

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Tekakwitha Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6 E Chestnut Sisseton, SD 57262	

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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50916</p> <p>Based on record review, interview, and policy review the provider failed to provide bed-hold notices to the resident and/or their representative regarding a transfer to the hospital for one of two sampled residents (33). Findings include:</p> <p>1. Review of resident 33's electronic medical record (EMR) revealed:</p> <p>*She fell on [DATE].</p> <p>*The physician was called at 6:30 p.m. and updated on her incident, injuries, and vitals.</p> <p>*An order was received to send the resident to the emergency room (ER).</p> <p>*The resident's representative was called by registered nurse (RN) F and updated on the residents's accident and transfer to the ER.</p> <p>*On 7/14/2024 at 9:22 p.m. RN F called the ER for an update and was told the resident would be sent to a local hospital for further evaluation regarding a fractured right femoral head (hip).</p> <p>*Progress note on 7/16/2024 at 10:24 a.m. stated the resident would be hospitalized until further notice.</p> <p>Further review of the EMR revealed there was no written notification to the resident or her representative regarding the Bed Hold policy.</p> <p>2. Interview on 07/18/24 at 10:26 a.m. with RN F regarding the bed hold policy revealed:</p> <p>*She did not notify resident 33 or their representative of the bed hold notice prior to or after the residents' transfer to the hospital.</p> <p>*She stated the charge nurse should have notified the resident representative of the bed hold notice and completed the form at the time of transfer to the hospital.</p> <p>*If the charge nurse had not done it then the facility office staff usually followed up.</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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*She could not find a signed bed hold notice for resident 33 related to her 7/14/2024 hospital transfer.</p> <p>3. Interview on 7/18/2024 at 11:15 a.m. with social service designee C revealed the nursing department took care of notifying family/power of attorney (POA) of bed hold notices regarding transfers to the hospital.</p> <p>4. Interview on 7/18/2024 at 11:54 a.m. with director of nursing B revealed her expectation was for the charge nurse to get the signature for the bed hold form the day the resident left and transferred to the hospital.</p> <p>5. Interview on 7/18/2024 at 12:05 p.m. with administrator A revealed:</p> <p>*The charge nurse should fill out the bed hold form when the resident left for the hospital or do a verbal notification with the resident's representative over the phone if the resident was unable.</p> <p>*She would collect the bed hold notice form once it was filled out and put it in a binder.</p> <p>*She confirmed that resident 33 did not have a bed hold policy form filled out for her 7/14/24 hospitalization .</p> <p>6. Review of the provider's undated Bed Hold Policy and Notification revealed:</p> <p>*Bed Hold Policy was given on date of admission in the admission binder booklet.</p> <p>*It stated what hospitalization and therapeutic leave was and the general rules for holding and paying for a bed.</p> <p>*It had not stated when the bed hold policy notification was to be given to the resident and/or their representative.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49238</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure resident care plans were revised to reflect the current needs of two of fifteen sampled residents as follows:</p> <p>*One of one sampled resident (23) who had a pressure ulcer.</p> <p>*One of one sampled resident (10) who had leisure interests including woodworking and driving a golf cart.</p> <p>Findings include.</p> <p>1. Observation on 7/17/24 at 10:15 a.m. of resident 23 revealed he was in bed lying on his back when licensed practical nurse (LPN) G went in to provide wound care.</p> <p>Interview on 7/17/24 at 10:41 a.m. with certified nursing assistant (CNA) H regarding resident 23 skin concerns revealed:</p> <p>*She stated, I think the skin issues are from the residents not being repositioned and she had voiced her concerns to management.</p> <p>*Administrator A had started rounds and things had improved.</p> <p>Interview on 7/17/24 at 2:10 p.m. with licensed practical nurse (LPN) G regarding resident 23 revealed:</p> <p>*They had changed out his entire bed and mattress a couple of weeks ago because his old one folded him up like a V with both his head and feet elevated.</p> <p>*They changed his heel boots to bunny boots, (a resilient, breathable polyfiber liner that allows air circulation for increased comfort for toe and heel pressure protection), but did not know when.</p> <p>*They should have changed his interventions sooner.</p> <p>Interview on 7/17/24 at 3:30 p.m. with director of nursing (DON) B regarding resident 23 revealed:</p> <p>*His bed was changed to one with an air mattress because he would slide down in his old one and that should have been done sooner.</p> <p>-This change was not on his care plan.</p> <p>*He had a turn and reposition clock in room, but the (CNAs) took it down.</p> <p>-That was not on his care plan.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Interventions for the wound (or skin condition) on his buttocks area had changed and she thought they were improving. have changed and thinks they are improving.</p> <p>-There were no wound interventions noted in his care plan.</p> <p>*The provider had added a wound nurse who sells dressings and would give recommendations for skin interventions.</p> <p>-That was not noted in his care plan.</p> <p>Observation and interview on 7/18/24 10:45 a.m. of resident 23 with registered nurse (RN) F revealed:</p> <p>*The resident was in his bed lying on his back when RN F entered his room to provide wound care.</p> <p>*She said an air mattress had been added.</p> <p>-That was not on his care plan.</p> <p>Review of resident 23's Minimum Data Set (MDS) assessment section M for skin conditions dated 3/10/24 signed by director of nursing (DON) B on 3/21/24 revealed:</p> <p>*He did not have pressure ulcer/injury, or scar over bony prominence.</p> <p>*He was at risk of developing pressure ulcers/injuries.