

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society Tyndall		STREET ADDRESS, CITY, STATE, ZIP CODE 2304 Laurel Street Tyndall, SD 57066	

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 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>51370</p> <p>Based on observation, record review, and interview, the provider failed to revise and update a care plan for one of fifteen sampled residents (22) to reflect her care needs for supervision while using the bathroom. Findings include:</p> <p>1. Observation and interview on 1/22/25 at 9:06 a.m. of resident 22 while seated in her wheelchair in her room revealed:</p> <ul style="list-style-type: none"> *Her right eye and cheek were bruised from the eyelid to an inch below her eye. *Her forehead was bruised from her eyebrow into her hairline. *She had what appeared to be a lump or area of swelling just below her hairline. -The lump was approximately one inch by one inch. *She said she had fallen on her head. *She thought she had fallen from her bed when reaching for something on the floor. *She said she was embarrassed by the bruising to her face. *Her makeup was not covering the bruising as much as she would have liked. <p>2. Refer to the fourth and sixth paragraphs in F689 finding 2 for information related to her history of unhooking the lift sling straps and her fall on 1/17/25.</p> <p>3. Review of resident 22's current care plan revealed:</p> <ul style="list-style-type: none"> *Her care plan did not include if staff were required to stay with her while she used the bathroom. *There was no documentation regarding need for supervision while toileting. <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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*It was noted that she had impaired cognitive function or impaired thought process relating to her diagnoses of multiple sclerosis, Alzheimer's disease, dementia, and other cognitive deficits.</p> <p>*Intervention for toilet use and transfers revealed:</p> <p>-She required two staff for toilet use.</p> <p>-She required the total body lift to transfer between surfaces, with the assist of two staff.</p> <p>*Her care plan was last revised on 1/20/24 and included that she was at risk for falls related to: Heart failure, Multiple sclerosis, Alzheimer's disease, Dementia, history of falls, poor safety awareness, and a history of removing the lift sling straps from the lift.</p> <p>4. Interview on 1/24/25 at 10:02 a.m. with clinical care leader C revealed that:</p> <p>*As a result of resident 22's fall on 1/17/25, she expected staff to supervise the resident while she was using the bathroom.</p> <p>*She confirmed that resident 22's care plan had not been updated to reflect that change.</p> <p>*When asked how nursing staff were supposed to know which residents required supervision in the bathroom, she said that there are a certain few that they [the staff] know they [the resident] will stay upright, they [the staff] know the ones [the residents] who they [the staff] can leave alone, and those [residents] who cannot.</p> <p>*CNAs learned of updated residents care information by:</p> <p>-Verbal communication between staff.</p> <p>-The wing binder, which included the daily nursing huddle report sheet and other relevant care notes for CNA use.</p> <p>-The bulletin board in the employee break room.</p> <p>-The resident's care plan/Kardex (a brief overview of the resident that was generated directly from care plan). However, she stated that the CNAs don't really use the Kardex.</p> <p>*Care plans were updated by nurses, the MDS coordinator, and herself.</p> <p>5. Interview on 1/24/25 at 10:28 a.m. with DON B revealed:</p> <p>*Staff would be educated that residents can be left connected to the total body lift while toileting with the tension removed to ensure they were not suspended.</p> <p>-Staff would need to know if the resident was cognitive to be left alone in the bathroom.</p> <p>*Information would be available on the Kardex, which came directly from the care plan.</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>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** 46453</p> <p>Based on observation, interview, record review, and policy review, the provider failed to identify and implement interventions to prevent falls for two of two sampled residents (22 and 55) who fell and sustained injuries.</p> <p>Findings include:</p> <p>1. Observation and interview on 1/22/25 at 9:16 a.m. with resident 55 while in the 200-hallway revealed:</p> <p>*She had a large bruise around her left eye.