

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER Avantara North		STREET ADDRESS, CITY, STATE, ZIP CODE 1620 North 7th Street Rapid City, SD 57701	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>40788</p> <p>Based on observation, interview, record review, and policy review, the provider failed to protect the residents' right to be cared for with respect and dignity for:</p> <p>*One of one sampled resident (6) by one of one certified therapy assistant (COTA) (K).</p> <p>*One of one sampled resident (32) who had a container for rinsing his colostomy bag stored on his bedside table in full view of others.</p> <p>Findings include:</p> <p>1. Observation on 1/13/24 at 8:33 a.m. of resident 6 in the dining room revealed:</p> <p>*She, three unidentified residents, and certified occupational therapy assistant (COTA) K were seated at a dining room table together.</p> <p>-COTA K was seated beside resident 6 to her left.</p> <p>*Resident 6's breakfast meal was in front of her and was mostly uneaten.</p> <p>*COTA K was looking at the cell phone in his lap.</p> <p>-He turned his attention to resident 6 after the surveyor walked by that table.</p> <p>2. Continued observation between 8:35 a.m. and 9:18 a.m. of COTA K and resident 6 at the dining room table revealed:</p> <p>*The resident fed herself no more than three bites of food during that time.</p> <p>*COTA K physically assisted her in bringing a fork with food on it from her plate to her mouth one time.</p> <p>*COTA K either had one hand on his forehead while he looked down at a cell phone, held the phone with both hands while he looked down at it, or looked down towards the top of the table and wrote on a piece paper on the table during the observation.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*He had a face mask on and it was not known if he had verbally interacted with the resident during that time.</p> <p>3. Continued observation and interview with certified nurse aide (CNA) G at 9:25 a.m. revealed:</p> <p>*She sat next to resident 6 and assisted her with eating after COTA K had left the dining room.</p> <p>*Two full glasses of fluid, a full-serving of mechanically altered sausage and gravy, most of her Cream of Wheat cereal, and one piece of french toast remained on resident 6's plate.</p> <p>*She shook her head yes or no to CNA G's questions and responded to her verbal encouragement to eat.</p> <p>*CNA G had known resident 6 had sat in the dining room for about an hour before she had arrived.</p> <p>-She agreed the resident's food was cold and would no longer have been appetizing.</p> <p>4. Interview on 1/13/25 at 9:40 a.m. with COTA K regarding the above dining room observation revealed:</p> <p>*Resident 6 was a feeder.</p> <p>-He had not known the use of that term was considered to have been derogatory.</p> <p>*The resident's occupational therapy goals had included improving her self-feeding abilities.</p> <p>-He had verbally interacted with the resident during the meal service but agreed it was disrespectful to have not made eye contact with her during those interactions.</p> <p>*He agreed the resident's food was likely cold and no longer tasteful after over an hour had passed.</p> <p>5. Interview on 1/14/24 at 7:45 a.m. with COTA/therapy program director L regarding the above dining room observation revealed:</p> <p>*That is not our standard of care expectation.</p> <p>*Cell phone use was prohibited except in the case of an emergency.</p> <p>*Eye contact and conversation with the resident was expected of COTA K during that meal. Appropriate verbal and/or physical assistance should have been provided. Food should have remained at a palatable temperature during the meal service.</p> <p>*The use of terms such as feeder to describe a resident was unacceptable.</p> <p>50915</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6. Random observations on 1/12/25 and 1/14/25 revealed resident 32's container for rinsing his colostomy bag was stored on his bedside table in full view of anyone who may have passed by or entered his room.</p> <p>7. Observation on 1/13/25 at 8:15 a.m. of resident 32 while in his room revealed the colostomy rinsing container was on his bedside table next to his breakfast tray while he was eating his breakfast.</p> <p>8. Interview on 1/14/25 at 2:25 p.m. with infection preventionist (IP) C revealed it was her opinion that having resident 32's colostomy rinsing container exposed on his bedside table was a dignity issue.</p> <p>9. Review of the provider's November 2024 Resident Dignity & Privacy policy revealed:</p> <p>*Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity, as well as, care for each resident in a manner and in an environment, that maintains resident privacy.