</p> <p>*He had a pressure reducing device for chair.</p> <p>*He had pressure reducing devices for bed.</p> <p>*He did not have a turning/repositioning program.</p> <p>*He did not have a nutrition or hydration intervention to manage skin problems.</p> <p>Review of resident 23's current care plan revealed the following:</p> <p>*He was at risk for pressure ulcers and skin breakdown due to incontinence and immobility.</p> <p>-That was initiated on 4/7/21.</p> <p>*[The resident first name] skin would be kept clean, dry and free of pressure ulcers and skin breakdown.</p> <p>*They would monitor for any signs and symptoms of skin breakdown and report to the primary care provider.</p> <p>*He had a pressure reducing mattress to bed and cushion to wheelchair to aid in the prevention of skin breakdown or pressure ulcers, initiated 4/7/21.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*They would prevent shearing the resident's skin during transfers and repositioning if possible.</p> <p>- That was initiated on 4/7/21.</p> <p>*The resident was incontinent of urine and occasionally incontinent of bowel. He should have been assisted with incontinence care after each incontinence episode.</p> <p>-That was initiated on 4/7/21.</p> <p>*The resident had a heel ulcer related to immobility.</p> <p>-That was initiated on 5/21/24, with a revision date of 6/12/24.</p> <p>*The resident would have intact skin, free of redness, blisters or discoloration through the review date</p> <p>-That was initiated on 12/11/23 with a revision date of 12/11/23, and a target date of 6/4/24.</p> <p>-Apply Bag Balm Ointment to buttocks as ordered for prevention and to heal breakdown on buttocks related to incontinence, was initiated on 12/28/22.</p> <p>*Apply heel foam Tegaderm to right heel ulcer as ordered and change every other day until healed, was initiated on 5/31/24.</p> <p>*He was dependent on one staff for assistance with bathing , dressing, personal care, and locomotion with a wheelchair and was dependent on two staff for assistance with transfers and toileting.</p> <p>-That was initiated on 3/21/23 with revision on 6/13/24.</p> <p>*The resident and staff were educated as to what caused skin breakdown including: transfers/positioning requirements and good nutrition and frequent repositioning.</p> <p>-That was initiated on 12/11/23, with a revision on 12/12/23.</p> <p>*The resident and family were taught the importance of changing positions for prevention of pressure ulcers. They were encouraged to make small frequent position changes due to immobility.</p> <p>-That was initiated on 5/21/24 with a revision date of 6/12/24.</p> <p>*The resident needed turned or repositioned at least every 2 hours, more often as needed or requested.</p> <p>-That was initiated on 12/11/23 with a revision date of 12/12/23.</p> <p>*He required the bed as flat as possible to reduce shear when repositioning, was initiated on 12/11/23 with revision on the same date.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*He would wear bunny boots while lying in bed every evening and night for skin protection and prevention was initiated on 1/24/23.</p> <p>*The resident had limited physical mobility related to dementia was initiated on 9/11/23 with a revision on 6/12/24.</p> <p>*He would remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdowns, and falls related injury throughout the next review date initiated on 9/11/23, with a target of date 6/4/24.</p> <p>*The resident was not able to ambulate was initiated on 9/11/23 with revision that same date.</p> <p>*For locomotion: the resident was totally dependent on one staff member for pushing his wheelchair short and long distances was initiated on 9/11/23 and revised on 9/11/23.</p> <p>43021</p> <p>2. Interview on 7/16/24 at 4:25 p.m. with resident 10 revealed he enjoyed:</p> <p>*Riding his golf cart around the town.</p> <p>*Woodworking and had a workshop in the facility's basement.</p> <p>Review of resident 10's electronic medical record (EMR) revealed:</p> <p>*He moved into the facility on [DATE].</p> <p>*His diagnoses included age-related cognitive decline and Alzheimer's disease.</p> <p>*An 11/9/23 Occupational Therapy (OT) Evaluation and Plan of Treatment documented:</p> <p>-A St. Louis University Mental Status (SLUMS) exam scored at 26 out of a possible 30 indicating Mild Neurocognitive Disorder.</p> <p>-An Assessment Summary that stated .The patient has been performing woodworking tasks for years and resulting had an accident resulting in a hand injury. The patient was alert and oriented x 4 on this date and did assist with making a safety plan for all his woodworking tasks/tools . The patient is motivated to follow recommendations and continue with his loved leisure task .</p> <p>*An undated Electric Motorized Device Skills Test - Outdoor assessment completed by an occupational therapist documented:</p> <p>-For Outside Safety a handwritten comment has cellphone.</p> <p>-He was Independent (Can complete safely without assistance) (Pass) for:</p> <p>--Negotiating the Outdoor Environment.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>--Negotiating the Street Crossing Environment.</p> <p>-No concerns with inclines or declines.</p> <p>-He was able to locate ramps and other pathways.</p> <p>-A handwritten comment stated Need to address pathway to reach golf cart.</p> <p>*Had recently completed a Brief Interview for Mental Status (BIMS) exam on 7/12/24 and had scored 10 out of a possible 15 indicating he was moderately cognitively impaired.</p> <p>Review of resident 10's EMR's comprehensive care plan on 7/17/24 at 11:13 a.m. revealed that:</p> <p>*It did not address his goals, preferences, strengths, weaknesses, or needs that were related to his leisure interests of woodworking or driving a golf cart.</p> <p>*It did not refer to the supplemental paper care plan for his woodworking.</p> <p>Review of resident 10's 11/1/23 supplemental paper care plan for his woodworking revealed:</p> <p>*OT evaluation related to woodworking safety.</p> <p>*Orientate and instruct [first name of resident 10] and staff that he will use his cell phone and his pager to call the staff while in the basement or garage-Relate to anything that [NAME] may need. Cell Phone Number for [first name of resident 10] [10 digit phone number]</p> <p>*Attempt to check on [first name of resident 10] often.