

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Claymont Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5166 Spanson Drive SE Uhrichsville, OH 44683	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801</p> <p>Based on medical record review, observation, interview, and policy review the facility failed to identify and timely investigate bruises of unknown origin and failed to ensure communication occurred with hospice services regarding medications not being administered per orders. This affected one (Resident #46) of one residents reviewed for hospice.</p> <p>Findings included:</p> <p>Medial record review revealed Resident #46 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, anxiety disorder, malignant neoplasm of female breast, osteoarthritis, insomnia, and major depressive disorder.</p> <p>Review of Resident #46's current orders dated 12/2024 revealed no evidence of orders for hospice.</p> <p>Review of Resident #46's Minimum Data Set (MDS) dated [DATE] revealed the resident was on hospice services and had severe cognition impairment. The resident was dependent for all activities of daily living (ADL) care and substantial/maximal assistance with rolling left to right (in bed), sit to lying, lying to sitting. The resident was dependent for chair to bed to chair transfer. The resident used a wheelchair and/or scooter and was dependent on staff for wheelchair/scooter mobility.</p> <p>Review of Resident #46's current plan of care revealed the resident receives hospice service for end stage Alzheimer's disease. The interventions included to follow physician's orders and hospice services as ordered. Hospice would collaborate care with the facility staff. Contact hospice for changes in the resident's condition. Nursing and Certified Nursing Assistants (CNA) to inspect the resident skin during care, administer medication as ordered.</p> <p>a. Review of Resident #46's hospice binder revealed a visit communication note dated 11/29/24 that indicated the resident had a large healing bruise on the base of their left hand of unknown injury. Register Nurse (RN) from the facility signed the hospice note along with hospice RN #300.</p> <p>Review of Resident #46's treatment administration record for November 2024 revealed a skin assessment was completed on 11/30/24. No negative findings were noted under assessment or in the progress notes regarding bruising on the left hand.</p> <p>Review of Resident #46's electronic medical record and paper medical record dated 11/01/24 to 12/03/24 revealed no documentation regarding the bruise on the left hand.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/03/24 at 3:50 P.M. with Licensed Practical Nurse (LPN)/Assistant Director of Nursing (ADON) #117 revealed she was just notified yesterday (12/02/24) by hospice of the bruising on the resident's left hand, however she had not had time to document the assessment she completed yesterday (12/02/24). The bruise on the left hand measured 3.0 centimeters (cm) by 4.0 cm and was brownish yellow in color. She believed the resident received the bruise from trying to get out of her wheelchair over the weekend.</p> <p>Interview on 12/05/24 at 9:45 A.M., with Resident #46's husband revealed he had noticed the bruise on his wife's hand was last week, however he was not sure how she got it. The resident's husband reported he had observed her pick at her skin, or she may have hit it against the wall.</p> <p>b. Review of hospice aide (#302) progress note dated 12/02/24 at 11:04 A.M. revealed the resident had a big purple bruise on the top of her left hand and inner left leg, by vaginal area, and down the other leg. LPN #112, Director of Nursing (DON), and hospice LPN #301 were notified of the bruising.</p> <p>Review of Resident #46's hospice visit communication note dated 12/02/24 at 11:22 A.M. revealed the hospice RN #303 noted the resident had unexplained ecchymosis area to the left hand and inner thighs that appeared older. ADON #117 had signed the communication note.</p> <p>Review of Hospice RN #303's progress note revealed upon arrival, this nurse spoke with the facility nurse who did not know anything about ecchymotic areas to the left hand and inner thighs, close to the vaginal area. The nurse declined any recent falls and stated that there was no recent documentation about the ecchymotic areas. The facility aide stated that over the weekend the resident had been restless while up in her tilt chair and was observed swinging her legs over the side of the chair and at one point, having her feet on the floor. The ecchymotic areas appeared to be older due to color and appearance. The resident was bedbound and unable to reposition self.</p> <p>Review of Resident #46's paper and electronic medical record dated 11/01/24 to 12/03/24 revealed no evidence of skin assessments to the ecchymotic areas to the left hand, inner thighs or any other areas.