</p> <p>-The bruise was above her eyebrow and extended to her cheekbone.</p> <p>-The bruise was brown with yellowing edges.</p> <p>*When asked about the bruise, she could not remember.</p> <p>Observation on 1/22/25 at 2:09 p.m. revealed that resident 55 was resting in bed with the bed in the lowest position to the floor. There was an air mattress overlay on the bed and a fall mat on the floor next to her bed.</p> <p>Review of resident 55's electronic medical record (EMR) revealed:</p> <p>*She admitted to the facility on [DATE] for rehabilitation after surgical repair from a previous fall with fractures at the assisted living facility where she previously resided.</p> <p>*She was hard of hearing and wore hearing aids in both ears.</p> <p>*Her 12/27/24 Brief Interview for Mental Status (BIMS) assessment score was 9, which indicated she had moderate cognitive impairment.</p> <p>*Her 12/27/24 falls tool assessment indicated she was at medium risk for falls. No interventions were selected in the Action Plan section.</p> <p>*Her 12/27/24 nursing admit data collection tool indicated the following:</p> <p>-She was not able to ambulate independently.</p> <p>-Grab bars had been installed on her bed.</p> <p>-She had received education about the following:</p> <p>--Resident orientated to room and call light use.</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>--Resident orientated to facility routines, activities, accommodations.</p> <p>--Therapy evaluations.</p> <p>--Meal times and routine.</p> <p>--Immunizations.</p> <p>--Safety and fall prevention.</p> <p>--Her impaired hearing was a barrier to education.</p> <p>--She had verbalized understanding.</p> <p>Review of her baseline care plan initiated on 12/27/24 in relation to falls, fall risks, and fall prevention revealed:</p> <p>*Educate resident not to bend over to pick up dropped items. Encourage use of grabber or to ask for assistance.</p> <p>*Ensure that Resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair.</p> <p>*The Safe Resident Handling Program (SRHP) intervention for ambulation safety was initiated on 12/30/24.</p> <p>*SRHP - TRANSFER - Transfer Between Surfaces: non-mechanical stand aide and 1 staff assist [assistance].</p> <p>*She required the assistance of one staff member for other activities like bed mobility, dressing, and personal hygiene.</p> <p>Incident note 12/28/24: At 0815 [8:15 a.m.], resident was found on the floor at the foot of her bed. Resident was alert. Yelling out, 'I want to go to bed.' Gripper socks were on. Call light was attached to grab bar on side of bed. w/c [wheelchair] was not within reach. No walker. When resident asked [what] happened or what she was trying to do she stated, 'I don't remember.' VS [vital signs] with neuro's taken. Laceration noted on forehead at the hairline. Moderate amount of bleeding. Total lift used to set resident in chair. Shower provided d/t [due to] bleeding on hands, hair and face. Laceration cleansed and dry telfa [Telfa, a brand of wound dressing] dressing applied. Ice offered, refused. 2cm [centimeters] superficial wound. Bruising noted across bridge of nose and on left hand. ROM [range of motion] was WNL [within normal limits]. Physician notified by fax and son contacted. Will care plan to put bed in lowest position at night with mat beside bed.</p> <p>*She continued to have increased pain, potentially from her multiple healing fractures, head laceration, and bruising from the fall.</p> <p>Interview on 1/24/25 at 10:42 a.m. with director of nursing (DON) B revealed:</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>*Her forehead was bruised from her eyebrow into her hairline.</p> <p>*She had what appeared to be a lump or area of swelling just below her hairline.</p> <p>-The lump was approximately one inch by one inch.</p> <p>*She said she had fallen on her head.</p> <p>*She thought she had fallen from her bed when reaching for something on the floor.</p> <p>Interview on 1/24/25 at 10:02 a.m. with clinical care leader C revealed:</p> <p>*Certified nursing assistants (CNAs) were trained that residents could have been left with the lift sling straps connected to lift equipment while using the toilet.</p> <p>-Some residents may have the lift sling straps loosened, and the lift equipment could have been left in front of them to supplement their upper body strength while they sat on the toilet.</p> <p>*Resident 22 had poor torso strength due to her diagnosis of multiple sclerosis.