

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/20/2024
NAME OF PROVIDER OR SUPPLIER  Avenue at Broadview Heights		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 Akins Road Broadview Heights, OH 44147	

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 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461</b></p> <p>Based on interview and closed record review, and hospital paperwork review, the facility failed to ensure they discharged a resident in a safe and orderly manner. This affected one resident (Resident #73) out of five residents reviewed for discharge. The facility census was 72.</p> <p>Findings include:</p> <p>Review of the closed medical record for the former resident (Resident #73) revealed an admitted [DATE] with a hospital stay from 12/03/24 to 12/04/24 and a final discharge date of [DATE] where she discharged home with her daughter. Diagnoses included urinary tract infection (UTI), altered mental status, history of pulmonary embolism, anxiety, major depressive disorder, type II diabetes mellitus, atrial fibrillation, congestive heart failure, hypertension, and aortic valve stenosis.</p> <p>Review of Resident #73 hospital paperwork revealed the resident had some cognitive deficit.</p> <p>Review of Resident #73's Care Plan revealed there was not a 48 hour Care Plan initiated for the resident.</p> <p>Review of Resident #73's progress note dated 12/03/24 at 5:09 P.M. created on 12/04/24 at 10:11 A.M. by the Director of Nursing (DON) revealed upon admission the resident was pleasantly confused, being treated for a UTI. After being oriented to room and dining area the resident became very aggressive with staff, hitting multiple staff members, exit seeking, screaming at the staff that she wanted to leave. The note stated the resident was a fall risk and was currently on anticoagulation therapy. The resident was unable to be redirected. A call was placed to Nurse Practitioner (NP) #810 and gave order to send the resident to the emergency room (ER) for a psych eval as the resident is a harm to others and herself. The unit manager to call nonemergent transport and call report to the ER. Further review of Resident #73's progress notes dated 12/03/24 at 5:18 P.M. authored by Registered Nurse (RN) #805 revealed the resident left the facility via facility van and Certified Nursing Assistant (CNA)/ Van Driver #804. The progress note stated the daughter was to meet CNA/Van Driver #804 at the emergency room (ER).</p> <p>Review of assignment sheets from 12/04/24 to 12/09/24 revealed there was a CNA designated to be one on one with Resident #73 every night until she discharged and during the day the resident was kept in common areas in direct supervision of nursing staff at all times and would be taken to a less stimulating environment such as her room, or the activity room when needed and staff would sit with her until behaviors passed.</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 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/11/24 at 12:40 P.M. with Resident #73's daughter revealed she was not given any paperwork and did tell the facility staff she would have to stop at home to let the dogs out and to get some clothing for her mother before going to the hospital.</p> <p>Interview on 12/12/24 at 12:24 P.M. with CNA/ Van Driver #804 revealed he overheard RN #805 state Resident #73 needed to go to the ER but could not find a nonemergent transport to take her and would have to wait hours. So, he volunteered to take her. CNA/Van Driver #804 stated the daughter of Resident #73 stated she was going to meet her at the ER but had to stop at home to get clothes first. CNA/Van Driver #804 stated he arrived at the ER and the daughter was not there, so he waited 10 minutes before he took her in. He was met at the door by the security guard, and they asked if he was going to stay, CNA/Van Driver #804 stated he told the security guard No, and the security guard told him it was ok, and he could leave the resident with him and the security guard would check her in. CNA/Van Driver #804 stated he waited an additional 20 minutes out in the van before he left. He stated no paperwork was sent with the resident, the daughter never showed before he left and the only person he spoke to was the security guard.</p> <p>Interview on 12/12/24 at 1:27 P.M. with RN #805 revealed she spoke with Licensed Practical Nurse (LPN) #807 regarding Resident #73 and LPN #807 stated the resident had become very agitated and adamant about leaving she was exit seeking, hitting and yelling at staff. LPN #807 stated the resident stated she felt they were trying to keep her from her family, she was here against her will. RN #805 went to Resident #73's room and asked the staff who were in the room to leave and sat one on one with her, she stated she pulled Resident #73 close to her and the resident slapped her. RN #805 stated she made sure the resident was safe and gave her some space, she reapproached her and tried to reorient the resident unsuccessfully, the daughter showed up and the resident's mood improved and then became much worse. RN #805 went to the DON and