</p> <p>Interview and observation on 12/03/24 at 3:50 with Licensed Practical Nurse (LPN)/Assistant Director of Nursing (ADON) #117 revealed she was just notified yesterday (12/02/24) by hospice of the bruising to the left hand and left thigh, however she had not had time to document her assessment she completed yesterday. The ADON rolled the resident over and there was bruise noted on the back of the left leg above the bend of the knee that was purplish yellow. A bruise was also observed at the bottom of the resident's incontinence brief, which was removed by the ADON. The resident had a dark purple bruise noted from the crease of the buttocks to the anus area. The ADON reported she was not aware of the bruise on the buttocks area, nor did she assess or measure that area yesterday. She was only aware of the hand and the area on the back of the leg. The ADON reported she thought the area were caused by the resident attempting to get out of her wheelchair over the weekend.</p> <p>Review of the facility's investigation dated 12/02/24 and skin assessments dated 12/03/24 revealed the resident had an area on the left hand and inner thigh. LPN #112 and CNA #142 were interviewed. Resident was noted to be restless and increase anxiety and was trying to get out of the chair. Resident was laid down in bed and was given Ativan (ordered from 11/29/24).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of LPN #112's written statement dated 12/02/24 revealed the resident was in the lounge trying to get out of the chair and had her leg over the arm of chair with her hand hanging down. Took resident back to room and laid her down. Ativan given.</p> <p>Review of CNA #141's written statement dated 12/02/24 revealed the staff member had laid the resident down with the nurse's help due to increased anxiety. Resident climbing out of chair.</p> <p>Review of a nursing progress note dated 12/03/24 at 3:56 P.M., revealed a general investigation was done for the bruises on the left hand/posterior left thigh/posterior left buttocks. Resident was climbing out of her wheelchair, left leg was over the arm of the chair and left hand was hanging down. Resident was seen to have increased anxiety; intervention was to put resident into bed so she could relax with increased anxiety. Hospice and family updated.</p> <p>Review of a wound skin grid #1 dated 12/03/24 of the left hand revealed the wound was acquired 12/02/24 revealed the bruise noted to left thigh bruise 3.0 cm by 4.0 cm by 0.0 cm. Bruise to left hand yellow brown fading. All other skin intact, no s/s of infection. Resident was two people assist and was dependent for bed mobility.</p> <p>Review of a wound skin grid #2 dated 12/03/24 of the left thigh revealed the wound was acquired 12/02/24 and revealed the bruise noted to left thigh measured 3.0 cm by 5.0 cm by 0.0 cm. Bruise to left inner thigh, skin intact, no s/s of infection.</p> <p>Review of wound skin grid #3 dated 12/03/24 of left posterior buttocks revealed the wound was acquired 12/02/24. The area measured 3.0 cm by 2.0 cm by 0.0. The bruise noted to left posterior buttocks, skin intact, no s/s of infection noted. The physician, family, and dietician notified.</p> <p>Review of skin assessment policy dated 03/15/24 revealed staff remains alert to potential changes in skin condition and monitor skin integrity during routine care.</p> <p>2. Observation on 12/02/24 at 3:20 P.M. 12/03/24 at 1:41 P.M., 12/04/24 at 10:40 A.M. and 1:52 P.M., and 12/05/24 at 8:30 A.M., the resident was lying in bed with eyes closed.</p> <p>Interview on 12/03/24 at 1:59 P.M., with Licensed Practical Nurse (LPN) #112 confirmed Resident #46 was receiving hospice services. The LPN reported staff usually get the resident up for breakfast and lunch to eat but she usually sleeps a lot in the evenings and doesn't eat as well.</p> <p>Review of Resident #46's medication records and current orders dated 12/2024 revealed the resident was ordered Ativan 0.5 milligrams (mg) every six hours (Midnight, 6:00 A.M., noon, and 6:00 P.M.) and one milligram at bedtime (7:00 P.M. to 10:00 P.M.) for restlessness/agitation. On 12/01/24 the resident didn't receive the 0.5 mg at midnight or noon due to sleeping. The 6:00 P.M. dose was not given however no indication as to why it was not administered. On 12/02/24 the midnight and noon dose were not administered due to sleeping. On 12/03/24 the 6:00 P.M. dose was not administered. On 12/04/24 the resident did not receive any doses of the 0.5 mg.</p> <p>Review of the hospice note authored by LPN #304 revealed the ADON had called requesting a medication review due to the resident intakes at supper had decreased. The ADON wanted to make sure the resident was not getting too much of anything (medication). The resident intakes at meals can range from 25-75% per the ADON. The facility has noticed a change since the increase of Ativan.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701</p> <p>Based on observation, medical record review and staff interview, the facility failed to ensure restorative nursing services were provided as indicated. This affected one (Resident #5) of one residents reviewed for restorative nursing services. The facility census was 47.