</p> <p>-She could be left with the straps loosened but remaining attached to the lift.</p> <p>-It was not documented in the resident's care plan to leave her on the toilet with the lift equipment still attached and in the bathroom with her.</p> <p>-Her care plan did not include that she required staff supervision was required while she used the bathroom.</p> <p>*She expected CNAs to know which residents could have been left alone and which were not safe to have been left alone.</p> <p>-The default was that residents could have been left alone in the bathroom while still attached to the lift equipment until they saw reasons that they resident should not have been left alone.</p> <p>*Resident 22 was not required to have been supervised while on the toilet at the time of her fall on 1/17/25.</p> <p>*CNAs learned of updated residents care information by:</p> <p>-Verbal communication between staff.</p> <p>-The wing binder, which included the daily nursing huddle report sheet and other relevant care notes for CNA use.</p> <p>-The bulletin board in the employee break room.</p> <p>-The resident's care plan/Kardex (a brief overview of the resident that was generated directly from care plan). However, she stated that the CNAs don't really use the Kardex.</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>*Care plans were updated by nurses, the MDS coordinator, and herself.</p> <p>Interview on 1/24/25 at 10:28 a.m. with DON B revealed:</p> <p>*Staff were educated that residents could be left connected to the total body lift while using the bathroom. The lift sling straps were loosened to ensure the resident was not suspended.</p> <p>-Staff would need to know if the resident was cognitive to be left alone in the bathroom.</p> <p>*Information would be available on the Kardex.</p> <p>-Nursing staff including CNAs have access to the Kardex.</p> <p>Review of resident 22's EMR progress notes revealed she had a history of unhooking the lift sling straps or threatening to unhook lift straps:</p> <p>*A 4/4/24 social services note Res [resident] unhooked lift strap on one occasion when she was talking with her.</p> <p>*A 4/5/24 nursing services note removes sling from lift before staff can start to lift her.</p> <p>*A 5/18/24 nursing services note she was grabbing the loop and trying to take it off the hook when staff were assisting her from the toilet with the total body lift.</p> <p>*A 6/23/24 nursing services note would attempt to unhook self and pull on [the] sling, making sling placement difficult. This could be a safety issue if behaviors continue.</p> <p>*A 6/24/24 social services note trying to remove straps from lift.</p> <p>*A 7/15/24 nursing services note needed redirection and distraction to keep her from attempting to unhook sling.</p> <p>*A 7/22/24 social services note res [resident] was removing straps to lift.</p> <p>*A 7/23/24 nursing services note Other observations: Agitation, Delusions. Impaired decision making. Safety concerns.</p> <p>*An 8/25/24 note indicated the resident was put on the toilet, when they returned she had unhooked the sling from the lift and had it off.</p> <p>*A 9/4/24 care plan review note Resident continues to think that she can walk so she tried to stand up and fell on the floor, Cna [CNA] found her on the floor by her bed.</p> <p>*A 9/25/24 nursing services note Nurse notice CNA going in the room with stand aid [a lifting device for those who have difficulty rising from a seated to standing position], Nurse [went] running down the hall and stated that resident was a Hoyer lift [total body lift]. Resident tried to tell CNA to ignore her [the nurse] and do what she was going to do, nurse stated No, the CNA needs to know so she doesn't lose her license and or drop you because you do not stand.</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>*She had taken the following medications in the last eight hours: antidepressant, antipsychotic, and a blood thinner.</p> <p>*She unhooked the straps and bar of the total body lift.</p> <p>*She was experiencing pain with movement.</p> <p>*It was also marked that she had a head injury, and abrasion, skin discoloration with bruising, and swelling.</p> <p>-There was a handwritten note that stated, right side hematoma.</p> <p>Review of resident 22's current care plan revealed:</p> <p>*It was noted that she had impaired cognitive function or impaired thought process relating to her diagnoses of multiple sclerosis, Alzheimer's disease, dementia, and other cognitive deficits.