on bilateral legs two times a day for edema on for 12 hours, off for 12 hours.<br><br>On 06/04/2024 at 8:55 AM, R43 laid alert in a bariatric specialty mattress. The resident was not covered with blanket which revealed edema on bilateral lower extremities, R43 was not wearing TED hose. There was no TED hose observed in the resident's room.<br><br>On 06/05/24 at 8:50 AM, R43 laid in bed with a fully consumed breakfast tray on bedside table. R43 indicated having a history of wearing compression stockings for edema in the past but had not used compression stockings since admission to this facility in March 2024. According to the resident, use of TED hose was discussed with R43 a few weeks ago but no one had followed through, discussed, provided nor applied a TED hose on the resident since.<br><br>On 06/05/2024 at 9:03 AM, a Certified Nursing Assistant (CNA) assigned to R43 indicated had been assigned multiple times to R43. The CNA indicated not being aware there were orders for TED hose for the resident and the CNA had not seen any compression devices in the resident's room even once. The CNA entered R43's room, uncovered R43' legs and confirmed R43 was not wearing compression stockings. The CNA looked around the resident's room and confirmed there was no TED hose device in the room.<br><br>On 06/05/2024 at 9:08 AM, the CNA explained compression stocking were typically ordered to be worn during the day and taken off at night. The purpose of the device was to improve circulation, preventing deep vein thrombosis (DVT) and managing edema. The CNA reviewed R43's medication administration record (MAR) and could not speak to why nurses were signing off on R43's TED hose application as the hose were not found in the room or on the resident.<br><br>R43's MAR for May 2024 and June 2024, revealed there were no missed administrations for R43's TED hose from 05/13/2024 until 06/05/2024. Multiple nurses had been signing R43's MAR as being administered at morning (AM) and removed at night (PM).<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/05/2024 at 9:14 AM, a Licensed Practical Nurse (LPN) indicated being newly assigned to R43 and was not familiar with R43's TED hose orders. The LPN indicated the LPN was completing medication administration for assigned residents and was planning to apply the resident's TED hose afterwards. The LPN reviewed R43's MAR for May 2024 and June 2024 and acknowledged multiple nurses except for this LPN, had been signing off the device as having been administered in accordance with physician's orders. The LPN could not speak to why the nurses were signing off on R43's TED hose.<br><br>On 06/05/2024 at 10:06 AM, the Director of Nursing (DON) was present during interview with the charge Registered Nurse (RN). The charge RN indicated being familiar with R43 and the resident's TED hose orders for edema management. The charge RN explained R43 was morbidly obese and the TED hose devices the facility had in stock were too small for R43. The charge RN confirmed an appropriately sized TED hose had not been ordered for R43 and the charge RN along with other nurses had been signing for the resident's TED hose as being administered from 05/13/2024 until 06/05/2024. The charge RN reviewed R43's MAR and confirmed signing for R43's TED hose five times in May 2024 (05/19/2024, 05/22/2024, 05/26/2024, 05/27/2024 and 05/29/2024) and three times in June 2024 (06/02/2024, 06/03/2024 and 06/04/2024). The charge RN verbalized signing for treatment services not rendered went against the facility's policies on documentation and medication administration and professional standards of practice specifically the Nurse Practice Act.<br><br>On 06/05/2024 at 10:18 AM, the DON expressed it was not acceptable for nurses to be signing off for treatment services which were not performed or administered because this went against the facility policy on following physician's orders and the five rights of medication administration which were, 1) right medication, 2) right dose, 3) right route, 4) right time and 5) right patient. The DON indicated the facility's policy were aligned with the Nurse Practice Act, so this inaccurate documentation went against professional standards of practice as well. According to the DON, if the TED hose in stock was too small, the nurse should have contacted the physician immediately to obtain a modification to the order.<br><br>The facility policy titled Applying Anti-Embolism Stockings (TED hose) dated 2001, documented the purpose of this procedure was to improve venous return to the heart, arterial circulation to the feet and to minimize edema to the legs and feet and to prevent complications associated with deep vein thrombosis and pulmonary embolism. The procedure included verifying with the physician if a thigh-length or knee-length stockings was to be used, obtaining measurements, and choosing appropriately sized stockings. Anti-embolism stocking should be applied in the morning and removed at night. Document the date and time the stockings were applied, schedule of removal or re-application and patient's response to the procedure.<br><br>4) Heparin<br><br>Resident 43 (R43)<br><br>R43 was admitted on [DATE], with diagnoses including hypertensive heart disease with heart failure, morbid obesity, and spondylosis of cervical region.<br><br>On 06/05/2024 at 8:58 AM, R43 indicated receiving Heparin injections once a day in the morning but the medication was not administered at night.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A physician's order dated 03/21/2024, documented to give Heparin Sodium (Porcine) Solution 5,000 units per milliliter (ml). Inject 5,000 units subcutaneously every 12 hours for deep vein thrombosis (DVT) prophylaxis.<br><br>On 06/05/2024 at 9:35 AM, the Licensed Practical Nurse (LPN) assigned to R43 explained R43's Heparin was scheduled to be administered twice a day at 6:00 AM and 6:00 PM. The LPN indicated not being steadily assigned to R43 but whenever the LPN was assigned to R43, the medication would be administered at 6:00 PM prior to ending the LPNs shift at 7:00 PM.<br><br>On 06/05/2024 at 3:17 PM, the DON reviewed R43's medication administration record (MAR) for the resident's Heparin for March 2024, April 2024, June 2024, and July 2024 which revealed the following:<br><br>March 2024: 21 Heparin vials administered.<br><br>April 2024: 59 Heparin vials administered.<br><br>May 2024: 61 Heparin vials administered.<br><br>June 2024: 9 Heparin vials administered.