</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>40788</p> <p>Based on observation, record review, interview, and policy review, the provider failed to document one of one sampled resident's (1) disrobing behavior that supported her continued need to have a dignity curtain placed inside of her room. Findings include:</p> <p>1. Observation on 1/12/25 at 3:54 p.m. of resident 1 in her room revealed:</p> <p>*There was a corridor about five to six feet in length upon stepping inside the room.</p> <p>*At the end of the corridor was a piece of patterned material (a dignity curtain) velcroed between the two walls at the end of the corridor.</p> <p>-The curtain was about five to six feet wide and between four and five feet high.</p> <p>*The resident's living space was on the other side of the curtain.</p> <p>*The resident was able to be visualized after taking a few steps inside the corridor and looking over the curtain.</p> <p>*The resident was lying on her low bed, fully clothed, and watching television.</p> <p>-She was able to make eye contact but was not able to be understood when she tried to communicate.</p> <p>Interview on 1/13/25 at 8:10 a.m. with registered nurses (RN) E and T regarding resident 1's dignity curtain revealed:</p> <p>*It was used to prevent visitors and residents walking by her doorway from seeing her if she had removed her clothes.</p> <p>-Placement of the curtain allowed staff to step inside of the room and look over the curtain to monitor the resident.</p> <p>*The resident had a history of a brain injury that resulted in cognitive impairment.</p> <p>Additional observations of the resident on 1/12/25 (at 6:15 p.m.), 1/13/25 (at 8:03 a.m., 10:06 a.m., and 4:15 p.m.), and 1/14/25 (at 7:40 a.m., 10:00 a.m., and 2:00 p.m.) revealed:</p> <p>*She was in her room lying on her low bed, fully clothed, and watching television. -The dignity curtain was up.</p> <p>Interview on 1/13/25 at 4:40 p.m. with administrator A and director of nursing B regarding resident 1 revealed:</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*The dignity curtain was used to protect the resident's privacy due to her disrobing behavior.</p> <p>-Neither knew if the frequency of the resident's disrobing behavior was being tracked to support the continued use of the dignity curtain.</p> <p>Review of resident 1's care plan revealed:</p> <p>*A focus area revised on 7/26/24 related to the resident's use of antidepressant and anti-anxiety medication.</p> <p>-An intervention initiated on 7/30/19: Monitor/record occurrence of target behavior symptoms of pacing, wandering, disrobing, inappropriate response to verbal communicating, violence/aggression towards staff/others, etc, and document per facility protocol.</p> <p>*A focus area revised on 3/20/34 related to her behaviors which included disrobing.</p> <p>-An intervention revised on 7/30/19: Document behaviors and my response to interventions per facility protocol.</p> <p>-An intervention revised on 3/20/24: Ensure that Velcro-cloth barrier is placed to shield view of [resident 1] when lying in bed and disrobing/removing brief to promote her dignity.</p> <p>Review of resident 1's electronic medical record (EMR) revealed:</p> <p>*Her diagnoses included vascular dementia, seizure disorder, chronic pain, depression, anxiety, and an anoxic brain injury.</p> <p>*A behavioral symptom monitoring tool included areas to document the frequency of 13 different types of behavior on a daily basis.</p> <p>-Disrobing was not one of those 13 listed behaviors.</p> <p>*Her behavioral progress notes and interdisciplinary progress notes between 11/12/24 and 1/13/25 did not mention the resident's disrobing behavior.</p> <p>*An 11/5/24 Behavior/Psychotropic Interdisciplinary Team Review included a list of the resident's behaviors that have been present the last 2 weeks.</p> <p>-Disrobing was not present during that time.</p> <p>-Targeted behaviors included verbal behaviors, resisting care, but not disrobing.</p> <p>*An 11/6/24 care conference note did not include a disrobing behavior.</p> <p>*An 11/20/24 psychiatry progress note completed by the certified nurse practitioner: [Resident 1's] behavior includes yelling and getting out of her chair but she has maintained a minimal amount of agitation on current medications.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Resident 1's 11/1/24, 9/11/24, and 7/19/24 Minimum Data Set assessments (Section E-Behavior Symptoms/other behavior symptoms not directed toward others such as disrobing in public) indicated that behavior was not exhibited at the time of those assessments.