spoke to her and during that time Resident #73 called the police a few times. RN #805 stated she was scared the resident would elope, so the DON and the Admission Director made a plan with the daughters consent to make plans to discharge the resident to a sister facility with a locked unit. However, Nurse Practitioner and the daughter wanted her sent to the ER for evaluation. RN #805 stated the daughter was in the facility and aware they were sending her to the ER for a psych evaluation. The daughter stated she would meet at the ER. RN #805 stated the daughter never stated she had to stop at home for any reason. RN #805 stated she was unsure if she printed the paperwork to send with the resident or not. RN #805 stated she thought LPN #807 printed it. RN 805 stated she called for a nonemergent transport to the ER but would have to wait for hours, CNA/Van Driver #804 overheard this and volunteered to take the resident.</p> <p>Interview on 12/12/24 at 1:55 P.M. with LPN #807 revealed she did not print the discharge paperwork or call nurse to nurse to the ER. They stated RN #805 was handling her discharge. LPN #807 stated she did not hear the daughter say she was going to meet the Resident at the ER or that she had to stop at home.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160463.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44461</p> <p>Based on interview and closed record review, the facility failed to ensure there was a baseline care plan put in place. This affected one resident (Resident #73) out of five residents reviewed for care plans. The facility census was 72.</p> <p>Findings include:</p> <p>Review of the closed medical record for the former resident (Resident #73) revealed an admitted [DATE] with a hospital stay from 12/03/24 to 12/04/24 and a final discharge date of [DATE] where she discharged home with her daughter. Diagnoses included urinary tract infection, altered mental status, history of pulmonary embolism, anxiety, major depressive disorder, type II diabetes mellitus, atrial fibrillation, congestive heart failure, hypertension, and aortic valve stenosis.</p> <p>Review of Resident #73 hospital paperwork revealed the resident had some cognitive deficit.</p> <p>Review of Resident #73's Care Plan revealed there was not a 48 hour Care Plan initiated for the resident.</p> <p>Interview on 12/11/24 at 1:50 P.M. with the Administrator revealed she verified there was no baseline care plan in place for Resident #73.</p> <p>Interview on 12/11/24 at 2:37 P.M. with the Minimum Data Set (MDS) nurse/ Registered Nurse (RN) #811 verified there was not a baseline careplan completed for Resident #73. RN #811 stated the entire list of MDS's, and care plans were behind since some time in November 2024.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160463.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44461</p> <p>Based on observation, interview, record review, review of resident shower sheets, and review of facility policy, the facility failed to ensure residents received showers per facility schedule and preference. This affected one resident (Resident #25) out of five residents reviewed for showers. The facility census was 72.</p> <p>Findings include:</p> <p>Review of Resident #25's medical record revealed an admitted [DATE]. Diagnoses included sacrum fracture with routine healing, spinal stenosis lumbar region, repeated falls, diabetes mellitus type II, hypertension, atrial fibrillation, and chronic kidney disease.</p> <p>Review of Resident #25's Medicare five-day Minimum Data Set (MDS) 3.0 dated 12/12/24 revealed the resident had intact cognition. Resident #25 required partial to moderate assistance by one staff member for transferring, showers, dressing, and toileting. Resident #25 required setup help only for eating.</p> <p>Review of Resident #25's care plan dated 12/10/24 revealed a care plan initiated related to the resident reaching maximum functional mobility. Interventions and goals included transferring, showering, dressing, and toileting with assistance by one staff member providing partial to moderate assistance.</p> <p>Review of the undated facility shower schedule revealed Resident #25 was to receive a shower on Tuesdays and Fridays.</p> <p>Review of facility shower documentation revealed documentation on Monday 12/09/24 Resident #25 received a shower.</p> <p>Interview on 12/12/24 at 11:30 A.M. with Resident #25 revealed she had not had a shower since she was admitted on [DATE]. She stated the last time she had a bed bath was in the hospital and the last time she had a shower was when she was at home. Resident #25 stated she is aware she is supposed to get a shower twice a week on Tuesday and Friday per the facility schedule. Resident #25 stated when asked about the alleged shower she had on 12/09/24 she denied having a shower. Additionally, an interview was conducted with Resident #25 on 12/16/24 at 10:15 A.M. revealed she had not received a shower on Friday 12/13/24 or at any time over the weekend. Resident #25 stated she knows her hair is greasy and she had body odor.