

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Sterling County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  309 Fifth St Sterling City, TX 76951	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48593</p> <p>Based on interviews and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 12 residents (Resident #22 and #6) reviewed for care plans.</p> <ol style="list-style-type: none"> <li>The facility failed to have a care plan in place to accurately address Resident #6's oxygen use.</li> <li>The facility failed to have a care plan in place to accurately address Resident #22's 1/4 side rail use.</li> </ol> <p>This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs.</p> <p>The findings included:</p> <p>Resident #6</p> <p>Resident #6 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #6 had medical diagnoses that included chronic diastolic congestive heart failure, heart disease, acute kidney failure, morbid obesity due to excess calories, and shortness of breath.</p> <p>Review of Resident #6's Quarterly MDS assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 14 indicating the resident was cognitively intact. She required maximum assistance and dependent on staff for all ADL's except for eating. She used a wheelchair for mobility. Under section O for Respiratory treatments C1. Oxygen therapy was selected as continuous while a resident at the facility.</p> <p>Record review of Resident #6's had order summary dated August 2024 that include, GIVE OXYGEN AT 1-10 LITERS VIA FACE MASK OR NASAL CANNULA CONTINUOUS. - every day and night shift Hospice has delivered a black concentrator that can deliver up to 10L, OXGEN: Oxygen AT 2-4 LPM CONTINUOUS via NC. Titrate for comfort. every shift.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #6's care plan dated 07/24/2024 revealed there was no care plan for oxygen use.</p> <p>Interview on 08/08/24 at 03:18 PM with MDS E stated that she would check orders and medical diagnosis for items that should be care planned. MDS E stated that there should be a care plan for oxygen especially for continuous oxygen use. MDS E stated that the care staff could look at the care plan and if her continuous oxygen use was not on there, they could miss that she needs to have O2 on continuously.</p> <p>Review of Resident #22's Admission Record, dated 8/7/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, high blood pressure, arthritis, and neuropathy (nerve disorder causing numbness or tingling).</p> <p>Review of Resident #22's Quarterly MDS Assessment, dated 6/24/24, revealed:</p> <p>She scored a 10 of 15 on her mental status exam (indicating moderate cognitive impairment)</p> <p>She had range of motion impairment on one side of the lower extremity and used a walker.</p> <p>She was independent in all of her ADLs including transfers and sitting to standing.</p> <p>Review of Resident #22's care plan, last revised on 6/27/24, revealed no care plan for side rails.</p> <p>Observation and interview on 8/6/24 at 10:49 a.m. revealed Resident #22 had 1/4 rails on both sides of her bed. Resident #22 said she did not know why she had the rails; they were built onto the bed. Resident #22 said she did not mind the rails, but she did not use them.</p> <p>Interview and record review on 08/08/24 at 03:34 PM the MDS Coordinator stated indicators for care plans started with cognition, pain, diagnoses, then MDS triggers. The MDS Coordinator stated 1/4 side rails would be just for mobility since they did not keep Resident #22 in the bed but would require a care plan. The MDS Coordinator stated the system for side rails was therapy did an assessment, if rails were indicated ADON got a consent from the resident or the responsible party. The MDS Coordinator said once the consent was obtained, she would get the order and do the care plan. The MDS Coordinator checked Resident #22's electronic file and said she did not see a consent for side rails.</p> <p>Review of undated facility policy titled Comprehensive Person-Centered Resident Care Planning revealed, in part:</p> <p>A comprehensive person-centered care plan is developed and implemented for each resident, consistent with the resident's rights, and will incorporate resident-centered goals and wishes about their care, activities, and lifestyle to include measurable short-term and long-term objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26221</p> <p>Based on observations, interviews, and record review the facility failed to attempt to use appropriate alternatives prior to installing a side or bed rail, assess the resident for risk of entrapment from bed rails prior to installation, and review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for 1 of 4 (Resident #22) residents reviewed for bed rails.