</p> <p>Findings include:</p> <p>Review of Resident #5's medical record revealed an admitted [DATE] with diagnoses that included cerebrovascular accident, chronic obstructive pulmonary disease and diabetes mellitus.</p> <p>Further review of the medical record revealed physician's orders from 02/27/24 to 10/31/24 which indicated the resident is recommended to wear a left hand splint as tolerated to decrease risk of worsening contracture, requires assistance to don (apply), monitor for skin irritation and encourage Passive Range of Motion (PROM) to left upper extremity (LUE) prior to donning and post doffing (removing) due to limited Range of Motion (ROM) and tone. An additional physician's orders from 12/14/23 to 01/15/24 also indicated the use of a soft rolled hand splint with digit separators to the left hand/forearm for up to four hours as tolerated to decrease risk of worsening contracture.</p> <p>Review of the medical record revealed Resident #5 was provided occupational therapy (OT) for contracture management services for the periods of 02/08/24 to 03/08/24, 05/21/24 to 06/17/24, 10/03/24 to 10/30/24 and 11/05/24 to 12/23/24.</p> <p>Review of Restorative Nursing Services (RNS) revealed no evidence of any documentation of RNS including splint device use of PROM exercises completed as ordered by the physician.</p> <p>Review of Resident #5's care plans revealed a self-care deficit care plan in place which included an intervention that the resident is recommended to wear left hand splint as tolerated to decrease risk of worsening contracture. The resident requires assistance to don, monitor for skin irritation and encourage PROM to LUE prior to donning and post doffing due to limited ROM and tone.</p> <p>Observation of Resident #5 on 12/02/24 at 9:15 A.M. revealed a left hand contracture with no evidence of a splint device in use.</p> <p>On 12/03/24 at 2:00 P.M., interview with Occupation Therapist (OTR/L) #205 revealed Resident #5 has been and is currently on the OT caseload several times this year for contracture management. Therapy staff apply the splint device five times per week and provide PROM exercises. OTR/L further indicated when Resident #5 is not on the OT caseload RNS is to provide the splint device and PROM daily.</p> <p>On 12/04/24 at 11:02 A.M. interview with the Director of Nursing verified there was no evidence of splint device use or PROM for Resident #5 provided by RNS when not on the therapy caseload.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51074</p> <p>Based on observation, record review, policy review and interview, the facility failed to ensure nebulizer masks and tubing were disposed during weekly oxygen and breathing treatment supply change. The deficient practice affected two residents (#35 and #26) of three residents reviewed for respiratory care. The facility census was 47.</p> <p>Findings include:</p> <p>1. Review of medical record for Resident #35 reveals an admitted [DATE]. Diagnoses include Type two diabetes mellitus, intellectual disabilities, chronic obstructive pulmonary disease (COPD), atrial fibrillation, essential hypertension, anxiety disorder, major depressive disorder and seizures. Review of the most recent Minimum Data Set (MDS) 3.0 reveals a Brief Interview for Mental Status (BIMS) of 9 out of 15 indicating cognitive impairment. The resident was assessed to require assistance and is dependent for all Activities of Daily Living (ADL's).</p> <p>Review of the plan of care dated 11/26/24 reveals the interventions: respiratory assessments, nebulizer treatments, Medications as ordered, monitor for s/s of distress & report to doctor - respiratory symptoms- dyspnea, cyanosis, cough, restlessness, confusion, anxiety, abnormal lung sounds, fatigue, fever, use of accessory muscle.</p> <p>Review of the physician orders for Resident #35 reveals order dated 08/30/24 for respiratory assessments three times a day and Albuterol Sulfate Nebulization Solution (2.5 milligrams per three milliliters) 0.083% every two hours as needed. Further review of the treatment administration record reveals that no treatments were provided for the month of November.</p> <p>On 12/03/24 at 8:55 A.M. observation of Resident #35's room revealed a nebulizer machine was located on the over bed table. The tubing was attached to the machine and a nebulizer mask was observed in a bag and hanging on the wall by the foot of the resident's bed. A second nebulizer mask and tubing was observed hanging on the wall, beside the window and a third nebulizer mask with tubing in bag laying on the chair in the corner of the room.</p> <p>On 12/03/24 at 9:05 A.M. interview with Licensed Practical Nurse (LPN) #123 verified there were three nebulizer masks with tubing in the resident's room, there were no orders for changing the tubing or evidence of the tubing and mask being changed and the resident had not received any breathing treatments during the month of November or December 2024.