</p> <p>*Family aware of woodworking in the basement and aware of the risks of wood working.</p> <p>*Ventilation in room and wears a mask for dust.</p> <p>*Make sure that [first name of resident 10] has non-skid shoes while doing wood working.</p> <p>*[first name of resident 10] is aware to make sure the power switch is off before he plugs into a power tools.</p> <p>*[first name of resident 10] is aware to not use a tool that is damaged.</p> <p>*Reminders to [first name of resident 10] to not rush given daily.</p> <p>*Will continue to update plan with issues as they arise.</p> <p>*Given to Activities and Nursing Departments on-11/1/23.</p> <p>Review of resident 10's 11/23/23 supplemental paper care plan revealed an intervention had been added:</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Will Wear safety gloves and must wear a safety shield on the saw (special saw will shut off immediately.)</p> <p>*Given to Activities and Nursing Departments on 11-23-23.</p> <p>Review of resident 10's 3/24/24 supplemental paper care plan revealed two interventions had been added:</p> <p>*Can only saw if he is supervised with a staff member.</p> <p>*If you notice any concerns with [first name of resident 10]'s driving the golf cart-Let [first name of administrator A] know or the nursing staff-So we can have OT [Occupational Therapy] do an assessment on [first name of resident 10].</p> <p>*Given to Activities and Nursing Departments on 3-24-24.</p> <p>On 7/17/24 at 2:40 p.m. DON B provided resident 10's comprehensive care plan from the resident's EMR that revealed:</p> <p>*His woodworking care plan was included in that comprehensive care plan.</p> <p>-She had added his woodworking care plan to his EMR's comprehensive care plan that day.</p> <p>-The resident's cell phone number had an incorrect area code.</p> <p>*It had not addressed his goals, preferences, strengths, weaknesses, or needs that were related to his leisure interest of driving a golf cart around town.</p> <p>Interview on 7/17/24 at 9:41 a.m. with activity director J regarding resident 10's leisure interests revealed:</p> <p>*He used one of the provider's garages in the building for parking his golf cart.</p> <p>*Their contracted therapy services had conducted an evaluation of his ability to safely navigate going to and from the garage and his ability to safely operate the golf cart.</p> <p>*He used a room in the provider's basement as his workshop for his independent woodworking activity.</p> <p>*She stated that he carried a walkie-talkie with him while he worked in the basement workshop and garage to communicate with staff.</p> <p>*When asked about his care plan and her involvement she stated that the above leisure interests were not part of his activities care plan and that she thought the nursing department had managed that aspect of his care.</p> <p>Interview and record review on 7/17/24 at 10:31 a.m. with director of nursing (DON) B regarding resident 10 revealed:</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*She stated he had been assessed by the provider's contracted therapy services for his ability to</p> <p>-Safely operate his golf cart.</p> <p>-Safely pursue his independent woodworking activities.</p> <p>*She provided those assessments.</p> <p>-An undated Electric Motorized Device (EMD) Skills Test- Outdoor.</p> <p>-An 11/9/23 Occupational Therapy (OT) Evaluation and Plan of Treatment.</p> <p>*She also provided an undated one-page printed paper titled Care Plan for [resident 10's name] for [NAME] Working.</p> <p>-She agreed the supplemental paper care plan for his woodworking was not part of his EMR's comprehensive care plan.</p> <p>Interview on 7/17/24 at 11:30 a.m. with administrator A regarding resident 10 revealed:</p> <p>*The one-page printed paper care plan for the resident's woodworking was a supplemental care plan and was not reflected in the comprehensive care plan in the provider's electronic health record (EHR).</p> <p>*His leisure interest of driving a golf cart around town was not addressed in his comprehensive care plan.</p> <p>Interview on 7/18/24 at 9:54 a.m. with social service designee C regarding resident 10 revealed:</p> <p>*She conducted the Brief Interview for Mental Status (BIMS) exam with the residents.</p> <p>*She agreed he was forgetful at times but was very aware of what he was doing.</p> <p>*He was not doing the woodworking when he admitted to the facility, but needed to find something to do and started his woodworking last fall and that his family was very supportive of his woodworking.</p> <p>*She was aware of his driving the golf cart around town, but stated he was aware that he should not travel to certain busy areas and highways.</p> <p>*She agreed that his driving the golf cart was not addressed on his care plan.</p> <p>*She was aware of the supplemental paper care plan regarding his woodworking, but was not aware if staff members supervised him while he used his woodworking saw.</p> <p>*She agreed that his comprehensive care plan in the provider's EHR had not included his independent activity of woodworking.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 7/18/24 at 10:21 a.m. with DON B regarding resident 10 revealed:</p> <p>*His supplemental paper care plan for his woodworking was kept in her office, and the interdisciplinary team had a copy of that care plan.</p> <p>*His comprehensive care plan in the provider's EHR had not included his independent activity of woodworking.</p> <p>Refer to F689.</p> <p>Review of the provider's undated policy on Care Plans - Comprehensive revealed:</p> <p>*Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.</p> <p>*3.g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; .i. reflect currently recognized standards of practice for problem areas and conditions.</p> <p>-9. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans; .b. When the desired outcome is not met; .</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>49238</p> <p>Based on observation, interview, record review, and policy review, the provider failed to prevent one of one sampled resident (23) from developing facility-acquired pressure ulcers.</p> <p>Findings include:</p> <p>1. Interview on 7/17/24 at 8:00 a.m. with director of nursing (DON) B revealed resident 23 had on heel protectors but wasn't sure the thread in them had not caused his pressure ulcer.