</p> <p>Resident #22 had two quarter-rail bed rails on her bed with no documentation of resident consent, physician orders, and no care plan prior to installation.</p> <p>This failure could place residents at risk of injury, hinder residents from getting out of bed, and/or cause a decline in resident's ability to engage in activities of daily living.</p> <p>Findings included:</p> <p>Review of Resident #22's Admission Record, dated 8/7/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, high blood pressure, arthritis, and neuropathy (nerve disorder causing numbness or tingling).</p> <p>Review of Resident #22's Quarterly MDS Assessment, dated 6/24/24, revealed: She scored a 10 of 15 on her mental status exam (indicating moderate cognitive impairment). She had range of motion impairment on one side of the lower extremity and used a walker. She was independent in all of her ADLs including transfers and sitting to standing.</p> <p>Review of Resident #22's care plan, last revised on 6/27/24, revealed no care plan for side rails.</p> <p>Review of Resident #22's Order Summary, dated 8/7/24, revealed no orders for any kind of side rails.</p> <p>Review of Resident #22's Side Rail Assessment, dated 6/24/24, revealed: Resident expressed a desire to have side rails raise in bed for their own safety and/or comfort? Yes. Is the resident able to get in and out of bed? Yes. Is the resident able to get in and out of bed safely? Yes. Does the resident have a history of falls? Yes. Summary of Findings: The resident requested side rails while in bed, 1/4 rails, right rail, left rail. Comments: Patient requires bed rail on B side for bed mobility and transfers. Signed by the Director of Rehabilitation.</p> <p>Review of Resident #22's electronic record revealed no consent for the side rails informing the resident and/or their responsible party of the risks and benefits of the side rail(s).</p> <p>Observation and interview on 8/6/24 at 10:49 a.m. revealed Resident #22 had 1/4 rails on both sides of her bed. Resident #22 said she did not know why she had the rails; they were built onto the bed. Resident #22 said she did not mind the rails, but she did not use them.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and record review on 08/08/24 at 03:34 PM the MDS Coordinator stated the system for side rails were, therapy did an assessment, if rails were indicated the ADON got a consent from the resident or the responsible party. The MDS Coordinator said once the consent was obtained, she would get the order and do the care plan. The MDS Coordinator checked Resident #22's electronic file and said she did not see a consent for side rails. The MDS Coordinator said as far as she knew Resident #22 did not need side rails. The MDS Coordinator stated therapy did assessments on everyone in Mid-June and she (the MDS Coordinator) was given a list of residents who were indicated for side rails. The MDS Coordinator showed the State Surveyor the list of residents assessed for side rails and Resident #22's column had a dash through it. The MDS Coordinator explained that meant Resident #22 did not need side rails and the MDS Coordinator did not know why Resident #22 had any. The MDS Coordinator said she care planned side rails according to the list. The MDS Coordinator said she would have to get consent from Resident #22's responsible party because Resident #22 had dementia and was very forgetful.</p> <p>Interview on 08/08/24 at 03:44 PM the DON confirmed the MDS Coordinator's list showed Resident #22 should not have side rails. The DON said she did not know why Resident #22 had the rails and would have to go look. At 3:46 p.m. the DON came back and said Resident #22 decided she wanted the rails later. When asked about the consent the DON left and returned with a consent signed by the resident.</p> <p>Interview on 08/08/24 at 04:29 PM the Administrator was informed Resident #22 did not have siderail consent, order, or care plan. The Administrator said Resident #22 had the consent now. The Administrator said he did not understand why there were side rails on the bed at all because the facility just bought new furniture and all the new beds had grab bars for them.</p> <p>Review of the facility's policy and procedure on Bed Safety and Bed Rails, revised August 2022, revealed:</p> <p>Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for the use of bed rails has been met.