<br><br>----------<br><br>Total administered: 150 Heparin single-dose vials<br><br>The Pharmacy manifest dated 03/21/2024 through 06/05/2024 revealed the following Heparin single-dose vial deliveries for R43:<br><br>03/21/2024: 14 Heparin vials<br><br>03/29/2024: 14 Heparin vials<br><br>04/08/2024: 14 Heparin vials<br><br>04/17/2024: 14 Heparin vials<br><br>04/24/2024: 14 Heparin vials<br><br>04/29/2024: 14 Heparin vials<br><br>05/22/2024: 14 Heparin vials<br><br>06/05/2024: 14 Heparin vials<br><br>----------<br><br>Total delivered: 112 Heparin vials.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/05/2024 at 3:25 PM, the LPN opened the medication cart and confirmed there were currently 19 Heparin vials remaining for R43.<br><br>The Inventory Report indicated Heparin 5,000 units/ml for injection was included in the list of available drugs in the facility's medication dispensing system.<br><br>On 06/06/2024 at 8:45 AM, the DON indicated speaking with the Pharmacist who verified there were no recorded retrievals of Heparin for Resident 43 from the dispensing system.<br><br>On 06/06/2024 at 8:47 AM, the DON confirmed the following for period covering 03/21/2024 to 06/05/2024:<br><br>-there were a total 150 recorded administrations of Heparin for R43<br><br>-there were 112 Heparin vials delivered for R43<br><br>-there were zero Heparin vial retrievals from the medication dispensing system<br><br>-there were 19 Heparin vials left in the medication cart for R43<br><br>- there were 57 recorded administrations in excess of the number of Heparin vials delivered for R43<br><br>On 06/06/2024 at 8:50 AM, the DON indicated the number of recorded administrations cannot exceed the number of Heparin vials delivered for R43. The DON confirmed there were 57 more Heparin administrations over the number of Heparin vial deliveries for R43. The DON stated not being able to speak to the discrepancy and could not think of possible explanations.<br><br>On 06/06/2024 at 9:06 AM, the Administrator confirmed there was a discrepancy between the number of recorded Heparin administrations versus the number of actual Heparin vials delivered for R43 which were unaccountable.<br><br>On 06/06/2024 at 9:20 AM, the Regional Director of Clinical Services could not explain the discrepancy but presented possible explanations such as nurses may have been documenting the medication prior to actual administration when the medication was not actually administered due to R43 being asleep or unavailable. The resident may have also refused at times and these refusals were not recorded. According to the Regional Director of Clinical Services, even if an explanation could not determine it was evident the facility's medication administration and documentation policies were not followed in this case.<br><br>On 06/06/2024 at 10:19 AM, the Consultant Pharmacist indicated the number of recorded administrations must match the number of vials delivered which would include the available supply in the medication cart. According to the Consultant Pharmacist, the number of recorded Heparin administrations cannot exceed the number of Heparin vials delivered especially taking into consideration there were no Heparin retrievals from the medication dispensing system for R43. The Consultant Pharmacist stated the discrepancy of 57 vials translated to missed doses regardless of whether the facility could provide an explanation or not. The pharmacist reviewed R43's record and indicated the resident had no documented refusals of Heparin.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Administering medications policy revised April 2019 documented if a drug was withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for the drug and dose. For residents not in the room or otherwise unavailable to receive medication on the pass, the MAR may be flagged. After completing medication pass, the nurse will return to the missed resident to administer the medication.<br><br>The Charting and Documentation policy revised July 2017 documented all medications, treatments or services performed would be documented in the patient's medical record. Documentation in the medical record will be complete and accurate. Entries must be recorded in accordance with state law and facility policy.<br><br>Cross reference to Tag F684 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131<br><br>Based on observations, interviews, record reviews, and document review, the facility failed to ensure:<br><br>1) an ACE wrap (elastic bandage) was applied as ordered or the order was clarified for 1 of 17 sampled residents (Resident 9);<br><br>2) skin assessments were completed as ordered for 1 of 17 sampled residents (Resident 9);<br><br>3) TED hose was applied as ordered for 1 of 17 sampled residents (Resident 43); and<br><br>4) Heparin medication was administered as ordered for 1 of 17 sampled residents (Resident 43).<br><br>These deficient practices could have led to several potential risks, including compromised patient care, delayed healing, an increased risk of injury or infection, and potential harm due to improper support or circulation issues.<br><br>Findings include:<br><br>Resident 9 (R9)<br><br>R9 was admitted on [DATE], with diagnoses including orthopedic aftercare following surgical amputation and peripheral vascular disease.<br><br>The Brief Interview of Mental status dated 05/22/2024, documented a score of 15/15, which indicated R9's cognitive status was intact.<br><br>The Nursing Admission/Readmission Evaluation/assessment dated [DATE], documented R9 had wound to left foot.<br><br>1) A physician's order dated 04/18/2024, documented the application of the ACE wrap on the left foot amputation surgical site every shift.<br><br>A Care Plan dated 04/18/2024, documented R9 had a surgical incision and was at risk for dehiscence of left lower extremity surgical incision.<br><br>On 06/04/2024 at 11:50 AM, R9 removed the non-skid socks from the left foot, revealed the toes had been amputated with stitches in place. R9 indicated being a diabetic, and the toes had undergone amputation. R9 indicated the wound nurse had provided the treatment, no ACE wrap was in place.<br><br>On 06/05/2024 at 8:42 AM, R9 was seated in bed. R9 showed the swollen left foot, which had no ACE wrap in place. R9 indicated the wound nurse had previously applied the ACE wrap, but it had not been done for more than a week. R9 expressed the ACE wrap was somehow reducing the swelling, but was wondering why it was no longer applied.