

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 405025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Centro Medico Wilma N Vazquez Snf		STREET ADDRESS, CITY, STATE, ZIP CODE Road 2 Km 39 5 Bo Algarrobo Vega Baja, PR 00693	

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884</p> <p>Based on observations made during the initial pool process and facility staff interview performed on 12/04/2024 through 12/06/2024 to from 8:00 AM through 3:30 PM, it was determined that the facility failed to promote the right of each resident to have personal privacy. This deficient practice had the potential to affect 8 out of 8 residents receiving services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During the initial pool process on 12/04/2024 at 8:55 AM it was observed that the resident located in room [ROOM NUMBER]-B (resident #58) participating in Occupational Therapy treatment. 2. The resident was observed sitting on the edge of the bed. 3. The resident was observed with only clothing from the waist down than the disposable diaper. 4. The curtain was drawn, however personnel failed to provide visual personal privacy before beginning the treatment. <p>The Nursing supervisor (employee #6) was asked by the surveyor on 12/04/2024 at 9:00 AM if residents had available pajama pants.</p> <p>The Nursing supervisor stated in an interview on 12/04/2024 that the resident had pajama pants available and that rehabilitation personnel must ensure the resident is dressed before beginning treatment.</p> <p>The Director of Nursing DON (employee #10) was asked by the surveyor on 12/04/2024 at 10:55 AM in relation to facility policy and procedure to promote personal privacy to residents.</p> <ol style="list-style-type: none"> 5. The DON stated that the facility does not have a personal privacy policy.

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47384</p> <p>Based on observations of the physical environment, review of policies procedures and facility staff interview performed on 12/04/2024 through 12/06/2024 to from 8:00 AM through 3:30 PM, it was determined that the facility failed to promote the residents right to receive services in a safe, clean, comfortable, and homelike environment. This deficient practice had the potential to affect 8 out of 8 residents receiving services at areas where the deficient environment and items (equipment) is located.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Residents on rooms [ROOM NUMBERS] complained about room temperatures being too cold, when the surveyor took temperature measurement it was noted that room temperatures exceeded the temperature stated in the facility's temperature policy Temperatura y Humedad relativa de las Habitaciones [NAME] Skilled Nursing Facility Temperature and Relative Humidity of the rooms of the Skilled Nursing Facility, which states that room temperature should be between 71- and 80-degrees () Fahrenheit (F). <ol style="list-style-type: none"> a. 101 - 66 F b. 104 - 64 F 2. Grab bars in the bathroom on rooms 111, 113 and 117 were observed loose. 3. Headlights cord behind beds were observed tied with ribbons or no cord (rooms 111, 121). 		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884</p> <p>Based on observations made during the initial pool process, records reviewed (RR) and facility staff interview performed on 12/04/2024 through 12/06/2024 to from 8:00 AM through 3:30 PM, it was determined that the facility failed to ensure that there is documentation of resident capacity and plan of care to have medications at bedside self-administer these medications. This deficient practice was identified in 1 out of 8 residents receiving services (RR#3).</p> <p>Findings include:</p> <p>The facility's Policy & Procedures, WNV-FARM-028 Self Administration of Medications last updated March 2023 is reviewed with pharmacist on 12/06/2024 at 9:00 AM.</p> <p>51637</p> <p>1. RR # 3 is an [AGE] year-old female resident with Dx of Pneumonia, Muscle Decondition, S/P hip arthroplasty, depression and anxiety disorder, was admitted on [DATE], due to status post left hip fracture, resident is chronically bedridden.</p> <p>The resident was visited on 12/04/2024 at 8:53 AM and observed several albuterol pumps (Brand name Proventil - is a bronchodilator that relaxes muscles in the airways and increases air flow to the lungs) on the side of the bed. The resident says that she needs to see them when she wakes up because if she does not see them, she has a panic attack.</p> <p>Several interviews and investigations were conducted and show the following:</p> <p>a. There was a total of 6 albuterol pumps (Proventil), 4 empty and 2 in use, all with expiration dates between March and May 2026.</p> <p>b. On 12/04/2024 at 9:35 AM during interview with the MDS coordinator (employee #7) to request self-administration policy and patient entitlement. Employee #7 provides a policy used in the hospital indicating that patients should not self-administer medications during their stay, except for some cases.</p> <p>The Interdisciplinary group care plan to address resident conditions and needs to self-administer this respiratory treatment was requested by the surveyor but was not available.</p> <p>2. On 12/04/2026 at 9:50 AM clinical record is reviewed, and residents have order for Albuterol inhale (Proventil) 2 pumps every 4 hours PRN. There is no medical order to have the medication at the bedside or self-administration.</p> <p>3. On 12/05/2024 at 10:30 AM Medical director (employee #15) is interviewed regarding what was identified on this resident medical record.</p> <p>(continued on next page)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The medical director (employee #15) stated that they have tried several times to remove the pumps from bedside and try another treatment, but the resident refused. She explains that they opted to leave the pump next to the bed so she can see them. She also says that the resident does everything with the help of the nursing staff except for the self-administration of the medication albuterol (Proventil).</p> <p>4. On 12/06/2024 at 9:10 AM an interview was conducted with the facility pharmacist (employee #14). This to evaluate why the medication regimen review did not include the Albuterol pump (Proventil) as a medication that resident had at bedside, to self-administer it.</p> <p>The facility pharmacist (employee #14) stated on 12/06/2024 at 9:30 AM that the resident had ordered to use Albuterol in pump as part of her drug regimen, but no to have the medication at bedside to self-administer. She stated that the facility plans to hold a meeting with the interdisciplinary group to discuss resident cases and determine if is appropriate and safe that this resident self-administer this medication.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20423</p> <p>Based on initial tour observation, resident interview, observations done during the assembly of the food trays, staff interviews and policies reviewed (Line assembly and delivery of meals or special foods), it was determined that the facility failed to ensure that food and drink is palatable, attractive, and at a safe and appetizing temperature. This deficient practice was identified in 1 out of 8 residents receiving services (sample resident #106).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #106 is an [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of Right Hip Fracture, on 12/04/2024 at 8:30 AM during resident interview he state that the food came on disposable Styrofoam every time and that when he eats was cold. 2. During the test trays performed on 12/04/2024 at 11:46 AM was observed that all the food came in a Styrofoam tray inside came a match sweat potatoes with chicken thigh that was an open tray, over them came a plastic glass with carrot, a plastic bowl with Stew with rice, plastic cup of milk, and plastic cup of apple sauce. During the temperature test the following was found: <ul style="list-style-type: none"> a. Mach sweat potatoes: 140 grade() Fahrenheit (F) b. Chicken Thigh: 109 F c. Carrots: 80 F d. Stew with rice: 137.7 F e. Apple sauce: 65.4 F d. Milk: 63.5 F. <p>51629</p> <ol style="list-style-type: none"> 3. During the assembly of the food trays carried out on December 4, 2024, at 11:20 AM, the food had the following temperatures: vegetable mash (146 Degrees () Fahrenheit (F)), meat (162 F), soup (168 F), milk (52 F). 4. Tray was performed on December 4, 2024, at 11:40 AM, the food had the following temperatures: vegetable mash (130 F), meat (109 F), soup (137.7 F), milk (63.5 F), fruit dessert (65.4 F). 5. Except for soup, hot foods were not covered. All components/food (hot and cold ones) were placed on a Styrofoam disposable tray. <p>Clinical Nutritionist (employee #1) stated in the interview on 12/04/2024 at 11:20 AM that the temperature parameters for food are 140 F for hot foods and 40 F for cold foods.</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>47384</p> <p>Based on observations of the Kitchen, review of policies procedures and facility staff interview performed on 12/04/2024 through 12/06/2024 from 8:00 AM through 3:30 PM, it was determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During the visual inspection of the kitchen area it was observed that the High Temperature Sanitizing Door-type Dishwasher was inoperable at the time of the survey. This was confirmed by the Nutritional Services Manager (employee #1) who stated Sanitizing Dishwasher has been broken since September 2024. 2. During the visual inspection of the kitchen area it was observed that the Dish washing detergent and Arrex dispenser were inoperable at the time of the survey. This was confirmed by the Nutritional Services Manager (employee #1) who stated that the automatic dispenser has been broken since October 2024. 3. Food remains were observed on the floor below the food line.