</p> <p>The use of bed rails or side rails (including temporarily raising the side rails for episodic use during car) is prohibited unless the criteria for the use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent.</p> <p>Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The follow information will be included in the consent:</p> <ul style="list-style-type: none"> <li>a. the assessed medical needs that will be addressed with the use of bed rails;</li> <li>b. The resident's risks from the use of bed rails and how these will be mitigated;</li> <li>c. The alternatives that were attempted but failed to meet the resident's needs; and</li> <li>d. the alternatives that were considered but not attempted and the reason.</li> </ul>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221</b></p> <p>Based on observations, interviews, and record reviews the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed.</p> <p>The facility failed to use pasteurized eggs for fried eggs for the residents.</p> <p>The facility failed to ensure temperatures of the mechanically altered diets were checked for safe holding temperatures.</p> <p>The facility failed to take out sweet potatoes in the dry storage when they were beginning to show signs of rot.</p> <p>The facility failed to keep the freezer clean, the freezer floor had food particles and debris.</p> <p>The facility failed to store dishes in a manner to prevent contamination, dishes were stored face-up.</p> <p>Facility staff failed to wear effective hair restraints.</p> <p>Facility staff failed to set up trays in a manner that prevented cross contamination, staff put their bare hands on the eating surface of the resident's bowls.</p> <p>These deficient practices could place residents who received prepared meals from the kitchen at risk for food borne illness and cross-contamination.</p> <p>Findings included:</p> <p>Initial kitchen observation on 8/6/24 at 9:40 a.m. revealed:</p> <ul style="list-style-type: none"> <li>-The facility had a box and a half of non-pasteurized shelled eggs, there were no pasteurized eggs seen in the refrigerator.</li> <li>-The dry storage had a box of sweet potatoes in it. Two of the sweet potatoes were beginning to rot, they were soft and had white around the soft spot.</li> <li>-The walk-in freezer had food debris under all three shelves.</li> <li>-Bowls, saucer plates, and coffee mugs were stored face up on a shelf by the door.</li> </ul> <p>Observation on 8/6/24 at 11:26 a.m. revealed a resident had a soft fried egg on their plate left in their room from breakfast. The resident said the Dietary Manager fixed her soft fried eggs (egg yolks are runny) because that was their preference.</p> <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 - Many</p>	<p>Observation in the kitchen on 8/7/24 at 2:20 p.m. revealed:</p> <ul style="list-style-type: none"> <li>-The Dietary Manager setting up the dessert bowls with his bare hands. While unstacking the bowls, the Dietary Manager put his bare hands on the inside of the bowl, touching the eating surface of the bowl.</li> <li>-The mushy/rotting sweet potatoes were still in the dry storage.</li> </ul> <p>Observation on 8/8/24 at 11:00 a.m. revealed the Dietary Manager's beard restraint was not effective and his moustache was not contained.</p> <p>Observation on 8/8/24 at 11:00 a.m. revealed the Dietary Manager taking five portions of chicken and placing it in the food processor. The Dietary Manager ran the blender so it was at a mechanical soft texture (chopped fine enough that residents with a chewing problem would not choke on it but it still had the texture of regular food), placed it in a pan, covered the pan, and placed the pan in the oven. Then the Dietary Manager made mechanical soft carrots and then puree carrots. He covered the carrots and placed directly on the steam table. At 11:13 a.m. the Dietary Manager took temperatures of all regular meal options - the main and the substitute which were not at temperature and the Dietary Manager took immediate action to get the food to the right temperature.</p> <p>Observation and interview on 8/8/24 at 11:29 a.m. revealed the first tray of food served. The Dietary Manager did not check the temperature for: the mechanical soft chicken, the mechanical soft carrots, the puree chicken, or the puree carrots. At 11:46 a.m. the first mechanical soft tray was served. At 12:09 p.m. the Dietary manager took the plastic covered bowls of puree and labeled them. At 12:09 p.m. the State Surveyor asked the Dietary Manager if he took temperatures of everything, and he said he did. The State Surveyor asked about the mechanical soft chicken, and he thought about it and said he was not sure. The Dietary Manager was informed he did not take temperatures of the puree, the mechanical soft chicken, or carrots.