</p> <p>*Intervention for toilet use and transfers revealed:</p> <p>-She required two staff for toilet use.</p> <p>-She required the total body lift to transfer between surfaces, with the assist of two staff.</p> <p>*Her care plan was last revised on 1/20/24 and included that she was at risk for falls related to: Heart failure, Multiple sclerosis, Alzheimer's disease, Dementia, history of falls, poor safety awareness, and a history of removing the lift sling straps from the lift.</p> <p>*Her care plan did not include if staff were required to stay with her while she used the bathroom.</p> <p>-There was no documentation regarding need for supervision while toileting.</p> <p>3. Review of the provider's 7/29/24 Fall Prevention and Management policy revealed:</p> <p>*Purpose</p> <p>-To promote resident well-being by developing and implementing a fall prevention and management program.</p> <p>-To identify risk factors and implement interventions before a fall occurs.</p> <p>-To give prompt treatment after a fall occurs.</p> <p>-To provide guidance for documentation.</p> <p>*Proactive Approach before a Fall Occurs (e.g., New Admit) Procedure</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Good Samaritan Society Tyndall		STREET ADDRESS, CITY, STATE, ZIP CODE 2304 Laurel Street Tyndall, SD 57066	
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F 0689 Level of Harm - Actual harm Residents Affected - Few	<ul style="list-style-type: none"> -1. On admission or readmission, review the applicable documents (i.e., discharge summary from transferring agency, transfer record, history and physical, lab values, nursing admit/readmit data collection) and any additional admit information documentation for fall risk factors. -2. Complete the Falls Tool UDA [user-defined assessment] for fall screening and identifying fall risk factors. -3. Care Plan the appropriate interventions, including personalizing all '(SPECIFY)' areas. -4. Communicate fall risks and interventions to prevent a fall before it occurs per the 24-Hour Report, care plan and Kardex, daily stand-up meeting, and/or Fall Committee meetings. 		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>46453</p> <p>Based on observation, interview, record review, and policy review the provider failed to ensure one of one sampled diabetic resident (33) was free from a potential insulin medication error.</p> <p>Findings include:</p> <p>1. Observation on 1/23/25 from 9:31 a.m. to 9:47 a.m. with registered nurse (RN) G during medication administration revealed:</p> <p>*RN G was preparing resident 33's insulin pen.</p> <p>*Resident 33 was scheduled to receive 10 units of Admelog insulin and 40 units of Tresiba insulin.</p> <p>*RN G primed both pens and dialed each pen to the correct ordered dose.</p> <p>-He then walked over to licensed practical nurse (LPN) J to verify the correct dosage. LPN J verified that each insulin pen was dialed at the correct dose.</p> <p>*While the surveyor walked with RN G back to resident 33's room, the surveyor heard a noise that sounded like the insulin pen was clicking as if the dose was changed.</p> <p>*RN G brought the insulin pens to resident 33's room and set the pens down on resident 33's bedside table.</p> <p>*The Tresiba insulin pen was then observed to be dialed at 32 units instead of 40 units.</p> <p>*RN G lifted the resident's shirt and prepared an area on her abdomen to inject the Tresiba.</p> <p>-Just as RN G was about to administer the incorrect insulin dose, the surveyor stopped RN G and requested that he verify the units again.</p> <p>-RN G was surprised that the Tresiba insulin was at 32 units rather than 40 units.</p> <p>-He did not know how the insulin pen was dialed back to 32 as he had verified with LPN J that the pen was dialed to correct dosage.</p> <p>*Had the surveyor not intervened, resident 33 would have received the wrong dose of insulin.</p> <p>*RN G then dialed the Tresiba insulin pen up to 40 units and administered the insulin to resident 33.</p> <p>*After leaving resident 33's room, RN G again indicated that he did not know how the insulin pen was dialed back to 32 units rather than 40 units.</p> <p>2. Interview on 1/23/25 at 12:53 p.m. with LPN J revealed:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*The facility's policy was to have two licensed nurses verify a resident's insulin dosage prior to administering the insulin.</p> <p>*She confirmed that she verified resident 33's Tresiba insulin pen was dialed to 40 units when RN G showed it to her.