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Medication Administration Record (MAR) dated 05/01/2024-06/04/2024, documented the ACE wrap was applied.<br><br>On 06/05/2024 at 9:36 AM, a Licensed Practical Nurse (LPN) indicated the process was to verify the orders, perform the assessment, and carry out the orders. The LPN confirmed the ACE wrap was an active order but was unsure of the indication and was unaware why it was not applied for more than a week.<br><br>On 06/05/2024 at 11:07 AM, the Wound Care Treatment Nurse (WCTN) explained the ACE wrap was ordered previously to support the dressing of the left foot surgical site but the order was changed to leave open to air. The WCTN confirmed the ACE wrap was an active order and was unsure for what indication.<br><br>On 06/05/2024 at 10:30 AM, the Director of Nursing (DON) indicated the staff members were expected to verify or clarify the indication of the order and carry it out. The DON indicated if the order was not necessary, the physician should have been notified to discontinue the order or obtain new orders.<br><br>2) A physician's order dated 04/17/2024, documented a complete head-to-toe weekly skin assessment under observation of skin risk daily on Tuesday and Friday.<br><br>On 06/05/2024 at 8:42 AM, R9 was seated in bed and exhibited a swollen left foot. R9 expressed uncertainty about any treatment for the swelling and indicated it was increasing in size and moving upward.<br><br>R9's medical records lacked documented evidence R9's head-to-toe weekly skin assessments were completed as ordered.<br><br>On 06/05/2024 at 11:07 AM, the WCTN confirmed there was no previous assessment of R9's left foot edema. The WCTN indicated the edema or swelling was not identified or assessed. The WCTN indicated the skin assessment should have been done consistently as ordered to monitor any changes in the resident's condition. The WCTN indicated would notify the physician.<br><br>On 06/05/2024 at 11:21 AM, the Wound Nurse indicated the physician advised discontinuing the ACE wrap because R9 had peripheral arterial disease and new orders were received to treat R9's edema.<br><br>On 06/06/2024 in the afternoon, the DON confirmed R9's weekly skin assessment was not consistently completed. The DON indicated the Licensed Nurse who was assigned to the resident's care was responsible for completing the assessment. Stressing the importance of timely assessments in resident care, the DON indicated the staff were aware of this requirement, and continuous education was provided.<br><br>A facility policy titled Prevention of Pressure Injuries revised 04/2020, documented assessing the resident on admission and repeating the risk assessment weekly and upon any changes in condition. During the skin assessment, check for erythema, skin and soft tissue temperature, and edema. Assess, report, and document potential skin changes.<br><br>40142<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2) TED hose (compression stockings)<br><br>Resident 43 (R43)<br><br>R43 was admitted on [DATE], with diagnoses including hypertensive heart disease with heart failure, morbid obesity, and spondylosis of cervical region.<br><br>A physician's order dated 05/13/2024, documented thrombo-embolic deterrent (TED) hose on bilateral legs two times a day for edema on for 12 hours, off for 12 hours.<br><br>On 06/04/2024 at 8:55 AM, R43 laid alert in a bariatric specialty mattress. The resident was not covered with blanket which revealed edema on bilateral lower extremities, R43 was not wearing TED hose. There was no TED hose observed in the resident's room.<br><br>On 06/05/24 at 8:50 AM, R43 laid in bed with a fully consumed breakfast tray on bedside table. R43 indicated having a history of wearing compression stockings for edema in the past but had not used compression stockings since admission to this facility in March 2024. According to the resident, use of TED hose was discussed with R43 a few weeks ago but no one had followed through, discussed, provided nor applied TED hose on the resident since.<br><br>On 06/05/2024 at 9:03 AM, a Certified Nursing Assistant (CNA) assigned to R43 indicated had been assigned multiple times to R43. The CNA indicated not being aware there were orders for a TED hose for the resident and the CNA had not seen any compression devices in the resident's room even once. The CNA entered R43's room, uncovered R43' legs and confirmed R43 was not wearing compression stockings. The CNA looked around the resident's room and confirmed there was no TED hose device in the room.<br><br>On 06/05/2024 at 9:08 AM, the CNA explained compression stocking were typically ordered to be worn during the day and taken off at night. The purpose of the device was to improve circulation, preventing deep vein thrombosis (DVT) and managing edema. The CNA reviewed R43's medication administration record (MAR) and could not speak to why nurses were signing off on R43's TED hose, as none were found in the room or on the resident.<br><br>R43's MAR for May 2024 and June 2024, revealed there were no missed administrations for R43's application of TED hose from 05/13/2024 until 06/05/2024. Multiple nurses had been signing R43's MAR as being administered at morning (AM) and removed at night (PM).<br><br>On 06/05/2024 at 9:14 AM, a Licensed Practical Nurse (LPN) indicated being newly assigned to R43 and was not familiar with R43's TED hose orders. The LPN indicated the LPN was completing medication administration for assigned residents and was planning to apply the resident's TED hose afterwards. The LPN reviewed R43's MAR for May 2024 and June 2024 and acknowledged multiple nurses except for this LPN, had been signing off the device as having been administered in accordance with physician's orders. The LPN could not speak to why the nurses were signing off on R43's TED hose.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/05/2024 at 10:06 AM, the Director of Nursing (DON) was present during interview with the charge Registered Nurse (RN). The charge RN indicated being familiar with R43 and the resident's TED hose orders for edema management. The charge RN explained R43 was morbidly obese and the TED hose devices the facility had in stock were too small for R43. The charge RN confirmed an appropriately sized TED hose had not been ordered for R43 and the charge RN along with other nurses had been signing for the resident's TED hose as being administered from 05/13/2024 until 06/05/2024. The charge RN reviewed R43's MAR and confirmed signing for R43's TED hose five times in May 2024 (05/19/2024, 05/22/2024, 05/26/2024, 05/27/2024 and 05/29/2024) and three times in June 2024 (06/02/2024, 06/03/2024 and 06/04/2024). The charge RN verbalized signing for treatment services not rendered went against the facility's policies on documentation and medication administration and professional standards of practice specifically the Nurse Practice Act.