| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 405023 | A. Building<br>B. Wing | 05/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Damas Hospital Snf | 2213 Ponce by Pass<br>Ponce, PR 00717 |

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

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|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884<br><br>Based on dining observations, and facility staff interview performed on 05/16/2024 through 05/17/2024 to from 8:30 AM through 4:30 PM, it was determined that the facility failed to provide services in a manner that respect, and dignity of residents was maintained. This deficiency was identified in 1 out of 19 cases reviewed during initial pool process (Resident #9).<br><br>Findings include:<br><br>1. Resident #9 is a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of Fracture of Left Femur. During the record review performed on 5/16/2024 at 10:12 AM it was found that resident was presenting periods of disorientation and had urine incontinence.<br><br>2. On 05/16/2024 at 12:00 PM resident was observed located in the recreative room seating on a wheelchair were other resident and she receive their lunch trays. When resident #9 is observed eating lunch she was constantly touching her back area and pulling a blue medical surgical pad that personnel put in the seat of the wheelchair. After she touches her back area and the area were the blue pad is located she continues eating from the lunch tray.<br><br>3. Nursing supervisor (employee #1) was interview on 05/16/2024 at 1:40 PM and she was ask in relation with resident #9 incontinence and she stated that this resident had been identified with incontinence since admission to the facility that she use disposable diapers and due to the situation that she present large urine spills and this is the reason why personnel put the blue pad on the wheelchair when they were going to move her outside her room or seat her on the wheelchair.<br><br>Nursing supervisor (employee #1) was asked by the surveyor on 05/16/2024 at 2:00 PM if there is the possibility that fabric urine spill pad is used with this resident in order to avoid that it was evident (due to the blue pad located on the seat of the wheelchair) that she present incontinence urine spills and maintain resident dignity when she was eating or is located in an area were other residents were eating. Nursing supervisor (employee #1) stated in an interview on 05/16/2024 at 2:10 PM that facility can get fabric urine spill pads to be used with residents who present large urine spills.<br><br>4. Facility failed to treat each resident with respect and dignity and provide care and services in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility failed to promote residents' dignity. |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| Damas Hospital Snf | 2213 Ponce by Pass<br>Ponce, PR 00717 |

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|---|---|
| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47384<br><br>Based on observations of the physical environment and facility staff interview performed on 05/16/2024 through 05/17/2024 from 8:00 AM through 4:00 PM, it was determined that the facility failed to ensure residents to reside and receive services in the facility with reasonable accommodation of residents.<br><br>Findings include:<br><br>During observational tour the following was observed related with environment in the facility:<br><br>1. During the evaluation of room [ROOM NUMBER], it was observed that the clinical staff was transferring the resident of 307A bed from the wheelchair to the bed using the crane. It was observed that the clinical staff invaded the space of the other resident with wheelchair and crane. Resident of #307 B expressed discomfort during the process. |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884<br><br>Based on observations, performed on 05/16/2024 through 05/17/2024 to from 8:30 AM through 4:30 PM, it was determined that the facility failed to promote the right to personal privacy and confidentiality for all aspects of care and services. This deficiency was identified in 1 out of 19 cases reviewed during initial pool process (Resident located on room [ROOM NUMBER]-1).<br><br>Findings include:<br><br>1. Nursing personnel (employee #7) proceed to perform the Dextrostix test to residents located on room [ROOM NUMBER]-1. Before proceeding to puncture resident finger with the lancet, nurse pulled the privacy curtain to provide privacy to resident, however the curtain did not slide completely in a way that covers resident bed area. No matter what the curtain did not slide completely in a way that covers resident area, the nurse proceeds to perform the blood glucose test.<br><br>In bed 309-2 it was observed relatives with the resident located in this bed that could see procedure perform to resident located on bed 309-1. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>47384<br><br>Based on Physical Environment observation, and facility staff interview performed on 05/16/2024 through 05/17/2024 from 8:00 AM through 4:00 PM, it was determined that the facility failed to maintain safe, clean, comfortable, and homelike environment.<br><br>Findings include:<br><br>1. During visual observation and patient interview on physical environment of the facility bathroom it was observed that lightning fixture mounted on the wall did not provide adequate illumination in the shower area. The light fixture location is lower than the shower curtain which does not permit full light difumination on this area.<br><br>2. During visual observation of residents sleeping areas it was noticed that bed platforms behind head rest had accumulation of dust particles. |