</p> <p>Interview on 8/8/24 at 12:09 p.m. after the meal service, the Dietary Manager looked in the mirror and agreed his beard restraint was not effective.</p> <p>Observation, interview, and record review on 8/8/24 at 2:02 p.m. the Dietary Manager he thought the kitchen was going alright until he realized he did not take the temperatures of the mechanically altered diets. The Dietary Manager stated over all he thought the kitchen went well. He said he believed the eggs were pasteurized. At that time, the Dietary Manager and the State Surveyor went to check the eggs and they were not pasteurized. The box read eggs to be cooked all the way through to prevent illness. The Dietary Manager said the potential outcome to the residents for eating soft fried eggs were they could get food poisoning. The Dietary Manager stated the kitchen was deep cleaned every weekend but at the end of every shift rotation, the different shifts cleaned everything top to bottom. The Dietary Manager was shown the sweet potatoes that were still in dry storage, and he said he would not eat them. The Dietary Manager stated glasses were stored drinking side down so that nothing fell into it. When asked why he would not store plates and bowls the same way he responded touche. The Dietary Manager said he would not be ok with someone's hands in the bowl he was eating out of, and it was not ok to be touching the eating surface of the bowls. When informed he was the one touching the inside of the bowl, he said he would have to pay more attention.</p> <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 - Many</p>	<p>Interview on 8/8/24 at 2:32 p.m. the Administrator stated the Dietary Manager knew he was supposed to order pasteurized eggs for the residents to eat. The Administrator was informed of the food debris on the freezer floor under the shelves and responded ok.</p> <p>The Administrator said it would not be ok for someone to touch the eating surface of a bowl. The Administrator said at his house he kept the glasses drinking side down to protect from contamination, he guessed it would be the same at the facility for bowls, and he had never thought about saucers being face side up. The Administrator was informed of the sweet potato and asked for clarification on how mushy/rotten the potato was. The Administrator informed State Surveyor that the Dietary Manager made him aware of the temperatures not taken on the mechanically altered foods. The Administrator said he did not have additional information to add.</p> <p>Review of the facility's policy and procedure on Food Preparation and Service, revised November 2022, revealed:</p> <p>Food and nutrition services employees prepare, distribute, and serve food in a manner that complies with safe food handling practices.</p> <p>Policy interpretation and Implementation</p> <ol style="list-style-type: none"> <li>1. Danger Zone means temperatures above 41 degrees F and below 135 degrees F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. Potentially Hazardous Foods or [NAME]/Temperature Control for Safety Foods held in the danger zone for more than 4 hours (if being prepared at ambient temperature) or 6 hours (if cooked and cooled) may cause a foodborne illness outbreak if consumes.</li> <li>2. Potentially Hazardous Food or Time/Temperature Control for Safety Food means food that requires time/temperature control for safety to limit the growth of pathogens (i.e. bacteria or viral organisms capable of causing a disease or toxin formation). Examples of PHF/TCS Foods include ground beef, poultry, chicken, seafood (fish or shellfish) cut melon, unpasteurized eggs, milk, yogurt and cottage cheese.</li> <li>3. Food Preparation means the series of operational processes involved in preparing foods for serving such as: washing, thawing, mixing ingredients, cutting, slicing, diluting concentrates, cooking, pureeing, blending, cooling and reheating.</li> <li>4. Food Distribution means the processes involved in getting food to the resident. This may include holding foods hot on the steam table or under refrigeration for cold temperature control, dispensing food portions for individual residents, family style and dining room service, or delivering meals to residents' rooms or dining areas etc. When meals are assembled in the kitchen and then delivered to residents' rooms or dining areas to be distributed, covering foods is appropriate, either individually or in a mobile food cart.