<br><br>On 06/05/2024 at 10:18 AM, the DON expressed it was not acceptable for nurses to be signing off for treatment services which were not performed or administered because this went against the facility policy on following physician's orders and the five rights of medication administration which were, 1) right medication, 2) right dose, 3) right route, 4) right time and 5) right patient. The DON indicated the facility's policy were aligned with the Nurse Practice Act, so this inaccurate documentation went against professional standards of practice as well. According to the DON, if the TED hose in stock was too small, the nurse should have contacted the physician immediately to obtain a modification to the order.<br><br>The facility policy titled Applying Anti-Embolism Stockings (TED hose) dated 2001, documented the purpose of this procedure was to improve venous return to the heart, arterial circulation to the feet and to minimize edema to the legs and feet and to prevent complications associated with deep vein thrombosis and pulmonary embolism. The procedure included verifying with the physician if a thigh-length or knee-length stockings was to be used, obtaining measurements, and choosing appropriately sized stockings. Anti-embolism stocking should be applied in the morning and removed at night. Document the date and time the stockings were applied, schedule of removal or re-application and patient's response to the procedure.<br><br>3) Heparin<br><br>Resident 43 (R43)<br><br>R43 was admitted on [DATE], with diagnoses including hypertensive heart disease with heart failure, morbid obesity, and spondylosis of cervical region.<br><br>On 06/05/2024 at 8:58 AM, R43 indicated receiving Heparin injections once a day in the morning but the medication was not administered at night.<br><br>A physician's order dated 03/21/2024, documented to give Heparin Sodium (Porcine) Solution 5,000 units per milliliter (ml). Inject 5,000 units subcutaneously every 12 hours for deep vein thrombosis (DVT) prophylaxis.<br><br>06/05/24 08:58 AM Resident # 43 indicated receiving Heparin injections once a day in the morning but the medication was not administered at night.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/05/2024 at 9:35 AM, the Licensed Practical Nurse (LPN) assigned to R43 explained R43's Heparin was scheduled to be administered twice a day at 6:00 AM and 6:00 PM. The LPN indicated not being steadily assigned to R43 but whenever the LPN was assigned to R43, the medication would be administered at 6:00 PM prior to ending the LPNs shift at 7:00 PM.<br><br>On 06/05/2024 at 3:17 PM, the DON reviewed R43's medication administration record (MAR) for the resident's Heparin for March 2024, April 2024, June 2024, and July 2024 which revealed the following:<br><br>March 2024: 21 Heparin vials administered.<br><br>April 2024: 59 Heparin vials administered.<br><br>May 2024: 61 Heparin vials administered.<br><br>June 2024: 9 Heparin vials administered.<br><br>---<br><br>Total administered: 150 Heparin single-dose vials<br><br>The Pharmacy manifest dated 03/21/2024 through 06/05/2024 revealed the following Heparin single-dose vial deliveries for R43:<br><br>03/21/2024: 14 Heparin vials<br><br>03/29/2024: 14 Heparin vials<br><br>04/08/2024: 14 Heparin vials<br><br>04/17/2024: 14 Heparin vials<br><br>04/24/2024: 14 Heparin vials<br><br>04/29/2024: 14 Heparin vials<br><br>05/22/2024: 14 Heparin vials<br><br>06/05/2024: 14 Heparin vials<br><br>---<br><br>Total delivered: 112 Heparin vials.<br><br>On 06/05/2024 at 3:25 PM, the LPN opened the medication cart and confirmed there were currently 19 Heparin vials remaining for R43.<br><br>The Inventory Report indicated Heparin 5,000 units/ml for injection was included in the list of available drugs in the facility's medication dispensing system.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/06/2024 at 8:45 AM, the DON indicated speaking with the Pharmacist who verified there were no recorded retrievals of Heparin for Resident 43.<br><br>On 06/06/2024 at 8:47 AM, the DON confirmed the following for period covering 03/21/2024 to 06/05/2024:<br><br>-there were a total 150 recorded administrations of Heparin for R43<br><br>-there were 112 Heparin vials delivered for R43<br><br>-there were zero Heparin vial retrievals from the medication dispensing system<br><br>-there were 19 Heparin vials left in the medication cart for R43<br><br>- there were 57 recorded administrations in excess of the number of Heparin vials delivered for R43<br><br>On 06/06/2024 at 8:50 AM, the DON indicated the number of recorded administrations cannot exceed the number of Heparin vials delivered for R43. The DON confirmed there were 57 more Heparin administrations over the number of Heparin vial deliveries for R43. The DON stated not being able to speak to the discrepancy and could not think of possible explanations.<br><br>On 06/06/2024 at 9:06 AM, the Administrator confirmed there was a discrepancy between the number of recorded Heparin administrations versus the number of actual Heparin vials delivered for R43 which were unaccountable.<br><br>On 06/06/2024 at 9:20 AM, the Regional Director of Clinical Services could not explain the discrepancy but presented possible explanations such as nurses may have been documenting the medication prior to actual administration when the medication was not actually administered due to R43 being asleep or unavailable. The resident may have also refused at times and these refusals were not recorded. According to the Regional Director of Clinical Services, even if an explanation could not determine it was evident the facility's medication administration and documentation policies were not followed in this case.