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>47384</p> <p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>Based on review of policies, procedures and facility staff interview performed on 12/06/24 to from 8:00 AM through 4:30 PM, it was determined that the facility failed to comply with the policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.</p> <p>Findings include:</p> <p>Review on 12/06/2024 at 10:00 AM of facility's policy and procedure Almacenaje, Limpieza y Mantenimiento de Neveras Departamentales, Storage, Cleaning and Maintenance of Departmental Refrigerators stated that all food in the refrigerator must be identified with the resident's initials, room number and date.</p> <p>Approximately at 9:30 AM some snacks (birthday cake and snacks) were observed with no date or labeled in the residents' refrigerator.</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>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20423</p> <p>Based on observation during the drug pass, it was determined that the facility failed to ensure establish and maintain an infection prevention to provide a safe, sanitary environment to help prevent the development and transmission of communicable diseases and infections and hand hygiene procedures be followed by staff involved in direct resident contact for 6 out of 6 observations</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During the drug pass performed on 12/05/2024 from 08:25 AM till 8:39 AM, it was observed that the registered nurse Registered Nurse (RN) #2 initiate with the drug pass without washing her hand and disinfecting the medication cart. 2. During the medication preparation for resident #106 the nurse put her glove without washing her hand, the resident request to RN #2 to provide a jar of gum in the floor, the RN proceed to take the gum jar of the floor placed it over the dinner table, and do not remove her glove and continue administrating the resident medication without removing her gloves and washing her hand. 3. When finish with the RN #2 discard the trash, remove her glove and without washing her hand put on another glove and continue to serve medication of the other residents. 4. The RN #2 failed to wash her hand on 5 out of 5 opportunities to wash her hands. <p>51629</p> <ol style="list-style-type: none"> 5. During the medication pass performed on 12/05/2024 from 8:40 AM through 9:30 AM, the following was identified: <ol style="list-style-type: none"> a. Register nurse (employee # 2) did not perform handwashing in 19 opportunities while administering medications to five patients under her care. 6. During review of the crash cart on 12/05/2024 at 9:30 AM, with the register nurse (employee # 2), the following was identified: <ol style="list-style-type: none"> a. Three Vacuproo safety blood collections had expiration date of June 2024. b. One blood gas [NAME] had expiration date of May 2023. 		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47384</p> <p>Based on observations of the physical environment, on 12/04/2024 through 12/06/2024 to from 8:00 AM through 3:30 PM, it was determined that the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition. This deficient practice had the potential to affect 8 out of 8 residents receiving services at areas where the deficient environment and items (equipment) is located.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Commodes on bathrooms of rooms [ROOM NUMBERS] were observed with rust in component parts. 2. 3 out of 3 four contact points walkers were observed with rust in the base. 3. 1 out of 4 crutches was observed with medical tape on the grab cushion. 		