</p> <p>2. Review of Resident #26's physician orders dated 11/22/24 revealed an order for ipratropium-albuterol 0.5-2.5 milligrams per three milliliters (for inhalation) every eight hours for ten days. There was no order to change the breathing treatment mask or tubing every week and the last breathing treatment was administered on 12/03/24 at 2:00 P.M.</p> <p>On 12/04/24 at 9:50 A.M. observation of Resident #26's room revealed a nebulizer mask and tubing was noted to be hanging on the wall near the head of the resident's bed and a nebulizer machine was sitting on the resident's over bed table.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/04/24 at 9:54 A.M. interview with Registered Nurse (RN) #102 verified the nebulizer machine with mask and tubing remained in the resident's room despite the completion of the order.</p> <p>On 12/04/24 at 8:56 A.M. interview with Regional Clinical Nurse #200 revealed it was no longer facility policy to date oxygen treatment supplies but an order is entered into the electronic medical record to trigger an entry on the treatment administration record (TAR) to change the oxygen supplies every Sunday on night shift. The nurse verified there was no order to change the tubing weekly.</p> <p>Review of policy and procedure titled Respiratory Equipment Cleaning and Disinfecting dated January 26, 2006, Revised July 30, 2024, revealed Section 5. a) clean the external surface as needed. b) Tubing and medication cups are changed weekly or as needed and are stored clean and dry. c) Upon discontinuation of therapy, remove tubing, wipe machine with a disinfectant, placed in a bag and return to storage area.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569</p> <p>Based on observation, record review, facility policy review, and interviews, the facility failed to date and label food items removed from the original packaging in the kitchen freezer, failed to date and remove expired food items from the resident's nourishment room refrigerator, and failed to have clean air returns and heater vents in the ceiling of the kitchen. This deficient practice had the potential to affect all residents residing in the facility and affected one resident (#38) having food items stored in the nourishment room refrigerator. The facility's census was 47.</p> <p>Findings Include:</p> <p>1. Observation on [DATE] from 8:15 A.M. to 8:35 A.M. revealed in the kitchen freezer a small personal pizza in an undated zip lock bag on the top shelf of the freezer. Further observation revealed an undated large zip lock bag which contained ten frozen hot dogs located on the third shelf of the freezer.</p> <p>Interview on [DATE] at 8:40 A.M. with Dietary Manager #132 confirmed the undated zip lock bag containing the small personal pizza and the undated zip lock bag containing ten hot dogs. Dietary Manager #132 stated food items are to be labeled and dated prior to storage in the cooler and/or freezer.</p> <p>Review of the facility's policy titled, Food Storage - Labeling and Dating revised ,d+[DATE] revealed, All food must have a date that includes Month/Day/Year on the package indicating the date in which it entered the facility. All items removed from its original packaging must be dated</p> <p>2. Observation on [DATE] at 2:21 P.M. revealed a refrigerator located in the medication storage room. On the top shelf of the refrigerator was a red plastic bag with a paper label listing the store's name, a list of items within the bag and Resident #38's name. Inside the red bag was a small unopened container of red grapes with a best used by date of [DATE], an opened package of half-eaten yellow and orange cheese with a best used by date of [DATE], and an un-opened package of the same type of cheese with a best used by date of [DATE].</p> <p>Interview on [DATE] at 2:26 P.M. with Licensed Practical Nurse (LPN) #123 confirmed the red plastic bag with a paper label listing the store's name, a list of items within the bag and Resident #38's name. Inside the red bag was the small unopened container of red grapes with a best used by date of [DATE], an opened package of half-eaten yellow and orange cheese with a best used by date of [DATE], and an un-opened package of the same type of cheese with a best used by date of [DATE]. LPN #123 stated the staff should be checking the dates of the residents' food items daily and remove expired food as needed.</p> <p>Review of the facility's policy titled, Use and Storage of Food Brought in by Family and Visitors revision date [DATE] revealed, The facility staff may assist residents n accessing and consuming food that is brought in by resident and family or visitors, if the resident is not able to do so on their own.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801</p> <p>Based on medical record review, observation, interview, and policy review, the facility failed to ensure residents with chronic wounds (pressure ulcers) were placed under enhanced barrier precautions (EBP) and failed to ensure personal protective equipment (PPE) was available on the 300 Hall. This affected three residents (#19, #38 and #44) and had the potential to affect an additional 27 residents who resided on the same halls as the affected residents.