<br><br>On 06/06/2024 at 10:19 AM, the Consultant Pharmacist indicated the number of recorded administrations must match the number of vials delivered which would include the available supply in the medication cart. According to the Consultant Pharmacist, the number of recorded Heparin administrations cannot exceed the number of Heparin vials delivered especially taking into consideration there were no Heparin retrievals from the medication dispensing system for R43. The Consultant Pharmacist stated the discrepancy of 57 vials translated to missed doses regardless of whether the facility could provide an explanation or not. The pharmacist reviewed R43's record and indicated the resident had no documented refusals of Heparin.<br><br>The Administering medications policy revised April 2019 documented if a drug was withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for the drug and dose. For residents not in the room or otherwise unavailable to receive medication on the pass, the MAR may be flagged. After completing medication pass, the nurse will return to the missed resident to administer the medication.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Charting and Documentation policy revised July 2017 documented all medications, treatments or services performed would be documented in the patient's medical record. Documentation in the medical record will be complete and accurate. Entries must be recorded in accordance with state law and facility policy. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131<br><br>Based on observations, interviews, record reviews, and document review, the facility failed to ensure: 1) a resident's wound was cleansed and dressing was replaced or applied as ordered after the wound was soaked with urine or feces, and 2) the wound dressing applied was dated per policy for 1 of 17 sampled residents (Resident 63). These deficient practices could have the potential to cause delayed healing, worsened wounds, infection, missed treatments and further complications.<br><br>Findings Include:<br><br>Resident 63 (R63)<br><br>R63 was admitted on [DATE], with diagnoses including stage IV (four) pressure ulcers of sacral region, and stage III (three) of right and left buttocks.<br><br>R63's Braden Scale for Predicting Pressure Sore Risk dated 05/01/2024, documented a score of 11, indicating a high risk for developing pressure sores. This high risk was due to very limited sensory perception, very moist skin, severely restricted bed mobility, and significant issues with friction and shear.<br><br>A Physician order dated 05/02/2024, documented to cleanse sacrum with wound cleanser, pat dry, apply Triad, cover with foam dressing daily for stage IV pressure injury.<br><br>A Care Plan dated 05/02/2024, documented R63 had a pressure ulcer to sacrum, stage IV and was at risk for further breakdown and /or slow, delayed healing related to advanced aging process, decreased mobility and incontinence of bowel. The interventions were to provide treatment as ordered. The goal was to prevent or delay deterioration to the extent possible.<br><br>On 06/04/2024 at 9:30 AM, a Certified Nursing Assistant (CNA) was cleaning R63 and provided incontinent care. The CNA confirmed R63's wound had no dressing in place when R63 was first cleaned and the diaper was soaked with urine and soft feces.<br><br>On 06/04/2024 at 2:35 PM, the CNA repositioned and turned R63 to the side, removed the diaper, and revealed R63's wound in the sacrum, which appeared approximately a quarter size, open wound and uncovered. The CNA indicated was not familiar with R63 and was uncertain if R63's wound required a wound dressing. The CNA explained could not change the wound dressing, but the Licensed Nurses and the Wound Care Treatment Nurse (WCTN) would be responsible for dressing change. The CNA indicated had failed to inform the assigned nurse or the Licensed Nurse.<br><br>On 06/04/2024 at 2:48 PM, a Licensed Practical Nurse (LPN) indicated was not informed R63's dressing needed to be changed. R63's wound should have been cleansed and the dressing would be replaced.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/04/2024 in the afternoon, the WCTN explained R63 had not been treated yet for the day and was not informed the dressing needed to be changed. The WCTN explained R63's order was to cover the wound with a foam dressing, and if the dressing was soiled, the Licensed Nurse or the wound team should be informed to cleanse the wound and apply the dressing. The WCTN indicated the wound should not be left open to prevent contamination with feces and urine, which could potentially worsen the wound or cause infection. The WCTN indicated the CNAs had no access to the treatment cart, which was the reason why the Licensed Nurses and WCTN should have been informed.<br><br>On 06/04/2024 in the afternoon, the Wound Physician indicated there was no harm if the dressing was not in place but the consideration was how long it was exposed to urine and feces. The Wound physician indicated the staff members were expected to follow the wound orders to promote healing.<br><br>On 06/05/2024 at 9:10 AM, the Director of Nursing (DON) indicated the staff members were expected to cover the wound to not be exposed with feces and urine to prevent contamination.<br><br>A facility policy titled Wound Care (undated), documented dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time and date and apply dressing.<br><br>A facility policy titled Prevention of Pressure Injuries revised 04/2020, documented to clean the skin promptly after episodes of incontinence. Use facility-approved protective dressings for at risk individuals.<br><br>2) A Physician order dated 05/02/2024, documented to cover with foam dressing right heel stage III.<br><br>A Physician order dated 05/21/2024, documented Venelex external ointment apply to right heel topically as needed for stage III, cover with foam dressing.<br><br>A Physician order dated 05/30/2024, documented cleanse left heel with wound cleanser, pat dry, apply Betadine, cover with foam dressing every Tuesday, Friday, Sun for unstageable pressure injury and as needed.<br><br>A Care Plan dated 05/02/2024, documented R63 had a pressure ulcer to right heel and was at risk for further breakdown and /or slow, delayed healing related to advanced aging process, decreased mobility. The interventions were to provide treatment as ordered. The goal was to prevent or delay deterioration to the extent possible.<br><br>On 06/04/2024 at 9:30 AM, a Certified Nursing Assistant (CNA) was cleaning R63 and provided incontinent care. R63's bilateral heels had wound dressing on bilateral heels which were undated.