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| F 0609<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884<br><br>Based on review of incidents and complaints during Quality assurance and performance improvement (QAPI) program review and staff interview performed on 05/17/2024 at 11:20 AM, it was determined that the facility failed to ensure that all alleged violations involving neglect are reported to the State Survey Agency within 5 working days of the incident to verified appropriate corrective action is taken.<br><br>Findings include:<br><br>Facility policy Title: Abuse and Neglect last updated May 2023 was review on 05/17/2024 at 2:35 PM with QAPI officer (employee #8) Policy clearly stated on the procedures that any incidents/violations that been sustained after investigation that abuse or neglect occur must be reported to the state agency and to the required state nursing examination board agency. This policy did not include provisions who establish the time period when the violation were going to be reported.<br><br>1. While the Quality assurance and performance improvement (QAPI) program review was performed on 05/17/24 at 11:23 AM it was referred by the QAPI program officer (employee # 8) refer that 15 days ago it was necessary to activate abuse and neglect protocol due to a situation that occurs on April 29, 2024 with a [AGE] years old female resident who are receiving services for rehabilitation due to a Left Knee Replacement and was admitted on [DATE].<br><br>2.Accordingly with information provided by QAPI program officer (employee #9) and Director of Nursing (DON) (employee #10) on 05/17/24 at 11:45 AM on 04/29/24 a nurse took this resident to the shower to receive a bath. DON explain that while resident was in the bathroom, nurse in charge of her did not provide assistance with resident hygiene. Resident is ambulatory enough to reach the bathroom and need minimal assistance bathing herself. However, the nurse did not stay nearby resident room in case the resident needs help.<br><br>3. Resident felt bad that nurse did not stay nearby her room in case she needs help. Resident bathed herself and put on her clothes as the best she could with the help of her husband. Resident proceeded to speak with her husband who was there visiting the resident. Resident and her husband proceed to complain about the nurse in charge's way of acting. As result of the situation resident said that felt sad and she did not want to go to receive physical therapy treatment what was she is going to do after taking a bath. Resident stated that she does not want this nurse to be around her or provide any service. Resident also stated that she was afraid to call for assistance to go to the toilet to empty her bladder or bowel because does want that the nurse that did not help her in the shower to provide assistance.<br><br>4.Facility refer the resident to neuropsychology services on May 02,2024. Neuropsychology department provides services to resident on May 02,2024,May 03,2024 and May 06, 2024. Main goals for the neuropsychology services were to facilitate collateral training and teach her how to redirect resident fear and anxiety and to reinforce guided relaxation strategies to enhance emotional regulation and positive mood throughout stay at the rehabilitation facility.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Neuropsychology personnel stated on their progress notes that the resident benefit from the replacing of the nurse (with which one resident had the incident) with another nurses and reassurance from other healthcare personnel to ease her apprehension and worry.<br><br>5. Accordingly with information provided by QAPI program officer (employee #9) on 05/17/24 at 11:55 AM facility create a temporary committee to investigate the situation (An Ad Hoc committee) and proceed immediately to activate the abuse and neglect protocol and proceed to investigate the incident on May 02, 2024.<br><br>6. This Ad Hoc committee investigate the circumstances where the incident occurs and interview personnel in charge, the resident, and her husband. The committee analyzed information collected accordingly with abuse and neglect policies and determined that neglect in relation with the management by the nurse to this resident while she was in the bathroom occurred.<br><br>A final determination with the decision was informed to the administrator of the facility on May 06, 2024. Nurse was suspended from work and salary from May 02, 2024 through May 08, 2024 and transferred from the Skilled Nursing Facility (SNF) to the hospital area (this is a SNF located in an hospital).<br><br>7. Facility administrator (employee #10) stated on interview on 05/17/24 at 1:00 PM that she receives the determination performed by the Ad Hoc committee on May 06, 2024, and did not notify to the state agency or any local entity (state nursing examination board agency).<br><br>8. Facility administrator (employee #10) stated on interview on 05/17/24 at 1:12 PM that she made a phone call on May 09, 2024 to the state Medicare division office and report that an resident complaints in relation with services provided by one of the nurses however did not specify that the situation was investigate by an Ad Hoc committee and that the Ad Hoc committee determine that negligence on the management of the case occur. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884<br><br>Based on a recertification survey and dining observations, performed on 05/16/2024 through 05/18/2024 to from 8:30 AM through 4:30 PM, it was determined that the facility failed to provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This deficiency was identified in 1 out of 19 cases reviewed during initial pool process (Resident #9).<br><br>Findings include:<br><br>1. Resident #9 is a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of Fracture of Left Femur. During the record review performed on 5/16/2024 at 10:12 AM it was found that resident was presenting periods of disorientation and had urine incontinence.<br><br>2. On 05/16/2024 at 12:00 PM resident was observed located in the recreative room seating on a wheelchair where other residents and she receive their lunch trays. Resident #9 is observed eating lunch without assistance from any personnel. She presents periods of distraction where she put down the cutlery and stop eating. No personnel were observed supervising or cueing the resident when distraction periods were presented. The resident ends up eating approximately 60% of food items in the lunch tray.<br><br>3. Facility failed to supervise or assist this resident who becomes easily distracted during meals. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884<br><br>Based on dining observations and record reviewed (RR) performed on 05/16/2024 through 05/18/2024 to from 8:30 AM through 4:30 PM, it was determined that the facility failed to provide the necessary care and services to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain grooming, and personal care. This deficiency was identified in 1 out of 19 cases reviewed during initial pool process (Resident #9).<br><br>Findings include:<br><br>1. Resident #9 is a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of Fracture of Left Femur. During the R.R. performed on 5/16/2024 at 10:12 AM it was found that resident was presenting periods of disorientation and had urine incontinence.<br><br>2. On 05/16/2024 at 12:00 PM resident was observed located in the recreative room seating on a wheelchair where other residents and she receive their lunch trays. When resident #9 is observed eating lunch she was constantly touching her back area and pulling a blue medical surgical pad that personnel put in the seat of the wheelchair. After she touches her back area and the area where the blue pad is located, she continues eating from the lunch tray. No personnel came to assist the resident or to review if she had a large spill of urine and it was necessary to provide perineal care and change of incontinence items.<br><br>2. Facility failed to review if incontinence absorbent pads or disposable pads needed changing and to promote a clean environment where residents eat. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>15884<br><br>Based on dining observations, review of policies procedures and facility staff interview performed on 05/16/2024 through 05/17/2024 to from 8:30 AM through 4:30 PM, it was determined that the facility failed to ensure that input received from residents and preferences related with food services are met. This deficiency affects 1 out of 19 cases reviewed during dining observations (Resident #77).<br><br>Findings include:<br><br>1. During dining observations on 05/16/24 at 12:00 PM it was observed that chicken asopao is the main dish in the lunch. It was observed that resident #77 made a bad face when she received the lunch tray.<br><br>2. Resident #77 was asked on 05/16/24 at 12:10 PM if she likes chicken asopao. She explains to the surveyor that she like soups and asopao but not as main dish because she is a big woman, she likes to eat and when she eats soup or asopao she gets hungry quickly.<br><br>3. Surveyor ask resident #77 on 05/16/24 at 12:15 PM if she wants a substitution in her lunch dinner tray. Resident stated that she wants the substitution and asked if facility had an alternate menu. Surveyor explained to the resident that facility had white rice, stewed beans, and grilled chicken.<br><br>4. Nursing personnel are observed assisting residents with lunch trays, however none of them were observed asking residents if they were ok with chicken asopao as main dish.<br><br>5. Nursing supervisor was informed on 05/16/24 at 12:50 PM in relation to resident #77 food preferences for lunch. She also was informed that nursing personnel were observed assisting residents with lunch trays, but that none of those personnel asked residents if they were ok with chicken asopao as main dish. Nursing supervisor stated on interview on 05/16/24 at 1:00 PM that it is responsibility of the nursing personnel to ask the residents if everything was ok with their lunch items and to offer food items substitution or change if resident does not want to eat the lunch that kitchen personnel brings. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884<br><br>Based on dining observations, and facility staff interview performed on 05/16/2024 through 05/17/2024 to from 8:30 AM through 4:30 PM, it was determined that the facility failed to distribute and serve food in accordance with facility established infection control precautions. This deficiency affects 19 out of 19 cases reviewed during dining observations.