</p> <p>Findings included:</p> <p>1. Medical record review revealed Resident #19 was admitted to the facility on [DATE] with diagnoses including fracture of left humerus, severe protein-calorie malnutrition, heart disease, chronic kidney disease, anemia, need for assistance with personal care, cirrhosis, and diabetes.</p> <p>Review of Resident #19's admission skin assessment dated [DATE] revealed the resident had an unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it was obscured by slough or eschar) on the right elbow measuring 4.0 centimeters (cm) by 4.0 cm.</p> <p>Review of the visiting wound nurse practitioner note dated 11/12/24 revealed the resident had an unstageable pressure ulcer on the right elbow measuring 0.9 cm by 1.1 cm and depth undetermined due to the wound bed was covered with 100% scabbed/crusted.</p> <p>Review of the visiting wound nurse practitioner note dated 11/19/24 revealed the resident an unstageable pressure ulcer on the right elbow measuring 0.7 cm by 0.8 cm and depth undetermined due to the wound bed was covered with 80% slough.</p> <p>Review of the visiting wound nurse practitioner note dated 11/26/24 revealed the resident an unstageable pressure ulcer on the right elbow measuring 0.6 cm by 0.6 cm by 0.2 cm due to the wound bed was covered with 10% slough.</p> <p>Review of the visiting wound nurse practitioner note dated 12/03/24 revealed the residents unstageable pressure ulcer on the right elbow was now a stage III pressure ulcer (full-thickness loss of skin, in which adipose (fat) was visible in the ulcer and granulation tissue and rolled wound edges) are often present. Slough and/or eschar may be visible) measuring 0.5 cm by 0.5 cm by 0.0 cm. The wound base was 100% scabbed/crusted.</p> <p>Review of Resident #19's medical record revealed no evidence the resident was on EBP.</p> <p>Observation on 12/02/24 at 10:20 A.M., revealed no evidence the resident was on EBP.</p> <p>Interview on 12/05/24 at 10:17 A.M., with the Director of Nursing (DON) confirmed Resident #19 was not placed on EBP because she didn't feel the pressure ulcer was a chronic wound because the resident was admitted with the pressure ulcer.</p> <p>28701</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Claymont Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5166 Spanson Drive SE Uhrichsville, OH 44683	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>2. Review of Resident #38's medical record revealed an admitted [DATE] with admission diagnoses that included paraplegia, neuromuscular dysfunction of bladder and decubitus ulcer. Further review of the medical record revealed current use of an indwelling urinary catheter since admission and wound treatment for a chronic decubitus ulcer.</p> <p>Review of Resident #38's care plans revealed a care plan in place for alteration in elimination with the use of an indwelling urinary catheter with interventions including EBP. An additional care plan for impaired skin integrity also indicated an intervention of EBP.</p> <p>Observation of the 300 hallway on 12/02/24 revealed two residents (Resident's #38 and #44) currently on EBP. Signs were posted under the resident's name next to the door indicating EBP in place. No PPE for staff use was observed near the rooms or in the hallway.</p> <p>3. Review of Resident #44's medical record revealed an admitted [DATE] with admission diagnoses that included spina bifida, paraplegia, neuromuscular dysfunction of bladder and decubitus ulcer. Further review of the medical record revealed current use of an indwelling urinary catheter since admission and wound treatment for a chronic decubitus ulcer.</p> <p>Review of Resident #44's care plans revealed a care plan in place for alteration in elimination with the use of an indwelling urinary catheter with interventions including EBP. An additional care plan for impaired skin integrity also indicated an intervention of EBP.</p> <p>On 12/02/24 at 11:38 A.M. interview with the Director of Nursing verified there was no PPE located on the 300 hall for staff use for residents on EBP. The Director of Nursing indicated the facility normally has one cart of PPE for each hallway for residents with EBP in place.</p> <p>Review of the facility policy Enhanced Barrier Precautions Best Practice dated 03/2024 indicated: EBP refers to the use of gown and gloves during high-contact care activities for residents with any of the following: infection or colonization with a Centers for Disease Control (CDC) targeted Multi Drug Resident Organism (MDRO) when contact precautions do not apply, chronic wound (ie pressure ulcer, diabetic foot ulcer, non-healing surgical wound, venous stasis ulcer), indwelling medical devices (ie central line, hemodialysis catheter, urinary catheter, feeding tube, tracheostomy/ventilator). PPE shall be located in the general vicinity of the resident's room and readily accessible to staff.</p>		