</p> <p>Observation on 7/17/24 at 10:15 a.m. of resident 23 revealed resident 23 was in bed lying on his back when licensed practical nurse (LPN) G went in to provide wound care.</p> <p>Interview on 7/17/24 at 10:41 a.m. with CNA H in regards to skin concerns revealed:</p> <p>*She stated, I think the skin issues are from the residents not being repositioned, and she had voiced her concerns to management.</p> <p>*Administrator A had started rounds and cares had improved.</p> <p>Interview on 7/17/24 at 12:45 p.m. with administrator A revealed:</p> <p>*She confirmed that resident 23's pressure ulcers on his sacrum and heel were avoidable, yes, they got to lay him down and get him off that area and he has boots on now.</p> <p>*She confirmed she had started rounds and things are better.</p> <p>Interview on 7/17/24 at 2:10 p.m. with LPN G in regard to resident 23's pressure ulcers revealed:</p> <p>*His sacral pressure ulcer was new in the last 30 days.</p> <p>*She stated, Yes they were preventable.</p> <p>*She stated she wondered if the certified nursing assistants (CNAs) knew what floating the heels meant.</p> <p>*They had changed out his entire bed and mattress a couple of weeks ago because his old one folded him he indicated like a V with both his head and feet elevated.</p> <p>*They changed his heel boots to bunny boots.</p> <p>*They should have changed the interventions for his skin sooner.</p> <p>*She thought his pressure ulcers were part of his dementia progression.</p> <p>*There had been some uneasiness among the CNAs playing the blame game in regards to care provided.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Administrator A had started doing rounds on the floor and followed up on complaints and things are better.</p> <p>*She did not work the night shift but the day CNAs did a good job but are rushed at times.</p> <p>Interview on 7/17/24 at 3:30 p.m. with DON B in regard to resident 23's pressure ulcers revealed:</p> <p>*His bed was changed to an air mattress because he would slide down in his old one.</p> <p>*She had placed a 'turn and reposition clock' in his room but the CNAs had taken it down and they would be written up for it but haven't been yet.</p> <p>*He has bunny boots now because he could feel the thread in the old ones which did not help.</p> <p>*His heels dug into the sheets when he moved around.</p> <p>*She agreed his pressure ulcers were avoidable and he should have been given an air mattress sooner.</p> <p>Observation on 7/18/24 10:45 a.m. of resident 23 with registered nurse (RN) F revealed he was in his bed lying on his back when RN F entered his room to provide wound care.</p> <p>Review of resident 23's electronic medical record (EMR) revealed his Braden scale for predicting pressure sores was scored at 13 (moderate risk) on 12/7/23 and 12 (high risk) on 7/17/24.</p> <p>Record review of resident 23's skin observation tool for his right heel pressure ulcer revealed:</p> <p>*It was discovered on 5/30/24 and measured 0.5 centimeters (cm) by 0.5 cm with no depth measurement noted.</p> <p>*It was staged at a two (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister).</p> <p>*It worsened to measure 1.1 by 1.1 cm by 0.1 cm on 6/18/24.</p> <p>Record review of resident 23's skin observation tool for his sacrum pressure ulcer revealed:</p> <p>*It was new on 6/20/24 and measured 1.0 cm by 0.6 cm and stage two.</p> <p>*It was documented on 7/9/24 to have worsened to 7.0 cm by 7.3 cm and stage three (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling).</p> <p>Review of the provider's undated pressure ulcer prevention and wound care policy revealed:</p> <p>(continued on next page)</p>

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F 0686 Level of Harm - Actual harm Residents Affected - Few	<p>*General skin care guidelines 1.c. noted, Nursing assistants and staff shall follow the turning schedule as assigned by the charge nurse, observe skin integrity and report changes to charge nurse immediately.</p> <p>-3.a noted, The resident shall be turned and repositioned every 2 hours and as needed, unless contraindicated.</p> <p>*General pressure ulcer management guidelines 1. Noted, the RN/LPN shall initiate Pressure Ulcer Management Guidelines for at risk resident on admission and/or later if the resident condition warrants.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43021</p> <p>Based on interview, observation, record review, and policy review, the provider failed to implement effective precautions and interventions to ensure the safety for one of one sampled resident (10) that contributed to multiple accidents involving woodworking equipment resulting in bodily injury. Specifically, the provider failed to either complete follow-up assessments, incident analysis, or review/revise/monitor interventions.</p> <p>Findings include:</p> <p>1. Interview on 7/16/24 at 4:25 p.m. with resident 10 revealed he enjoyed woodworking and had a workshop in the facility's basement.</p> <p>Interview on 7/17/24 at 9:41 a.m. with activity director J regarding resident 10's woodworking interest revealed:</p> <p>*He used a room in the provider's basement as his workshop for his independent woodworking activity.</p> <p>*She stated that he carried a walkie-talkie with him while he worked in the basement workshop and garage to communicate with staff.</p> <p>Interview on 7/17/24 at 10:31 a.m. with director of nursing (DON) B regarding resident 10 revealed:</p> <p>*She stated he had been assessed by the provider's contracted therapy services for his ability to safely pursue his independent woodworking activities.</p> <p>*She provided the 11/9/23 Occupational Therapy (OT) Evaluation and Plan of Treatment.</p> <p>*She also provided an undated one-page printed paper titled Care Plan for [resident 10's name] for [NAME] Working.</p> <p>*When asked regarding ongoing assessments for the resident as he had a diagnosis of Alzheimer's Disease (a brain disease that gets worse over time), she agreed that ongoing assessments were necessary, but stated that since the 11/9/23 OT Evaluation, no other OT evaluation was completed.</p> <p>*After he had an accident in March 2024, she revealed the electric saw equipment was changed to the current equipment that had an automatic shut-off if a problem was detected.