</p> <p>*She did not know how the insulin pen was dialed back to 32 units in the time RN G walked to resident 33's room.</p> <p>*She would have considered that situation a medication error if RN G would not have noticed the insulin pen was at the incorrect dosage.</p> <p>-Had resident 33 received 32 units of insulin rather than 40 units, her blood sugar level may have been higher than normal due to the reduced amount of insulin administered.</p> <p>3. Interview on 1/23/25 at 1:13 p.m. with director of nursing (DON) B revealed:</p> <p>*She would have considered the above observation a medication error.</p> <p>*She said, The resident would have been at risk.</p> <p>4. Review of resident 33's electronic medical record revealed she had a physician's order for Tresiba FlexTouch Subcutaneous Solution Pen injector 200 UNIT/ML [milliliter] (Insulin Degludec) Inject 40 [units] subcutaneously one time a day .</p> <p>5. Review of the manufacturer's instructions for the Tresiba FlexTouch insulin pen revealed:</p> <p>* .3. Prime your pen: Turn the dose selector to 2 units, press and hold the dose button until the dose counter shows '0,' and ensure a drop of insulin appears.</p> <p>*4. Select your dose: Turn the dose selector to the number of units you need to inject.</p> <p>6. Review of the provider's 9/5/24 Medication: Insulin Administration, Insulin Pens, Insulin Pumps policy revealed:</p> <p>*Insulin Pen .Procedure</p> <p>- .2. Verify provider order .</p> <p>- .11. Dial in the ordered dose on units.</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>46453</p> <p>Based on observation, interview, record review, and policy review, the provider failed to follow infection prevention practices by not having ensured:</p> <p>*Shared resident lift equipment (at least six different stand aids) was maintained in a clean and sanitary manner per the manufacturer's recommendations.</p> <p>*One of one registered nurse (RN) (G) used a clean utensil to open a packet of powdered nutrition supplement and performed appropriate hand hygiene during an observed medication administration.</p> <p>Findings include:</p> <p>1. Observation on 1/22/25 at 4:52 p.m. in the 100-hallway revealed:</p> <p>*There was a buildup of an unidentified brown substance in the footwell of the non-motorized stand aid. The black anti-slip covering in the foot plate was loose and rolling upwards from the edges, that exposed more of an unidentified brown substance.</p> <p>*There were food crumbs and unidentified white flakes in the footwell of the motorized stand aid. The black anti-slip strips were torn and peeling away.</p> <p>Additional random observations throughout the survey from 1/21/25 through 1/24/25 revealed:</p> <p>*The stand aids in the 100-hallway remained in the same unclean condition.</p> <p>*Three non-motorized stand aids in the 200-hallway had an unidentified brownish-orange and black buildup in the border of the footwells.</p> <p>-The black anti-slip covering in one of those stand aids appeared to have been loose and stretched out, and exposed more buildup underneath.</p> <p>*One of the non-motorized stand aids in the 300-hallway had an unidentified brownish-orange and black buildup in the border of the footwells.</p> <p>Interview on 1/24/25 at 10:26 a.m. with activities director F revealed:</p> <p>*She was cleaning one of the non-motorized stand aids in the 300-hallway at the time of the interview.</p> <p>*To her knowledge, all shared resident lift equipment was cleaned with sanitizing wipes after each resident use.</p> <p>*She did not know if the resident lift equipment was deep cleaned.</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>Interview on 1/24/25 at 10:30 a.m. with licensed practical nurse (LPN) I revealed that she did not know if the resident lift equipment was deep cleaned or how often deep cleaning was supposed to have occurred.