</li> <li>5. Food Service means the processes involved in actively serving food to the resident. Ehen actively serving residents in a dining room or outside a resident's room where trained staff are serving food/ beverages choices directly from a mobile food cart or steam table, there is no need for food to be covered. However, food should be covered when traveling a distance (i.e., down a hallway, to a different unit or floor).</li> </ol> <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>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30057</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 (Resident #1, #12 and #28) of 4 residents reviewed for infection control practices.</p> <p>LVN A failed clean and sanitize the glucometer (portable device that measure blood glucose levels) with the appropriate sanitizing wipes while checking Resident #1 and Resident #12's blood sugar.</p> <p>RN D failed to wash or sanitize her hands in between glove changes during wound care for Resident #28.</p> <p>This failure could affect the residents by placing them at risk for the spread of infection.</p> <p>Finding included</p> <p>RESIDENT #1</p> <p>Record review of Resident #1's admission record dated 08/08/2024 indicated she was admitted to the facility on [DATE] with diagnosis of type 2 diabetes. She was [AGE] years of age.</p> <p>Record review of Resident #1's care plan dated 08/06/24 indicated in part: Problem: Diabetes: Resident is at increased risk for complications related to diabetes type 2. Goal: Resident will have blood glucose within normal . Interventions: Accu-checks as ordered per MD.</p> <p>Record review of Resident #1's order summary report with active orders as of: 08/08/2024 indicated in part: ACCUCHECKS (a proprietary blood glucose measuring system used for monitoring of glucose) CALL MD IF ABOVE 400 OR BELOW 60 HOLD INSULIN FOR BLOOD GLUCOSE BELOW 110 CLEAN GLUCOMETER BEFORE &amp; AFTER EACH USE before meals and at bedtime. order date 11/09/2023.</p> <p>Record review of Resident #12's admission record dated 08/08/2024 indicated she was admitted to the facility on [DATE] with diagnosis of type 2 diabetes. She was [AGE] years of age.</p> <p>Record review of Resident #12's care plan dated 10/06/23 indicated in part: Problem: Diabetes: Resident is at risk for hyper/hypoglycemia (high/low blood sugar). Goal: Diabetic status will remain stable evidenced by blood glucose levels within resident's normal limits and absence of signs of hypoglycemia or hyperglycemia for the next 90 days. Interventions: Accu-checks as ordered per MD.</p> <p>Record review of Resident #12's order summary report with active orders as of: 08/08/2024 indicated in part: ACCUCHECK TID AND HS CALL MD IF ABOVE 400 OR BELOW 60 HOLD INSULIN FOR BLOOD GLUCOSE BELOW 110 CLEAN GLUCOMETER BEFORE &amp;AFTER EACH USE before meals and at bedtime related to TYPE 2 DIABETES. Order date 03/01/2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Sterling County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  309 Fifth St Sterling City, TX 76951	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 08/06/24 at 11:08 AM LVN A performed a blood sugar check by checking Resident #12's blood with the use of a glucometer and a test strip. The LVN used an alcohol prep pad to clean and sanitize the glucometer after checking the resident's blood sugar.</p> <p>During an observation 08/06/24 at 11:15 AM LVN A performed a blood sugar check by checking Resident #1's blood with the glucometer she had previously cleaned and sanitized with the alcohol pad.</p> <p>During an interview on 08/06/24 at 04:36 PM LVN A said that she usually used the germicidal wipes and not the alcohol prep pads to clean and sanitize the glucometer in between resident use. The LVN said the reason she used the alcohol prep pad was because it was there, and she got nervous because the State Surveyor was observing her. LVN A said she knew it was inappropriate to use the alcohol pads to clean and sanitize the glucometer but again she said she had gotten nervous and used the wrong thing to sanitize the glucometer. The LVN said she had been trained to use the germicidal wipes to sanitize the glucometers in between residents. LVN A said if she did not use the germicidal wipes then that could possibly lead to cross contamination and the spread of germs. The LVN again said she had gotten nervous and messed up and had not used the correct wipes to clean the glucometer.