<br><br>On 06/04/2024 in the afternoon, the WCTN explained R63 had wounds on both heels and was receiving active treatments. The WCTN confirmed R63's wound dressings were not dated and mentioned having been trained by the former trainer at the facility not to put dates on the dressing. The WCTN indicated dating the dressings was important for monitoring when the last treatment was done and for ensuring continuity of care.<br><br>A facility policy titled Dressings, Dry/Clean dated 09/2013, documented to apply the ordered dressing. Label with date and initials to top of dressing. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131<br><br>Based on observations, interviews, record reviews, and document review, the facility failed to ensure the Lidocaine patch was applied as ordered and removed on schedule to manage the resident's pain for 1 of 17 sampled residents (Resident 166). This deficient practice could potentially lead to inadequate pain management, an increased risk of adverse effects, and compromised patient safety.<br><br>Findings include:<br><br>Resident 166 (R166)<br><br>R166 was admitted on [DATE], with diagnoses including muscle spasm, bacteremia, and a history of liver transplant.<br><br>A Physician order dated 05/31/2024, documented the application of a Lidocaine patch, 5 percent (%) topically, daily to the affected area. Apply at 9:00 AM and remove at 8:59 PM.<br><br>A Care Plan dated 05/31/2024, documented R166 was at risk for pain or discomfort due to neck pain. The interventions included administering medication as ordered.<br><br>On 06/04/2024 at 10:18 AM, R166 reported experiencing pain on the right side of the neck. Upon observation, a Lidocaine patch dated 06/02/2024 with the nurse's initials was in place. R166 and the family confirmed the patch had been applied two days ago in the morning. A Licensed Practical Nurse (LPN) verified the patch on R166's neck, confirming it had been there for two days. The LPN indicated the Lidocaine patch should have been removed at night following a 12-hour administration period and acknowledged a new patch was not applied on 06/03/2024.<br><br>The Medication Administration Record (MAR) documented the following:<br><br>-06/02/2024 at 8:59 PM, the Lidocaine patch was recorded as removed when it was still on.<br><br>-06/03/2024 at 9:00 AM, the Lidocaine patch was recorded as applied without applying a new patch.<br><br>-06/03/2024 at 8:59 PM, the Lidocaine patch was recorded as removed when it was still on.<br><br>On 06/05/2024 in the morning, R166 indicated somehow the Lidocaine patch was helping to alleviate the pain and the desire to receive the patch timely.<br><br>On 06/05/2024 at 11:00 AM, the Physician Assistant (PA) indicated the Lidocaine patch was ordered to manage the pain and should have been applied and removed timely for efficacy. The PA indicated there was no harm if the patch was not removed for more than 12 hours, but the staff were expected to follow the orders for the effectiveness of pain management.<br><br>On 06/05/2024 at 2:33 PM, the Director of Nursing (DON) indicated the Lidocaine patch should have been applied and removed as ordered. The staff were expected to follow the orders for the effectiveness of the pain medication based on the resident's assessment and goals.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/06/24 at 08:46 AM, the Pain Specialist indicated the application timing and removal times of the Lidocaine patch were crucial for pain management. The Pain Specialist explained the patch should be removed after 12 hours to prevent skin irritation. The Pain Specialist also mentioned a previous incident where a resident's skin was burned due to the untimely removal of the patch. The Pain Specialist indicated the staff were expected to administer the pain medication timely to alleviate the resident's pain.<br><br>A facility policy titled Pain Management dated 10/2022, indicated the pain management program was based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice. Pain management was defined as the process of alleviating the resident's pain based on their clinical condition and established treatment goals. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>41903<br><br>Based on observation, interview, record review and document review, the facility failed to ensure the medication error rate was below five percent (%), based on three errors identified out of 29 opportunities observed, resulting in an error rate of 10.34%. Failure to follow physician orders during medication administration had the potential to cause harm or injury to residents.<br><br>Findings include:<br><br>1:<br><br>On 06/05/2024 at 08:02 AM, a Licensed Practical Nurse (LPN) prepared and administered 10 medications including one Sodium Bicarbonate 650 milligrams (mg) oral tablet for Resident 34 (R34).<br><br>A physician order dated 05/31/2024, documented Sodium Bicarbonate (Antacid) Oral Tablet 325 mg, give 325 mg by mouth three times per day for supplement.<br><br>On 06/05/2024 at 09:46 AM, the LPN confirmed the Sodium Bicarbonate tablet administered to R34 was 650 mg per tablet. The LPN confirmed the physician order for Sodium Bicarbonate was 325 mg per tablet. The LPN acknowledged had administered the incorrect amount of medication to R34 and explained should have cut the 650 mg tablet in half. The LPN acknowledged the wrong dose of medication could have potentially caused R34 complications of elevated Sodium Bicarbonate.<br><br>On 06/06/2024 at 01:17 PM, the Director of Nursing (DON) confirmed the physician order for Sodium Bicarbonate for R34 was 325 mg and explained if tablets available were of 650 mg strength, staff were to call the doctor to inform of the medication strength available. The DON confirmed the LPN administered more Sodium Bicarbonate than ordered for R34 and R34 should have been monitored for adverse reaction.<br><br>2:<br><br>On 06/05/2024 at 08:02 AM, an LPN prepared and administered 10 medications including one Cyanocobalamin Injection Solution 1000 Microgram/Milliliter (MCG/ML) for R34. The LPN administered the injection into R34's abdomen.<br><br>On 06/05/2024 in the morning, the LPN explained had administered Cyanocobalamin Injection Solution 1000 MCG/ML in R34's abdomen because believed order stated to be given subcutaneous for quicker absorption. The LPN then confirmed and acknowledged the order specified intramuscular administration and medications were to be administered per physician orders.<br><br>A physician order dated 06/03/2024, documented Cyanocobalamin Injection Solution 1000 MCG/ML, inject 1 ML intramuscularly one time a day every Wednesday for supplement.