</p> <p>Interview on 1/24/25 at 10:40 a.m. with director of nursing (DON) B revealed:</p> <ul style="list-style-type: none"> *The shared resident lift equipment was to be cleaned after each use with sanitizing wipes. *She was not aware of the buildup of the unidentified substances in the footwells. *She did not know if the lift equipment was on a deep-cleaning schedule. <p>Review of the 2/25/21 manufacturer's EZ Way Equipment Cleaning Guide revealed:</p> <ul style="list-style-type: none"> *To keep your EZ Way equipment clean and in good condition, we recommend that you use a standard germicidal spray, Sani-Wipe, or similar product and that you follow these guidelines: -DO NOT SPRAY PRODUCT DIRECTLY ON THE MACHINE. -Spray the cleaner onto a cloth or paper towel then wipe the unit to clean it. -The germicidal spray, Sani-Wipe, or similar product can be used on the control panel and front panel graphics. If not using a wipe, make sure to spray the cleaner onto a cloth or paper towel then wipe the unit to clean it. -Be careful not to wipe off the model and serial number sticker (located on the side of the mast, on floor lifts and sit-to-stands). <p>2. Observation on 1/23/25 from 9:31 a.m. to 10:12 a.m. of RN G during medication administration revealed:</p> <ul style="list-style-type: none"> *RN G did not perform hand hygiene prior to putting on a clean pair of gloves. He then checked resident 33's blood sugar level which involved pricking the resident's finger for a blood sample. *RN G then gathered those used supplies and went back to the medication cart. -With those gloved hands, he cleaned the glucometer, then removed those gloves and performed hand hygiene. *RN G prepared resident 33's insulin and brought the insulin pens into her room. -He set the insulin pens down onto a barrier on her overbed table. -He did not perform hand hygiene and put on a clean pair of gloves. -After he administered the resident's insulin, he removed those gloves, did not perform hand hygiene, and went back to the medication cart to prepare the rest of resident 33's medications. <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>*While RN G was preparing resident 33's powdered nutrition supplement:</p> <p>-He pulled a pair of scissors out of his shirt pocket. Without cleaning or sanitizing the scissors, he cut open the pouch of powdered nutrition supplement and poured the contents into a plastic cup.</p> <p>*He prepared the rest of resident 33's medications and brought them to her room.</p> <p>-He did not perform hand hygiene and put on a pair of clean gloves.</p> <p>-He assisted the resident with taking her medications, including administering her eye drops.</p> <p>-After the resident finished taking her medications, RN G removed his gloves and discarded them into the trash. He did not perform hand hygiene. He went back to the medication cart to prepare the next resident's medications.</p> <p>Interview at that time with RN G about the above observations revealed:</p> <p>*He stated he was nervous about the survey process.</p> <p>*He agreed he missed several opportunities for hand hygiene throughout the medication administration observation.</p> <p>*He was not aware that the scissors should have been cleaned and sanitized prior to using them to open the pouch of powdered nutrition supplement.</p> <p>Interview on 1/23/25 at 1:13 p.m. with DON B revealed:</p> <p>*She expected staff to perform hand hygiene before putting gloves on, and after taking gloves off.</p> <p>*Staff should not use scissors to open packages of powdered nutrition supplement, medicated patches, or other packages used for medication administration.</p> <p>Review of the provider's 3/29/22 Hand Hygiene policy revealed:</p> <p>*Policy:</p> <p>- .All employees are responsible for maintaining adequate hand hygiene by adhering to specific infection control practices.</p> <p>-All employees in patient care areas .will adhere to the 4 Moments of Hand Hygiene and 2 Zones of Hand Hygiene.</p> <p>--1. Entering Room.</p> <p>--2. Before Clean Task.</p> <p>--3. After Bodily Fluid/Glove Removal.</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>--4. Exiting Room.</p> <p>--5. Zones: Patient zone and Health-care zone.</p> <p>- .Gloves are a protective barrier for the HCW [healthcare worker] according to standard precautions.</p> <p>--1. Gloves are never to be reused or sanitized.</p> <p>--2. Hand hygiene should be performed after glove removal.</p> <p>*Procedure: HCW will use waterless alcohol-based hand sanitizer or soap and water to clean their hands:</p> <p>-When entering patient room.</p> <p>-Before preparing or administering medications.</p> <p>-Before donning sterile gloves.</p> <p>-If gloves are used to perform a clean/aseptic procedure, hand hygiene must be completed before donning gloves.</p> <p>-After removing gloves regardless of task completed.</p> <p>- .When moving from contaminated body site to a clean body site during patient care.</p> <p>-When entering healthcare zone (supply drawers, linen drawers or cupboards).</p> <p>-When exiting patient room.</p>