</p> <p>Interview on 12/12/24 at 2:00 P.M. with the Director of Nursing (DON) revealed she confirmed there was only one shower sheet filled out for Resident #25 for Monday 12/09/24 which was not her shower day.</p> <p>Observation on 12/12/24 at 11:35 A.M. of Resident #25 revealed she appeared to have greasy hair and there was a smell of body odor coming from the resident when she would move her arms when talking.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 12/16/24 at 10:00 A.M. of Resident #25 revealed she appeared to have greasy, unkept hair.</p> <p>Review of the facility policy titled Bathing-Personal Care, last revised August 2022 revealed The Residents of health care facilities of Progressive Quality Care will receive personal care in the facility according to the Resident's plan of care to promote dignity, cleanliness, and general well-being. Under the procedure bullet point one Shower, Bath or Tub is offered to the resident twice a week and as needed.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159935.</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>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461</b></p> <p>Based on observation, interview, record review, and review of manufacturer instructions revealed the facility failed to ensure proper administration of insulin was followed. This affected one resident (Resident #52) out of five residents reviewed for medication administration. The facility census was 72.</p> <p>Findings include:</p> <p>Based on review of the medical record for Resident #52 revealed an admitted [DATE]. Diagnoses included cellulitis of left lower limb, Methicillin Resistant Staphylococcus Aureus infection, type II diabetes mellitus insulin dependent, anxiety disorder, heart failure, diabetic retinopathy, and hypertension.</p> <p>Review of Resident #52's quarterly Minimum Data Set (MDS) 3.0 dated 10/12/24 revealed the resident had intact cognition. Resident #52 required set up or clean up assistance with eating, oral hygiene, and upper body dressing. They required partial to moderate assistance with personal hygiene, and substantial to maximal assistance with toileting and showers. Resident #52 was dependent on nursing staff for administration of medication including insulin.</p> <p>Review of Resident #52's physician orders dated December 2024 revealed she was to receive Humalog insulin 100 units/Milliliter (mL) inject 15 units subcutaneously before meals and at bed time for diabetes mellitus and Humalog insulin 100 Units/mL per sliding scale if blood sugar result is 151-200 give two units, 201-250 give four units, 251-300 give six units, 301-350 eight units, 351-400 give 10 units and if over 400 administer 10 units and contact the physician. Sliding scale is to be given in addition to the 15 units.</p> <p>Observation on 12/12/24 at 11:25 A.M. of medication administration by Registered Nurse (RN) #803 for Resident #52 revealed RN #803 performed a blood sugar check with results of 204 milligrams (mg)/ Deciliter (dL) indicating the residents was to receive Humalog insulin 15 units/mL plus four additional units to equal 19 units/mL. During the observation RN #803 did not cleanse the top of the pen with alcohol prior to applying the needle and did not prime the needle with two units of insulin prior to administering the accurate dose per the manufacturers instructions.</p> <p>Interview on 12/12/24 at 11:28 A.M. with RN #803 revealed she verified she did not cleanse the insulin pen with alcohol prior to applying the needle and she verified she did not prime the needle with two units of insulin prior to administering the accurate dose per the manufactures instructions.</p> <p>Review of the manufacturer's instructions for the Humalog insulin pen under the category titled Priming your Pen revealed the pen was to be primed before each injection by turning the dosing knob to select two units, hold the pen with the needle pointing up, tap the cartridge holder gently to collect air bubbles at the top, continue holding the pen with the needle pointing up, push the dose knob in until it stops and 0 is seen in the dose window and count to five slowly, you will see insulin at the tip of the needle. If you do not see insulin at the tip of the needle repeat priming steps no more than for times.</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	This violation was issued relative to incidental findings that were discovered during this complaint investigation completed from 12/11/24 to 12/16/24.		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461</b></p> <p>Based on observation, interview and record review, the facility failed to ensure staff followed infection control policy and procedures related to hand hygiene and proper use of Personal Protective Equipment when administering medications and when administering medications to residents in Enhanced Barrier Precaution isolation rooms. This affected three residents (Residents #4, #25, and #33) out of five residents reviewed for infection control related to hand hygiene and proper Personal Protective Equipment. The facility census was 72.