</p> <p>Interview on 7/18/24 at 9:54 a.m. with social service designee C regarding resident 10's woodworking revealed:</p> <p>*She agreed he was forgetful at times but stated he was very aware of what he was doing.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*He was not doing the woodworking when he was admitted to the facility, but had started his woodworking last fall and she stated that his family was very supportive of his woodworking.</p> <p>*She was aware of the care plan interventions regarding his woodworking but was not sure if staff members supervised him while he used his woodworking saw.</p> <p>Interview on 7/18/24 at 10:21 a.m. with DON B regarding resident 10 revealed:</p> <p>*When asked about the care plan intervention that stated he was only to use the electric saw if supervised by a staff member, she stated</p> <p>-This does not happen all the time.</p> <p>-He was aware of the need to be supervised with the electric saw, but will use the saw unsupervised.</p> <p>-When the staff had a meeting and heard the electric saw in operation, a staff member went down to check on him.</p> <p>-He can get agitated with staff as he liked to be independent.</p> <p>*There was no video camera or alternative method that monitored his workshop activity when staff were not in supervising him.</p> <p>Interview on 7/18/24 at 10:25 a.m. with administrator A regarding resident 10's woodworking revealed:</p> <p>*The maintenance director's office and the provider's laundry area were also located in the basement, and maintenance and laundry staff checked with the resident during the day while they were working.</p> <p>*He was only to be working in the workshop between 7:00 a.m. and 8:00 p.m.</p> <p>*He had purchased a new electric saw in March 2024 after an incident had occurred.</p> <p>-The new saw had a special safety feature that shut off the saw if an error was detected.</p> <p>-When he was operating the saw, a staff member had to be supervising him.</p> <p>Observation and interview on 7/18/24 at 10:36 a.m. with resident 10 in his basement workshop revealed:</p> <p>*He was alone in his basement workshop.</p> <p>*He had a walkie-talkie on a shelf in his workshop and had his personal cell phone in the front pocket of his overalls.</p> <p>*When asked how often he used his electric saw, he stated, Maybe once a day.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-He stated he had called the maintenance director many times to supervise him while he was operating the electric saw.</p> <p>-He wasn't sure where his safety gloves were that he was supposed to wear when using his electric saw.</p> <p>-He stated At times the staff was busy, and I don't always get someone [when operating the electric saw].</p> <p>Interview on 7/18/24 at 10:55 a.m. with activity director J regarding resident 10's woodworking revealed:</p> <p>*She checked in with him throughout the day when she worked.</p> <p>*He would call me at times when he needed to cut a board on his electric saw.</p> <p>*She agreed with the safety interventions on his supplemental paper care plan.</p> <p>*She had no concerns with his woodworking.</p> <p>An interview on 7/18/24 at 1:36 p.m. with administrator A and DON B regarding the provider's walkie-talkies revealed that multiple staff members, including the administrator, DON, dietary manager, cooks, nurses, medication aides, certified nursing assistants, housekeepers, and maintenance director, had walkie-talkies with them while they worked.</p> <p>Review of resident 10's electronic medical record (EMR) revealed:</p> <p>*He moved into the facility on [DATE].</p> <p>*His diagnoses included age-related cognitive decline and Alzheimer's disease.</p> <p>*A 10/23/23 Health Status progress note at 12:01 a.m. stated At approximately 7:30 pm last evening [10/22/23] resident came to this nurse with his left pointer finger bleeding, resident stated he was working with his table saw and the piece of wood slipped and got his finger, tip of finger noted to be cut off, area cleaned, Bactroban applied and covered with pressure bandage, Dr. [last name of resident's primary physician] and family updated on the above, new orders for Bactroban and dressing daily until healed.</p> <p>*An 11/9/23 Occupational Therapy (OT) Evaluation and Plan of Treatment documented:</p> <p>-Diagnoses Age-related cognitive decline.</p> <p>-Current Referral Reason for Referral: The patient has been referred for a cognitive evaluation s/p [status post] a wood working injury resulting in a cut to digit.</p> <p>-Background Assessment: Patient Preferences: Hobbies: [NAME] working, making bird houses.</p> <p>(continued on next page)</p>

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>-A St. Louis University Mental Status (SLUMS) exam scored at 26 out of a possible 30 indicating Mild Neurocognitive Disorder.</p> <p>-An Assessment Summary that stated .The patient has been performing woodworking tasks for years and resulting [sic] had an accident resulting in a hand injury. The patient was alert and oriented x 4 on this date and did assist with making a safety plan for all his woodworking tasks/tools. Per the SNF [skilled nursing facility], the facility will be placing together a policy to ensure safety during such leisure tasks. The patient is motivated to follow recommendations and continue with his loved leisure task .</p> <p>Review of resident 10's initial care plan for his woodworking revealed the following interventions:</p> <ul style="list-style-type: none"> *OT evaluation related to woodworking safety. *Orientate and instruct [first name of resident 10] and staff that he will use his cell phone and his pager to call the staff while in the basement or garage-Relate to anything that [first name of resident 10] may need. Cell Phone Number for [first name of resident 10] [10 digit phone number] *Attempt to check on [first name of resident 10] often. *Family aware of woodworking in the basement and aware of the risks of wood working. *Ventilation in room and wears a mask for dust. *Make sure that [first name of resident 10] has non-skid shoes while doing wood working. *[first name of resident 10] is aware to make sure the power switch is off before he plugs into a power tools. *[first name of resident 10] is aware to not use a tool that is damaged. *Reminders to [first name of resident 10] to not rush given daily. *Will continue to update plan with issues as they arise. *Given to Activities and Nursing Departments on-11/1/23. <p>Continued review of resident 10's electronic medical record (EMR) revealed:</p> <ul style="list-style-type: none"> *An 11/13/23 Daily Charting progress note at 10:30 a.m. stated Skilled OT d/c [discontinued] due to evaluation only 11-9-23 with safety recommendations issued. *An 11/17/23 Skin/Wound progress note at 9:10 p.m. stated Resident came to nurse's station after working in his shop, left arm noted to be bloody, resident stated he ran into a piece of wood downstairs, large abrasion to left arm, area cleaned, Bactroban applied and covered with 4X4 Island dressing, Tx [treatment] received to monitor and cover area during the day until healed. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*An 11/18/23 Skin/Wound progress note at 9:54 a.m. stated Resident to nurses station, stated that he bumped his Lt. [left] thumb on hood, 1.5 x 1cm open area where skin was off, moderate amount of bleeding due to blood thinners. Tx. [treatment] received for cleanse with betadine, apply bactroban and dressing daily until healed.</p> <p>*No follow-up assessment or incident analysis had been documented in the resident's EMR for the 11/17/23 incident or the 11/18/23 incident.</p> <p>Review of resident 10's 11/23/23 woodworking care plan revealed an intervention had been added that stated Will Wear safety gloves .</p> <p>Continued review of resident 10's electronic medical record (EMR) revealed:</p> <p>*A 3/16/24 Incident progress note at 12:00 noon stated Resident called for help from basement work room and was assisted by med [medication] aide who entered to find resident with left hand wrapped in a bloody paper towel. Med [medication] Aide brought resident upstairs to nurses station. Resident is alert and oriented and conversing and answering questions appropriately. Moderate amount of blood covering hand. Noted deep, jagged cuts to 2nd, 3rd and fourth fingers. Immediately placed 4x4's and wrapped generously with kerlix, elevated the extremity. Resident placed call to his Grandson at this time and transport to CDP [Coteau des Prairies] ER [emergency room] was arranged.</p> <p>*A 3/16/24 progress note at 2:00 p.m. stated Resident returned from CDP [Coteau des Prairies] ER [emergency room] at this time. The affected fingers are wrapped. Resident states 20 stitches total. Written Orders Received: Wash the laceration with peroxide and apply and antibiotic ointment twice a day. Dr. [last name of resident's primary physician] to remove stitches on 03/28/24.</p> <p>*No follow-up assessment or incident analysis had been documented in the resident's EMR for the 3/16/24 incident.</p> <p>Review of resident 10's 3/24/24 woodworking care plan revealed an intervention had been added that stated Can only saw if he is supervised with a staff member.</p> <p>Continued review of resident 10's electronic medical record (EMR) revealed:</p> <p>*A 6/19/24 Skin/Wound progress note at 12:10 a.m. stated Resident rang call light at this time to ask to see the nurse, when nurse entered room resident was sitting in his recliner with shirt off and abdomen exposed, nurse noted a large bruise to the right side of abdomen that measured 5 in [inches] X 3 in [inches] with a small gash in the middle, resident then turned and showed nurse his left side of abdomen and nurse noted large bruise with scrape running through the middle of the bruise, area measures 10 in [inches] X 5 in [inches], both sides were cleaned and antibiotic ointment was applied to open area on right abdomen and then covered with 4x4 island dressing, resident denies pain to areas when asked, he states he was using his saw in his work shop and it kicked the boards back at him and hit his abdomen a few times, when asked about how long ago this happened and resident stated around 8 pm tonight [6/18/24], resident offered a cold pack and Tylenol but interventions were refused.</p> <p>*No follow-up assessment, incident analysis or review/revision of current interventions was documented in the resident's EMR for the 6/18/24 incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*A recently completed Brief Interview for Mental Status (BIMS) exam on 7/12/24 was scored at 10 out of a possible 15 indicating he was cognitively moderately impaired.</p> <p>Review of the provider's undated policy on Resident safety during leisure tasks revealed:</p> <p>*Policy Statement: Resident will be free from accidents and hazards while doing leisure tasks.</p> <p>*Accidents and Supervision.</p> <p>-[Name of provider] will ensure that the resident's environment will be free from accidents and hazards over which the facility has control to prevent avoidable accidents and will provide supervision and assistive devices to each resident. This will include identifying, evaluating, analyzing and then implementing interventions to reduce hazards and risks and then monitoring for effectiveness and then modifying interventions if necessary.</p> <p>A request for resident 10's incident reports related to his woodworking was made on 7/18/24 at 10:20 a.m. from administrator A and no incident reports were received by the end of the survey.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49238</p> <p>Based on observation, interview, and policy review, the provider failed to ensure expired medications were removed from one of one medication room, one of two medication carts, and one of two treatment carts.</p> <p>Findings include.</p> <p>1. Observation and interview on 7/18/24 at 10:00 a.m. of the provider's north hall medication room, medication cart, and treatment cart with registered nurse (RN) F revealed:</p> <p>*Two of seven containers of stock aspirin enteric coated 25 milligram (mg) had expired in April 2024.</p> <p>*Eight of eight hydrogen peroxide had expired in April 2023.</p> <p>*Three of three isopropyl rubbing alcohol 70 % had expired in March 2023.</p> <p>*Two of two tubes of oral glucose gel had expired in October 2023.</p> <p>*Three of three Heparin injectable syringes had expired in December 2023.</p> <p>*Five of five Prevnar 13 (pneumococcal vaccine) injectable had expired in September 2023.</p> <p>*One of one bottle of Aalcare hand sanitizer had expired in March 2024.</p> <p>*Thirty two of thirty six packets of white petroleum had expired in 2019.