</p> <p>Interview on 1/14/25 at 8:10 a.m. with restorative therapy aide (RTA) U and certified nurse aide (CNA) J regarding resident 1's disrobing behavior revealed:</p> <p>*RTA U stated the frequency of resident disrobing had improved. It had occurred maybe a couple times per day.</p> <p>*CNA J stated disrobing had occurred maybe a couple times per month which was a decrease from a few days a week.</p> <p>Interview on 1/14/25 at 2:15 p.m. and review of resident 1's 12/30/24 Siderail/Other Devices Evaluation form with administrator A revealed:</p> <p>*The Evaluation was to be completed quarterly to evaluate the use of the dignity curtain and to ensure it was not being used as a seclusionary device.</p> <p>*The Non-Physical Restraint Evaluation stated Barrier [dignity curtain] is being used to promote [resident 1's] dignity as chooses to remove her briefs when soiled with urine or BM [bowel movement], removes clothing, and lays naked on bed.</p> <p>*She agreed the lack of behavioral documentation had not supported the continued need for the dignity curtain.</p> <p>Review of the provider's revised 2/10/24 Psychotropic Medications policy revealed: 8. Residents receiving psychotropic medication will have adverse side effects and target behaviors addressed in the care plan and will be monitored, recorded, and summarized each quarter. Assessment (User Defined Assessment) will include resident specific behaviors, non-pharmacological interventions attempted and the resident's response to the interventions.</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>40788</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview, and policy review, the provider failed to ensure residents' prepared food was served and distributed in a palatable manner during two of two observed meal services. Findings include:</p> <p>1. Observation and interview on 1/12/25 from 5:00 p.m. through 6:00 p.m. with cook O and certified dietary manager (CDM) N in the kitchen during the evening meal service revealed:</p> <p>*Cook O removed pizza from the oven at 5:08 p.m., sliced it, and moved it onto a baking sheet.</p> <p>-The sheet was too large to fit inside the steam table well and too short to cover the well opening it was placed on.</p> <p>*A temperature probe was inserted into the pizza by cook O and read 132 degrees Fahrenheit (F) at 5:16 p.m. That temperature was too low CDM N returned the pizza to the oven.</p> <p>-It was expected the internal temperature of that pizza was to be 165 degrees F when it was served.</p> <p>*At 5:23 p.m. CDM N removed the pizza from the oven and it was re-temped by cook O</p> <p>-The internal temperature of that pizza was 158 degrees F and returned to the oven by CDM N.</p> <p>*At 5:30 p.m. CDM N removed the pizza from the oven and it was re-temped by cook O.</p> <p>-The internal temperature of that pizza was 162 degrees F and served to the residents.</p> <p>*At 5:55 p.m. two pieces of pizza remained on the baking sheet on the steam table.</p> <p>-The internal temperature of that pizza was 106 degrees F and the pizza appeared dry.</p> <p>*CDM N would have preferred the pizza was placed on a perforated pan that fit inside of the steam table well to have maintained its internal temperature.</p> <p>-He had not known why re-heating the pizza in the oven had not increased its internal temperature to the acceptable temperature of 165 degrees F.</p> <p>2. Observation on 1/13/25 from 8:33 a.m. through 9:00 a.m. and interview with cook P in the kitchen during the breakfast meal service revealed:</p> <p>*She began serving breakfast at 7:30 a.m. that morning.</p> <p>*At 8:33 a.m. nine residents had not arrived to the dining room for breakfast.</p> <p>*The uncovered food on the steam table included Cream of Wheat cereal, sausage gravy, mechanical soft sausage, pureed sausage, and pureed cinnamon french toast.</p> <p>(continued on next page)</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>-That food remained uncovered until the last resident's breakfast was plated at 8:58 a.m.</p> <p>*Food on the steam table retained acceptable temperatures when it was temped at 9:00 a.m. but the uncovered food had developed a dry film over the top of it or appeared dry.</p> <p>*Cook P agreed covering the metal food containers on the steam table would have kept the food moist and decreased the likelihood of a crust forming over the top of the food.</p> <p>3. Interview on 1/13/25 at 9:30 a.m. with CDM N regarding food service revealed:</p> <p>*Food left on the steam table for extended periods of time was expected to have been covered to retain moisture and heat and prevent potential cross-contamination.</p> <p>*He had determined during the 1/12/24 evening meal the oven had been switched to a cool down fan which circulated air inside the oven and was not heating the pizza to the acceptable temperature.