</p> <p>Findings include:</p> <p>1. Review of Resident #4's medical record revealed and admitted [DATE]. Diagnoses included nontraumatic intracerebral hemorrhage, acute respiratory failure, moderate protein-calorie malnutrition with gastrostomy tube placement, cardiac murmur, and personal history of other infectious and parasitic diseases.</p> <p>Review of Resident #4's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had impaired cognition and was dependent on staff for all Activities of Daily Living (ADLs).</p> <p>Review of Resident #4's care plan dated 10/17/24 revealed the resident was to be in Enhanced Barrier Precautions (EBP) related to gastrostomy tube, tracheostomy, and history of infectious disease process. Interventions included EBP will be maintained through the review period, perform hand hygiene before and after glove use, remove gowns and gloves promptly after care activities and dispose of in proper receptacle, and train healthcare personnel on the rationale, indications, and proper use of EBP.</p> <p>Observation on 12/12/24 at 8:50 A.M. of Registered Nurse (RN) #801 administering medications to Resident #4 revealed they did not perform hand hygiene prior to applying gloves to administer medications through Resident #4's gastrostomy tube and did not wear proper Personal Protective Equipment (PPE) including a gown while administering medications through the gastrostomy tube.</p> <p>Interview on 12/12/24 at 9:00 A.M. with RN #801 revealed they verified they did not perform hand hygiene prior to applying gloves and did not wear proper PPE while administering medications through Resident #4's gastrostomy tube including a gown due to resident being in EBP.</p> <p>2. Review of Resident #25's medical record revealed an admitted [DATE]. Diagnoses include sacrum fracture with routine healing, spinal stenosis lumbar region, repeated falls, diabetes mellitus type II, hypertension, atrial fibrillation, and chronic kidney disease.</p> <p>Review of Resident #25's Medicare five-day Minimum Data Set (MDS) 3.0 dated 12/12/24 revealed the resident had intact cognition. Resident #25 required partial to moderate assistance by one staff member for transferring, showers, dressing, and toileting. Resident #25 required setup help only for eating.</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 - Few</p>	<p>Review of Resident #25's care plan dated 12/10/24 revealed a care plan initiated related to the resident reaching maximum functional mobility. Interventions and goals included transferring, showering, dressing, and toileting with assistance by one staff member providing partial to moderate assistance.</p> <p>3. Review of Resident #33's medical record revealed an admitted [DATE]. Diagnoses included severe protein-calorie malnutrition with gastrostomy tube placement, dysphagia, polyneuropathy, gastric ulcer and spinal stenosis.</p> <p>Review of Resident #33's quarterly MDS dated [DATE] revealed the resident has some cognitive impairment but could make needs known. Resident #33 required partial to moderate assistance by staff for all ADLs including medication administration.</p> <p>Review of Resident #33's care plan revealed the resident required Enhanced Barrier Precautions to reduce transmission of multidrug-resistant organisms (MDROs) related to indwelling devices. interventions included EBP will be maintained through the review period, perform hand hygiene before and after glove use, remove gowns and gloves promptly after care activities and dispose of in proper receptacle, and train healthcare personnel on the rationale, indications, and proper use of EBP.</p> <p>Observation made on 12/12/24 at 9:10 A.M. of Licensed Practical Nurse (LPN) #802 administering medications to Resident #25 and at 1:00 P.M. administering medications to Resident #33 revealed they did not perform hand hygiene prior to pulling Resident #25's medication from the medication cart. Additionally LPN #802 did not perform hand hygiene prior to applying gloves to administer medications through Resident #33's gastrostomy tube and did not apply proper PPE including a gown prior to administering medications through Resident #33 who was in EBP.</p> <p>Interview on 12/12/24 at 1:15 P.M. with LPN #802 revealed they confirmed they did not perform hand hygiene prior to pulling Resident #25's medications and they confirmed they did not perform hand hygiene prior to applying gloves to administer medications through Resident #33's gastrostomy tube and did not apply proper PPE including a gown while in Resident #33's room who was in EBP.</p> <p>Review of the facility policy titled Medication Administration-General Guidelines last revised October 2017 revealed under Preparation bullet point number two Handwashing and Hand Sanitization: The person administering medications adheres to good hand hygiene, which includes washing hands thoroughly before beginning a medication pass, prior to handling any medications, after coming into direct contact with a resident, before and after administration of medications via enteral tubes.</p> <p>This deficiency was issued relative to incidental findings that were discovered during this complaint investigation completed on 12/20/24.</p>		