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/06/2024 at 01:17 PM, the Director of Nursing (DON), confirmed the order for Cyanocobalamin Injection Solution 1000 MCG/ML for R34 documented intramuscular route. The DON acknowledged when an injection was not administered in the ordered route, absorption was compromised. The DON explained incorrect administration of the injection should have been reported to the physician.<br><br>3:<br><br>On 06/05/2024 at 08:37 AM, an LPN prepared and administered nine medications including 4 tablets of Zinc Sulfate, 50 mg per tablet, for a total of 200 mg of Zinc Sulfate for resident 274 (R274).<br><br>A physician order dated 02/29/2024, documented Zinc Sulfate Capsule 220 mg, give 1 capsule by mouth one time a day for zinc deficiency.<br><br>On 06/05/2024 at 08:59 AM, the LPN confirmed the physician order was for Zinc Sulfate 220 mg. The LPN acknowledged administered 200 mg to the resident. The LPN reported would contact the ordering provider to clarify order. The LPN acknowledged should have obtained clarification of the order prior to administering a dose of 200mg, when the ordered dose was 220 mg.<br><br>On 06/06/2024 at 01:17 PM, the Director of Nursing (DON) confirmed Zinc Sulfate 50mg per tablet was available in the LPN's medication cart. The DON confirmed the physician order for R274 was Zinc Sulfate 220 mg and R274 was administered an incorrect dose of Zinc Sulfate 200 mg, a lower dose of Zinc Sulfate than ordered by physician.<br><br>A policy titled Administering Medications revised April 2019, documented medications were to be administered in accordance with prescriber orders. The individual administering the medication checks the label three times to verify the right resident, right dosage, right time, and right method (route) of administration before giving the medication. |

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| | 295106 | A. Building<br>B. Wing | 06/07/2024 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>41903<br><br>Based on observation, interview, record review, and document review the facility failed to ensure 1) a single dose of narcotic medication was documented as administered in the Narcotics Logbook, and 2) medication cart was free of loose pills, personal food items and an unlabeled white powdery substance in a plastic cup. The failed practice could have increased the potential for medication administration errors and a breach of infection control measures.<br><br>Findings include:<br><br>Medication Cart Station 1:<br><br>On 06/06/2024 at 01:58 PM, an inspection of Station 1 medication cart was conducted with a Licensed Practical Nurse (LPN) present. Loose pills were found under medication packets including half of a white pill, half of a yellow pill and a full pink pill.<br><br>On 06/06/2024 at 01:58 PM, the LPN reported had not looked under the medication packets while cleaning the medication cart at start of shift. The LPN reported pills could have fallen under medication packs when they were cut or medication packets opened and acknowledged the medication cart should have been free of loose pills.<br><br>Medication Cart Station 2:<br><br>On 06/06/2024 at 01:38 PM, an inspection of Station 2 medication cart was conducted with an LPN and the Director of Nursing (DON) present. One administration of a narcotic medication was found not logged in as administered in the Narcotics Logbook. There were personal food items including a bag of cheese crackers and multiple small chocolate bars in a drawer next to clean supplies. A white powdery substance was found in a clear plastic cup, uncovered, unlabeled, and placed on top of clean supplies.<br><br>On 06/06/2024 at 01:38 PM, the LPN confirmed the narcotic medication was administered to the resident and acknowledged the administration of the narcotic had not been documented in the Narcotics Logbook as required. The LPN acknowledged the personal food items were theirs and was aware food was not to be stored in medication carts and consumed on the nursing floor. The LPN reported the white powdery substance found in a clear plastic cup, unlabeled, and uncovered was thickener for fluids to provide to a resident.<br><br>On 06/06/2024 at 01:38 PM, The DON explained narcotics needed to be logged in the Narcotics Logbook the moment they were administered to residents. The DON confirmed personal food items could not be stored in medication carts and explained staff was not to eat on the nursing floor. The DON acknowledged all medication had to be labeled and stored correctly.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A policy titled Storage of Medications, revised November 2020, documented the facility stored all drugs and biologicals in a safe, secure, and orderly manner. Nursing staff was responsible for maintaining medication storage areas in a clean, safe, and sanitary manner. Medications were stored separately from food and were labeled accordingly. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131<br><br>Based on observations, interviews, record reviews, and document reviews, the facility failed to ensure the transmission-based precautions (TBP) and Enhanced Barrier Precautions (EBP) were followed upon entering the rooms for 2 of 17 sampled residents (Residents 166 and 33), and the vial topper was disinfected prior to drawing the medication for 1 of 17 sampled residents (Resident 34). These deficient practices could potentially lead to the spread of infectious diseases, an increased risk of cross-contamination, and compromised health and safety for both residents and staff.<br><br>Findings include:<br><br>A facility policy titled Isolation-TBP and Enhanced Barrier Precautions revised in September 2022, documented when a resident was placed on TBP, a notification was posted on the room entrance door to inform personnel and visitors of the required precautions. The signage provided the staff with details about the types of precautions, instructions for personal protective equipment (PPE) use, and/or directions to consult a nurse before entering the room.<br><br>Resident 166 (R166)<br><br>R166 was admitted on [DATE], with diagnoses including sepsis, bacterial agents as the cause of diseases, bacteremia, methicillin-resistant Staphylococcus aureus infection, and immunodeficiency.<br><br>A Physician order dated 05/31/2024, documented contact precautions due to Methicillin-resistant Staphylococcus aureus (MRSA) in the blood.