</p> <p>Review of the provider's revised 3/19/20 Food Temperatures policy revealed:</p> <p>*5. If temperatures are not at acceptable levels and cannot be corrected in time for meal service, make an appropriate menu substitution.</p> <p>*8. Palatability of foods determines appropriate temperature at bedside or tableside food. Generally hot food is palatable between 110 degrees F and 120 degrees F or greater .</p> <p>*9. Reheating foods for hot holding either in the oven or microwave must reach 165 degrees F and hold for 15 seconds.</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>40788</p> <p>Based on observation, interview, record review, and policy review, the provider failed to effectively implement and ensure appropriate and necessary infection prevention and control practices were followed:</p> <p>*When one of one observed licensed practical nurse (LPN) (F) did not wear a mask during a facility acknowledged respiratory outbreak.</p> <p>*When the use of appropriate enhanced barrier precautions (EBP) was not followed by one of one certified nurse aide (CNA) (H) during personal care for one of one sampled resident (7) on EBP.</p> <p>*When appropriate hand hygiene and glove use was not followed by one of one CNA (G) during personal care for one of one sampled resident (1).</p> <p>*For the cleaning of shared resident equipment by CNAs (H and I) after use by one of one sampled resident (45) on EBP.</p> <p>*When the use of EBP was not followed by one of one registered nurse (RN) (E) during the administration of nutritional formula through a tube for one of one sampled resident (17) who was on EBP.</p> <p>*When the use of EBP was not done when an unidentified CNA was obtaining vital signs on resident 31.</p> <p>*For resident 32 who's colostomy bag (a bag attached to the body that collects stool and needs to be emptied and rinsed periodically) rinse container was kept on his bedside table.</p> <p>Findings include:</p> <p>1. Observation on 1/12/25 at 2:00 p.m. inside the enclosed entryway of the facility revealed:</p> <p>*A box of surgical masks was on a table against the wall.</p> <p>-An alcohol-based hand sanitizer dispenser was mounted above that table.</p> <p>*A type-written notice was taped on the door that led into the facility.</p> <p>-The facility was in respiratory outbreak status and mask use was required inside of the facility.</p> <p>2. Continued observation inside of the facility revealed:</p> <p>*LPN F sat behind the nurses' station without a mask on her face.</p> <p>*She approached an unknown resident in front of the nurses' station and commented to that resident, I suppose I should be wearing a mask.</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>*She walked towards the enclosed entry referred to above, entered a code on the wall-mounted key pad, pushed open the door, and without performing hand hygiene placed a mask over her face.</p> <p>3. Interview on 1/12/25 at 2:15 p.m. with LPN F revealed the facility was in respiratory outbreak status related to an employee who had tested positive for COVID-19.</p> <p>4. Observation and interview on 1/12/25 at 2:15 p.m. with certified nurse aide (CNA) H in resident 7's room revealed:</p> <p>*A notice on the room door for EBP (A set of infection control-measures that require the use of gowns and gloves to reduce the spread of multidrug-resistant organisms).</p> <p>*Without putting on a gown or gloves she placed her arms under the resident's armpits and lifted her up from her wheelchair to a standing position.</p> <p>-She transferred the resident to her bed.</p> <p>*She moved the resident's urine catheter bag from the wheelchair, attached it to her bed, and placed it inside a cloth bag.</p> <p>*CNA H stated resident 7 was on EBP because she had a catheter. She had not needed to put on a gown or gloves unless she was emptying the catheter bag.</p> <p>5. Observation on 1/12/25 at 3:29 p.m. near resident 45's room revealed:</p> <p>*A notice was posted on the room door for EBP to have been followed.</p> <p>*CNA I exited the room with a mechanical lift that she had left along the wall near that room.</p> <p>-A bag was hung on the lift that contained disinfectant wipes.</p> <p>*CNA I returned to the resident's room before she exited again with CNA H.</p> <p>*The mechanical lift was not cleaned by either staff after they had left the room.</p> <p>6. Interview on 1/12/25 at 4:30 p.m. with CNA H regarding the above observation revealed:</p> <p>*She and CNA I had used the mechanical lift to transfer resident 45 from his bed to his wheelchair.