<br><br>Findings include:<br><br>1. During dining observations procedures performed on 05/16/24 at 12:00 PM it was identified that kitchen personnel (employee #4) brought the lunch trays in a food warmer cart.<br><br>2. Kitchen personnel (employee #5) did not check if resident was in the room before taking out the lunch tray from the food warmer cart. He took off the trays of room [ROOM NUMBER]-2, 308-2 309-2 and 311-1before checking if those residents were in the room. Since residents were not in their room, he returns the lunch tray again to the food warmer.<br><br>3. Kitchen personnel return lunch trays to the food warmer cart that had been in the environment of resident's rooms and could be in contact with room surfaces.<br><br>4. It was asked to the infection control officer (employee #3) on 05/16/24 at 2:00 PM if is correct that Kitchen personnel (employee #5) return the lunch trays to the food warmer once there had been in the environment of resident's rooms and could be in contact with room surfaces.<br><br>5. Infection control officer (employee #3) stated interview on 05/16/24 at 2:10 PM that Kitchen personnel (employee #5) must first review if the resident is in the room before taking the lunch tray from the food warmer cart. She also explains that this way it prevent that lunch trays who could had been in the environment of residents rooms and could be in contact with room surfaces be return to the food warmer cart where there are all the others lunch trays. |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>47384<br><br>Based on review of Quality Assessment Performance Improvement (QAPI) activities performed on 05/16/24 through 05/17/24 from 8:00 AM till 5:00 PM and interview with the facility QAPI (employee #8) it was determined that facility failed to ensure the participation of all required members on the QAPI committee meetings.<br><br>Findings include:<br><br>1. During review of facility QAPI committee meetings during year 2023 and the months of February 2024 and April 2024 the following was identified:<br><br>Upon review of facility attendance list related to QAPI program committee meeting activities it was identified that the Infection Preventionist did not participate in every QAPI committee meeting.<br><br>a. There is no evidence of participation of facility Infection Preventionist on QAPI committee meetings performed on May 25, 2023, September 14, 2023, October 26, 2023, February 15, 2024, and April 15, 2024.<br><br>b. During interview on 05/17/24 at 1:30 PM facility QAPI (employee #8) stated that infection control officer gave her the infection control report and discusses with her relevant areas and is her as the QAPI, who present the findings on the QAPI committee meetings. |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20423<br><br>Based on infection control observation, and facility staff interview performed on 05/16/2024 through 05/17/2024 from 8:00 AM through 4:30 PM, it was determined that the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>Findings include:<br><br>During the medication Pass performed on 5/17/2024 from 8:30 AM till 9:35 AM it was the following:<br><br>1. During the medication pass with the registered nurse employee #6 it was observed that nurse did not wash her hand before putting on the non-sterile glove in 4 out of 4 opportunity to wash her hand before gloving hands.<br><br>2. During the employee #6 was serving the medication, a piece of paper from the surveyor fell on the floor and the nurse picked it up from the floor and gave it to the surveyor. She continued serving the medication without washing her hands.<br><br>3. During the process that the employee #6 performed the medication administration, it was observed that the nurse enter the Medication Administration Record (MAR) to resident room, put them over the dinner table without disinfect the table, then return the MAR to the medication car put over the medication car then put on the medication record, However did not disinfected the medication cart and continue serving the medication.<br><br>4. It was observed that employee #6 used a scissor to cut and open the Lidoderma patch without disinfect the scissor previous to used.<br><br>5. It was observed that during the nurse served the medication the registered Nurse employe#6 remove the medication from the Pyxie Machine (Automated dispensing cabinet for single and multi-facilities medication management) and put them on the top of the pixie, then put on the medication cart resident box, then when goes to administrate the medication, the Registered Nurse put each individual preserved medication into the medication cup, then when into to the resident room she remove the preserved medication from the cup opened the medication then put them in the same used medication cup, this was a potential cross contamination.<br><br>15884<br><br>6. The following observations were made while the initial observational tour at the facility is performed on 05/16/24 from 8:00 AM through 12:20 PM:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 405023 | A. Building<br>B. Wing | 05/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Damas Hospital Snf | 2213 Ponce by Pass<br>Ponce, PR 00717 |