<br><br>A Care Plan dated 05/31/2024, documented R166 was on isolation precautions, requiring contact precautions. The interventions included informing residents and visitors about isolation precautions: performing hand hygiene when visiting residents, and taking enhanced precautions. Residents were educated on the transmission of infections and ways to prevent illness.<br><br>On 06/04/2024 at 10:06 AM, contact precaution signage was visible and posted by the door. Outside of R166's room, PPE supplies were readily available. Outside R166's room, PPE was readily available. A Certified Nursing Assistant (CNA) entered the room with no PPE. The CNA explained did not realize the resident was on contact precautions. The CNA explained PPE should have been worn to protect against cross contamination.<br><br>On 06/04/2024 at 10:12 AM, R166's family, who stayed most days, assisted R166 at the bedside without wearing PPE. The family indicated no one in the facility had informed the family PPE was required during the stay or visitation.<br><br>On 06/04/2024 at 10:20 AM, three family members came to visit R166. The family inquired about the reason for the contact precautions, and the nurse explained R166 had an infection in the blood. The family then entered R166's room without wearing PPE. The staff did not provide education on the requirement to wear PPE upon entering R166's room.<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 - Few | On 06/04/2024 at 10:45 AM, the housekeeper was changing the sharps containers in each resident's room. The housekeeper noticed the signage posted by R166's door but entered the TBP room wearing only gloves, not a gown. The housekeeper confirmed seeing the precaution signage but admitted to not paying attention and failing to don a gown.<br><br>On 06/06/2024 at 12:22 PM, the Infection Preventionist (IP) explained the contact precaution process required washing or cleaning hands before entry to TBP rooms and donning gloves and a gown to protect both the resident and the staff or visitors. The IP explained the Licensed Nurses should have called the family to inform of the precautions so the family would know what to do during visitation. The IP indicated if the precautions were not followed, there was a risk of cross-contamination and exposure for residents and other individuals. The IP indicated the staff members received education on donning PPE and handwashing, along with verbal reminders almost daily during rounds.<br><br>40142<br><br>Resident 33 (R33)<br><br>R33 was admitted on [DATE], with diagnoses including unspecified dementia and urinary tract infection.<br><br>On 06/04/2024 at 9:41 AM, an orange signage was observed on R33's door. The signage read: Contact Precautions: everyone must clean their hands before entering and when leaving the room. Put on gloves and gown before room entry.<br><br>On 06/04/2024 at 9:42 AM, the Certified Nursing Assistant (CNA) assigned to R33 explained the resident was confirmed to be infected with Clostridium difficile (C. diff - a bacteria which causes inflammation of the colon which spreads by contact with infected persons, objects, or surfaces) on 06/02/2024 and everyone was required to wash hands and don gown and gloves prior to entering the room.<br><br>A Lab Results Report received on 06/02/2024, documented R33's stool sample tested positive for C. diff.<br><br>A physician's order dated 06/03/2024, documented contact isolation for ten days.<br><br>On 06/04/2024 at 10:21 AM, a visitor was observed sitting on the side of R33's bed feeding the resident yogurt. The visitor was not wearing gown and gloves.<br><br>On 06/04/2024 at 10:32 AM, R33's visitor identified self as a family member who visited daily and stayed for most of the day. The family member indicated not being told by any staff member regarding being required to wear gloves and gown during visits. The family member indicated confining self to the resident's room and went straight to the parking lot right after the visit.<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 - Few | On 06/04/2024 at 10:37 AM, the Infection Preventionist (IP) confirmed the observation regarding R33's family member providing care to the resident without gown and gloves. The IP indicated isolation precautions applied to staff, providers and visitors and staff members were expected to educate visitors on hand hygiene and PPE requirements. During this interview, an ancillary staff member was observed entering R33's room without performing hand hygiene and donning gown and gloves. The IP confirmed the observation and identified the staff member as the admissions director. The admissions director and the family member were observed leaving R33's room without performing hand hygiene. The admissions director was observed putting arms over the family member's shoulder which was described as the IP as a comfort touch. The IP indicated the failure of both parties to wear appropriate PPE and perform hand hygiene and wander outside R33's room placed other residents and staff members at risk for cross contamination. The IP stated the admissions director clearly ignored the contact isolation signage posted on R33's door.<br><br>The Isolation - Transmission based precautions and Enhanced Barrier precautions policy revised September 2022, documented contact precautions were implemented for residents known or suspected to be infected with microorganisms which can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items. When a resident was placed on transmission-based precautions, appropriate notification was placed on the entrance door so that personnel and visitors were aware of the need and type of precaution.<br><br>41903<br><br>On 06/05/2024 at 08:02 AM, during medication pass, a Licensed Practical Nurse (LPN) prepared and administered one Cyanocobalamin Injection Solution to resident 34 (R34). The LPN accessed the medication vial with a syringe without disinfecting the vial topper prior to drawing the medication.<br><br>On 06/05/2024 at 08:14 AM, the LPN confirmed had not disinfected the vial topper prior accessing the vial. The LPN stated disinfecting the vial topper with alcohol was not needed for new sterile vials.<br><br>On 06/06/2024 at 01:17 PM, the Director of Nursing (DON) confirmed all medication vials, regardless of being new and intact or not, needed to be wiped with alcohol to disinfect the vial topper.<br><br>A facility policy titled Administering Medication revised April 2019, documented staff followed established facility infection control procedures for the administration of medications. |