</p> <p>*The lift was expected to have been cleaned after it was used but neither she nor CNA I had cleaned it.</p> <p>7. Observation on 1/13/25 and interview with CNA G at 4:15 p.m. while in resident 1's room revealed:</p> <p>*CNA G put on a gown and gloves to change the resident's soiled incontinence brief.</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>-She used wet wipes to clean stool off of the resident's skin then discarded those wipes into a plastic bag.</p> <p>*With dirty gloves she:</p> <p>-Dispensed skin barrier cream onto the dirty glove and applied it onto the resident's skin.</p> <p>-Placed a clean incontinence brief on the resident.</p> <p>*She then removed her dirty gown and gloves, placed them in the plastic bag, and washed her hands.</p> <p>*She stated she was expected to have removed her dirty gloves, performed hand hygiene, and applied clean gloves before she had applied barrier cream and put a clean brief on the resident to prevent cross-contamination.</p> <p>8. Interview on 1/14/25 at 1:45 p.m. with woundcare registered nurse (RN)/infection preventionist (IP) C revealed:</p> <p>*All staff were expected to wear masks while the facility was in respiratory outbreak status.</p> <p>-Hand hygiene was expected to have been performed before putting on a mask.</p> <p>*All shared resident equipment was expected to have been cleaned by staff after it was used.</p> <p>*Gown and glove use was expected during the care of any resident on EBP.</p> <p>*Gloves were expected to have been removed, hand hygiene performed, and new gloves put on after providing resident's personal care and before applying a barrier cream or a clean continence brief.</p> <p>Review of the provider's revised 6/21/24 Enhanced Barrier Precautions policy revealed:</p> <p>*2. a. Gowns and gloves should be used during high contact resident care activities that provide opportunities for transfer of MDROs [multi drug resistant organisms] to staff hands and clothing.</p> <p>-Transferring a resident was included in that list of resident care activities.</p> <p>Review of the provider's 2/20/24 Cleaning and Disinfection of Equipment policy revealed I. A. Supplies and equipment will be cleaned immediately after use.</p> <p>Review of the provider's revised 2/20/24 Standard Precautions policy revealed:</p> <p>*Personal Protective Equipment (PPE):</p> <p>-Gloves should be removed, hand hygiene performed, and a new pair of gloves applied before moving from a contaminated area to a clean area.</p> <p>47780</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Avantara North		STREET ADDRESS, CITY, STATE, ZIP CODE 1620 North 7th Street Rapid City, SD 57701	
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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9. Observation on 1/12/25 at 3:39 p.m. in resident 17's room revealed:</p> <p>*She had an EBP sign on her door.</p> <p>*Hanging on the resident's door were gloves, masks, and gowns.</p> <p>*An unknown staff member knocked on resident 17's door and asked if she was ready to take her after-dinner pill.</p> <p>Review of resident 17's electronic medical record (EMR) revealed:</p> <p>*She received nutritional formula through an Enteral tube two times a day.</p> <p>*Resident 17 had an order for Lansoprazole (medication) Capsule Delayed Release 30 MG once a day for GERD (a digestive disease in which stomach acid irritates the food lining).</p> <p>*Her diagnoses included: tubule-interstitial nephritis, moderate protein-calorie malnutrition, dementia, Alzheimer's, and dysphagia.</p> <p>Observation on 1/13/25 at 2:44 p.m. with RN E while in resident 17's room revealed:</p> <p>*Resident 17 was lying in bed with the head of the bed elevated.</p> <p>*RN E had hand sanitized her hands and then put gloves on both hands. She:</p> <p>-Had placed a clean barrier on the resident's bedside table and placed two cartons of Jevity 1.2 (the enteral nutrition formula), a measuring pitcher, three plastic cups, a pH tester strip in one of the plastic cups, and a sterile syringe.</p> <p>-She filled one of the plastic cups with tap water from the bathroom faucet.</p> <p>-She poured approximately 300 ml (milliliters) of Jevity 1.2 into the measuring pitcher.</p> <p>-She had informed the resident that it was time for her formula administration session and the resident assisted in removing the blankets.</p> <p>-RN E explained she needed to check the pH of the stomach contents.</p> <p>-She opened the sterile syringe and attached it to the PEG (percutaneous endoscopic gastrostomy) tube.</p> <p>-With the plunger, she injected air into the PEG tube.</p> <p>-She then pulled the plunger back and obtained residual stomach contents into the syringe.