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

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | a. Canister with dirty linen is located at the same side and near 5 wheelchairs on the hallway that starts in room [ROOM NUMBER] and ends in room [ROOM NUMBER]. It was asked to the facility head nurse (employee #2) on 05/16/24 at 10:00 AM if wheelchairs are disinfected and ready to use with residents and she stated that before locating the wheelchairs on this area nursing personnel disinfect them with Caviwipes disinfectant wipes.<br><br>b. Kitchen personnel (employee #5) is observed on 05/16/24 from 11:55 AM through 12:20 PM giving residents their lunch trays in room [ROOM NUMBER], # 308, #309, and #310. No nursing personnel were observed providing resident hand hygiene before beginning to eat.<br><br>c. Kitchen personnel (employee #5) are observed providing a lunch tray to a resident that was seated on the recreative therapy room. It was observed that this resident begins to eat, and no nursing personnel were observed providing resident hand hygiene before beginning to eat.<br><br>d. Resident #9 is a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of Fracture of Left Femur. During the record review performed on 5/16/2024 at 10:12 AM it was found that resident was presenting periods of disorientation and had urine incontinence.<br><br>e. On 05/16/2024 at 12:00 PM resident was observed located in the recreative room seating on a wheelchair where other residents and she receive their lunch trays. When resident #9 is observed eating lunch she was constantly touching her back area and pulling a blue medical surgical pad that personnel put in the seat of the wheelchair. After she touches her back area and the area where the blue pad is located, she continues eating from the lunch tray. No nursing personnel were observed providing resident hand hygiene on instances were resident touch her back before she continues eat from her lunch tray. When resident #9 ends eating lunch at 12:50 PM and nursing personnel take away the lunch trays no nursing personnel were observed cleaning and disinfecting table surfaces that resident #9 touch.<br><br>7.The following observations were made when nursing personnel (employee #7) perform a Dextrostix blood monitoring to resident located on room [ROOM NUMBER]-1 on 05/17/24 at 8:15 AM:<br><br>a. Nursing personnel (employee #7) disinfect glucometer and prepare the lancet and test strip before entering room [ROOM NUMBER]-1. When she entered room [ROOM NUMBER]-1, she left the glucometer case wide open exposing to the environment the lancets, alcohol wipes and test strip bottle.<br><br>b. Nursing personnel (employee #7) proceed to perform the Dextrostix test to resident located in room [ROOM NUMBER]-1. When finishes she goes near the resident food tray and puts the breakfast near the resident. No hand hygiene was provided to the resident before giving the breakfast tray.<br><br>8. The following observations were made with head nurse (employee #2) on 05/17/24 at 8:55 AM:<br><br>a.At the clean linen room it was observed a plastic container used to store clean linen located directly on the floor.<br><br>(continued on next page) |

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|---|---|---|---|
| | 405023 | A. Building<br>B. Wing | 05/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Damas Hospital Snf | 2213 Ponce by Pass<br>Ponce, PR 00717 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Head nurse (employee #2) stated on interview on 05/17/24 at 9:00 AM that this room had 2 shelves to put the plastic container with clean linens but the shelve located on the higher position is located in a very high position and nursing personnel could not reach the shelve, to put the container when laundry personnel bring the clean linens or to take the container to take off the sheets before use them. |

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|---|---|---|---|
| | 405023 | A. Building<br>B. Wing | 05/17/2024 |

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| Damas Hospital Snf | 2213 Ponce by Pass<br>Ponce, PR 00717 |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>47384<br><br>Based on observations of the physical environment and facility staff interview performed on 05/16/2024 through 05/17/2024 from 8:00 AM through 4:00 PM, it was determined that the facility failed to ensure residents to reside and receive services in the facility with reasonable accommodation.<br><br>Findings include:<br><br>During observational tour with Engineering Director (employee #10) the following was found:<br><br>1. 3 out of 15 wheelchairs were found with loose brake frame<br><br>1out of 2 four contact points walking canes with paper creating pressure on suctions cup.<br><br>2 of 2 chairs in occupational therapy found with rust.<br><br>2. Plastic box used to store linen was observed directly on the floor of the clean linen room<br><br>3. Biomedical waste room was observed with the door open and garbage overflowing from the container<br><br>4. Two cardboard boxes containing medical equipment (masks and lines) were observed directly on the floor of the respiratory therapy room. |

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|---|---|---|---|
| | 405023 | A. Building<br>B. Wing | 05/17/2024 |

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| Damas Hospital Snf | 2213 Ponce by Pass<br>Ponce, PR 00717 |

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|---|---|
| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47384<br><br>Based on observations of the physical environment performed on 05/16/2024 through 05/17/2024 from 8:00 AM through 5:00 PM, it was determined that the facility failed maintain an effective pest control program so that the facility is free of pests.<br><br>Findings include:<br><br>1. Spiders, spider webs and ants were observed behind curtains in rooms #309, #310, #311, #317 and #319.<br><br>2. Particulate, apparent soil was observed in the corner of room [ROOM NUMBER] indicative of an anthill starting to form. |