</p> <p>*Six of six packets of Vaseline gauze six of six had expired in June 2022.</p> <p>*She stated medication expiration dates would have been checked before administering to a resident and should have been removed.</p> <p>Interview on 7/18/24 at 3:30 p.m. with director of nursing (DON) B revealed:</p> <p>*She had not been able to keep up with removing expired medications from the medication rooms and carts but should have been removed and destroyed.</p> <p>*She confirmed the pharmacy audits were completed but their audits did not include expired medications.</p> <p>Review of the provider's undated storage of medications policy revealed 4. NO discontinued, outdated, or deteriorated drugs or biologics are available for use in the facility, All such drugs are destroyed.</p> <p>(continued on next page)</p>		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the provider pharmacy 5/29/24 and 6/27/24 audits revealed that outdated medications were not part of their audit.		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45683</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure:</p> <p>*Necessary food safety guidelines were followed for appropriate storage and labeling of food items in one of one main kitchen.</p> <p>*Proper temperature documentation was completed for three of three refrigerators and three of three freezers in the main kitchen.</p> <p>Findings include:</p> <p>1. Observation on 7/15/24 at 5:11 p.m. during the initial tour of the main kitchen revealed:</p> <p>*The document posted on the walk-in refrigerator was titled sanitation/record of refrigerator temperatures.</p> <p>*The document had six columns labeled:</p> <ul style="list-style-type: none"> -Walk-in cooler. -Walk-in Freezer. -Reach-in Freezer. -Cooks cooler. -Reach-in Juice cooler. -Unlabeled. <p>*The documentation was missing for at least five days in July for all six columns of the temperature record.</p> <p>Interview on 7/16/24 at 11:52 a.m. with cook I in the kitchen revealed:</p> <p>*He agreed the sanitation/record for refrigerator and freezer temperatures should have been filled out daily.</p> <p>*Staff were educated on refrigerator and freezer documentation on a regular basis.</p> <p>*He confirmed he had not documented the temperatures for his last two shifts.</p> <p>Record review and interview on 7/17/24 at 2:18 p.m. with dietary manager D regarding the sanitation/record of refrigerator temperatures revealed:</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Tekakwitha Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6 E Chestnut Sisseton, SD 57262	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*The April, May, and June 2024 sanitation/record of refrigerator temperature logs were each missing several days of documentation for temperatures.</p> <p>*She had provided education to staff for temperature documentation.</p> <p>*Her expectation was that staff would document refrigerator and freezer temperatures daily.</p> <p>*She had given verbal warnings to staff that had not completed documentation.</p> <p>*She agreed staff were not documenting refrigerator and freezer temperatures.</p> <p>Review of the provider's undated refrigerator/freezer temperature monitoring policy revealed:</p> <p>*Temperatures of all freezers and refrigerators will be monitored daily.</p> <p>*4. All unit temperatures are to be recorded daily on the Record of Refrigeration Temperatures form. Records of forms will be maintained for 6 months.</p> <p>50916</p> <p>2. Observation on 7/15/24 from 5:11 p.m. to 6:10 p.m. during the initial main kitchen tour revealed:</p> <p>*There was a metal shelving unit which held the following improperly stored and labeled food items:</p> <ul style="list-style-type: none"> -Opened powdered sugar in the original package, closed with a twisty tie, and no use by date. -Opened bag of Rice Krispies, closed with a twisty tie, and no use by date. -Opened spice cake mix with no use by date. -Cinnamon rolls in metal baking pan, covered with plastic wrap, and no use by date. -Marshmallows in a plastic container with no use by date. <p>*Outdated food items in one of two refrigerators:</p> <ul style="list-style-type: none"> -Bag of chopped chicken dated 3/20/24, closed with a twisty tie. -Sausage patties and links with no use by date, closed with a twisty tie. -Coleslaw in a metal bowl covered with plastic wrap and handwritten date of 7/9. -Meatloaf in plastic container with handwritten date of 7/9 -Opened turkey breast in original package with handwritten date of 7/7. -Roast beef slices in zip lock bag with handwritten date of 6/7. <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Chicken salad in metal bowl covered with plastic wrap and handwritten date of 7/3.</p> <p>*Uncovered food items in one of two refrigerators:</p> <p>-Pumpkin pie with one slice missing.</p> <p>-Butterscotch pudding dished into individual serving cups and placed on serving tray.</p> <p>-Sliced cheese on a tray.</p> <p>3. Interview and observation on 7/17/2024 at 2:06 p.m. with dietary manager D in the main kitchen regarding food storage and labeling revealed:</p> <p>*She tossed the uncovered pie with no date on it into the trash and stated it should have been covered and thrown out by now.</p> <p>*She threw away outdated items in one of two refrigerators including the roast beef, chicken salad, and sausage.</p> <p>*She stated food items in the fridge are only good for seven days and everything should have been covered, dated, and thrown away if outdated.</p> <p>4. Interview on 7/18/2024 at 12:05 p.m. with administrator A about expectations on food storage and labeling revealed:</p> <p>*Her expectations were that staff will throw away outdated items.</p> <p>*The staff should keep food items covered and and date them accordingly.</p> <p>5. Review of the provider's 2013 Food Storage policy Procedure revealed:</p> <p>*4. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled and dated.</p> <p>*13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within three days or discarded.</p> <p>*14. Refrigerated Food Storage: -f. All foods should be covered, labeled, and dated. All foods will be checked to assure foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49238</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure appropriate infection control measures were followed by two of two nurses licensed practical nurse (LPN) G and registered nurse (RN) F for pressure ulcer dressing changes.