</p> <p>-She dripped some of the residuals onto the pH tester strip and reported that the pH was 4.5.</p> <p>-RN E then flushed the feeding tube with 50 CC (cubic centimeters) of water.</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>-She then poured the liquid medication into the syringe.</p> <p>-After filling the syringe twice more with formula to reach the ordered amount to be given, she flushed the tube with water.</p> <p>-She replaced the cap on the PEG tub.</p> <p>-She then threw the Jevity cartons, syringe, plastic cups, measuring pitcher, and gloves into the trash can.</p> <p>-She went into the resident's bathroom and washed her hands.</p> <p>Continued interview on 1/13/25 at 3:00 p.m. with RN E regarding a resident on EBP precautions revealed she was unaware she was to be wearing a gown when she was with a resident with a feeding tube.</p> <p>Interview on 1/14/25 at 1:20 p.m. with DON B regarding the above observation revealed:</p> <p>*She stated all staff had received education regarding EBP in Relias (a learning platform that offers training for healthcare organizations) when hired.</p> <p>*She stated the nurses had a monthly meeting that discussed EBP.</p> <p>*Her expectation of staff was to follow all EBP.</p> <p>Review of the provider's revised March 2024 Enhanced Barrier Precautions policy revealed:</p> <p>Definition:</p> <p>Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.</p> <p>ENHANCED BARRIER PRECAUTIONS should be used for all residents or for those residents colonized/infected with a novel or targeted MDRO [multi-drug resistant organism], when they no longer meet requirements for contact Precautions:</p> <p>1. When a resident has any of the following:</p> <p>b. indwelling Medical Devices:</p> <p>.Feeding Tube</p> <p>50915</p> <p>1. Observation on 1/12/25 at 4:00 p.m. during the initial tour of the facility of an unidentified CNA revealed:</p> <p>*The CNA was obtaining vital signs on resident 31.</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>*Resident 31 was on EBP.</p> <p>*There was a sign on his door indicating he was on EBP.</p> <p>*The CNA was not wearing a gown or gloves.</p> <p>2. Random observations throughout the survey from 1/12/25 through 1/14/25 of resident 32's room revealed:</p> <p>*Resident 32 had a colostomy bag (a bag that collects stool and needs to be emptied and rinsed periodically).</p> <p>*Resident 32 would assist staff with rinsing his colostomy bag.</p> <p>*The container used to rinse the colostomy bag was kept on his bedside table.</p> <p>*On 1/13/25 at 8:00 a.m., resident 32 was eating his breakfast in his room with the colostomy rinsing container sitting next to his breakfast tray.</p> <p>*He said that he had never been asked to store the rinsing container elsewhere by staff.</p> <p>3. Interview on 1/13/25 at 9:37 a.m. with licensed practical nurse (LPN) D revealed:</p> <p>*She was aware resident 32 kept his colostomy rinsing container on his bedside table.</p> <p>*She said, I think its gross.</p> <p>*She said staff have asked him to keep the rinsing container in the bathroom and he refuses.</p> <p>*She said that he was very particular about the way his possessions were situated in his room.</p> <p>4. Interview on 1/14/25 at 2:30 p.m. with infection preventionist (IP) C revealed:</p> <p>*She was not aware resident 32 kept his colostomy rinsing container on his bedside table.</p> <p>*She said, That's disgusting.</p> <p>*She agreed that was an infection control issue.</p> <p>*Referring to personal protective equipment used for obtaining vital signs for a resident on EBP, she wanted to review her policy before answering questions on the topic.</p> <p>*She agreed staff should be following the policy.</p> <p>5. Interview on 1/14/25 at 3:15 p.m. with director of nursing (DON) B revealed:</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>*She was not aware resident 32 was keeping his colostomy rinsing container on his bedside table but agreed that this was an infection control issue, and she would talk to the resident and have it moved.</p> <p>*Referring to EBP, she said staff should be following the policy any time direct care was being provided to a resident on EBP, this included obtaining vital signs.</p> <p>6. Review of the provider's February 2024 Infection Prevention Program policy revealed:</p> <p>*I. Goals</p> <p>The goals of the infection prevention and control program are to:</p> <p>A. Decrease the risk of infection to residents and personnel.</p> <p>B. Prevent, to the extent possible, the onset and spread of infection.</p> <p>D. Monitor for occurrence of infection and implement appropriate control measures.</p> <p>E. Identify and correct problems relating to infection prevention practices.</p>		