</p> <p>Findings include:</p> <p>1. Observation and interview on 7/17/24 at 10:15 a.m. of resident 23's wound care with LPN G revealed she:</p> <p>*Stated he was on enhanced barrier precautions (EBP) (precautions to prevent transmission of infectious agents) due to his wounds.</p> <p>*Prepared for the resident's wound care at the nurses' station.</p> <p>*Poured Vashe wound solution into a med cup and placed a gauze in the cup without gloves and placed it on top of the treatment cart.</p> <p>*Opened the Mepilex sacral dressing package, placed it on its wrapper and wrote the date on it with a marker and placed it top of the treatment cart.</p> <p>*Pushed the wound treatment cart down the hall and into the resident's room.</p> <p>*Confirmed the resident did not have a dressing on his sacrum when the certified nursing assistants (CNA's) H and K removed his brief.</p> <p>*Cleaned bowel movement from the area.</p> <p>*Changed her gloves but did not wash her hands or use hand sanitizer.</p> <p>*Sprayed the wound with wound cleanser and changed her gloves but did not wash her hands or use hand sanitizer.</p> <p>*Applied the gauze that had been soaked in Vashe wound solution to the wound.</p> <p>*Covered the wound with the Mepilex sacral dressing.</p> <p>*Removed her gloves and washed her hands.</p> <p>*Cleaned the wound cart and hard-surfaced items used and removed the cart from the resident's room.</p> <p>Observation and interview on 7/18/24 at 10:45 a.m. of resident 23's heel dressing change with RN F revealed she:</p> <p>*Confirmed he was on EBP.</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 - Some</p>	<p>*Entered his room with the wound treatment cart.</p> <p>*Removed the bunny boot and sock from his right foot.</p> <p>*Confirmed he did not have a dressing on his heel wound.</p> <p>*Did not change her gloves or wash her hands after she removed his boot and sock.</p> <p>*Sprayed the wound with dermal wound cleanser and placed a foam Tegaderm dressing on the wound.</p> <p>*Removed her gown and gloves, wiped down the treatment cart and items she had used prior to pulling the cart out of the room and into the hall.</p> <p>*Confirmed the resident was on EBP due to his wound.</p> <p>*Was not sure if she should have taken the wound treatment cart into the room for a resident on EBP, but that is what she was used to doing.</p> <p>*Agreed she should have changed her gloves and washed her hands after removing his boot and sock before applying the new dressing to his heel wound.</p> <p>Interview with DON B on 7/18/24 at 3:30 p.m. related to infection control in regards to dressing changes and wound care revealed:</p> <p>*She was frustrated that the nurses had not performed hand hygiene appropriately during wound care.</p> <p>*She stated, Hand hygiene during wound care was standard care and they had been educated about this frequently.</p> <p>*She stated there was nothing to say but the treatment cart should not have gone into the resident's room as resident 23 was on EBP.</p> <p>Review of the provider's undated pressure ulcer prevention and wound care policy revealed wound care for dressing changes indicated that nurses should have used clean (meticulous handwashing, maintaining a clean environment by preparing a clean field, using clean gloves, and prevention of direct contamination of materials and supplies).</p> <p>Review of the providers undated enhanced barrier precautions policy revealed:</p> <p>*The provider would have implemented barrier precautions for the prevention of transmission of multidrug-resistant organisms.</p> <p>*The definitions noted Enhanced barrier precautions were an infection control intervention designed to reduce transmission or multidrug-resistant organisms (MDROs) in nursing homes. Enhanced barrier precautions involved gown and glove use during high-contact resident care activities for residents known to be colonized (germs are on the body but do not make you sick) or infected with a MDRO as well as those at increased risk of MDROs acquisition (ex: residents with wounds or indwelling medical devices).</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 - Some</p>	<p>-Wound in relation to this guidance, this generally had included residents with chronic wounds, and not those with shorter -lasting wounds, such as skin breaks or skin tears covered with a Band-Aid or similar dressing. Examples of chronic wounds include but are not limited to, pressure ulcers diabetic foot ulcers, unhealed surgical wounds and chronic venous stasis ulcers.</p> <p>*Wound care would be any skin opening requiring a dressing would have been considered a high contact resident activity.</p> <p>*General considerations indicated, enhanced barrier precautions are recommended for residents with indwelling medical devices or wounds, who do not otherwise meet the criteria for contact precautions, even if they had no history of MDRO colonization. This was because devices and wounds are risk factors that would have placed these residents at high risk for carrying or acquiring a MDRO and many residents colonized with a MDRO are asymptomatic or not presently known to be colonized.</p>

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>49238</p> <p>Based on interview and record review, the provider failed to have a qualified infection preventionist for the facility.</p> <p>Findings include.</p> <p>1. Interview on 7/15/24 at 6:05 p.m. with administrator A revealed:</p> <ul style="list-style-type: none"> *Director of nursing (DON) B was the infection preventionist (IP). *DON B had not been trained as an IP but had been completing some of the tasks. *The provider had not had an IP for at least two years. <p>Interview on 7/18/24 at 3:30 p.m. with DON B revealed she:</p> <ul style="list-style-type: none"> *Had been acting as the facility's IP the last two years. *She had not signed off as an IP because she had no training or certification as an IP. *They had tried to get one of their registered nurses to take the program but it had not worked out for them. <p>Record review of the providers infection control program revealed:</p> <ul style="list-style-type: none"> *The provider did not have an IP. *The annual review signature form had not been signed by an IP for at least two years.