</p> <p>During an interview on 08/08/24 at 02:00 PM the DON was made aware of the observation of LVN A sanitizing the glucometer with an alcohol pad in between checking resident's blood sugars. The DON said it was expected for the nurses to use the germicidal wipes to sanitize the glucometer in between resident use. The DON said the alcohol pads were not appropriate as they did not sanitize the glucometer as the germicidal wipes did plus it was the manufacturers recommendation to use germicidal wipes to sanitize the glucometer. The DON said if the nurses did not use the germicidal wipes that could possibly lead to cross contamination such as the spread of germs. The DON said she was responsible for doing the training on how to sanitize the glucometer and had recently done some training with the staff to include the nurse that had not used the germicidal wipe. The DON said the failure occurred because the nurse probably got nervous and used the alcohol wipe since it was available instead of using the germicidal wipes.</p> <p>During an interview on 08/08/24 at 02:28 PM the Administrator said was made aware of the observation of LVN A sanitizing the glucometer with an alcohol pad in between checking resident's blood sugars. The Administrator said the nurses were supposed to use the wipes in the containers with the purple tops (Germicidal wipe container). The Administrator said it was the DON's responsibility to train the nursing staff on proper sanitizing of the glucometers .</p> <p>RESIDENT #28</p> <p>Resident #28 was a [AGE] year-old female. Resident #28 was admitted to the facility on [DATE] with diagnosis that included a fracture of unspecified part of the lumbosacral spine and pelvis, urinary tract infection, dementia, and moderate protein calorie malnutrition.</p> <p>Record review of Resident #28's MDS dated [DATE] revealed a BIMS score of 03 indicating severe cognitive impairment. Under Section M - Skin Conditions, M1200. Skin and Ulcer/Injury Treatments selected was pressure ulcer/injury care, application of nonsurgical dressings (with or without topical medications) other than to feet, and applications of ointments/medications other than to feet.</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>Record review of Resident #28's care plan revealed in part a problem of pressure ulcer: Resident has an unstageable pressure ulcer to right inner elbow measurements (6/14/2024) unstageable, stage 3 pressure ulcer to her right elbow: (6/14/24) and is at risk for impaired healing r/t advanced age and impaired mobility to right upper extremity. With interventions that include provide wound care to Stage 3 pressure ulcer to right elbow as ordered per MD . Provide wound care to Unstageable Pressure ulcer to right inner elbow as ordered per MD.</p> <p>Record review of Resident #28's order summary for August 2024 revealed in part wound care: abrasion/lesion to rt front thigh, apply gentamycin ointment to wound bed, cover w/bordered dressing daily until healed monitor for s/s of infection. every day and night shift. Wound Care: Right elbow skin tear-cleanse with wound cleanser, pat dry w/gauze, apply gentamycin ointment to wound bed, cover w/bordered dressing daily until healed. Everyday shift for pressure ulcer May use TAO until Gentamycin is available. Wound Care: Right inner elbow pressure ulcer - unstageable - cleanse with wound cleanser, apply Mupirocin ointment, cover w/gauze, secure w/ cover roll stretch tape, daily and PRN, apply Ace wrap to protect dressing, until healed. as needed for dressing soiled, wet, or dislodged. Wound Care: Right inner elbow pressure ulcer - unstageable - cleanse with wound cleanser, apply Mupirocin ointment, cover w/gauze, secure w/ cover roll stretch tape, daily and PRN, apply Ace wrap to protect dressing, until healed, every day shift for pressure ulcer.</p> <p>Observation of wound care on 08/08/24 at 02:21 PM performed for Resident #28 by RN D with the ADON assisting with resident positioning. RN D did not wash hands prior to prep for care. RN D did use hand sanitizer. RN D did not clean the bedside table prior to care. RN D placed a sterile drape as a barrier on the bedside table then flipped the barrier over. RN D placed all the supplies on top of this barrier. RN D placed extra gloves on the resident's bed. After removing the dressing to the resident's elbow, RN D removed gloves and changed into new gloves. RN D did not use hand sanitizer or wash hands between glove changes. RN D grabbed keys out of her pocket wearing the same gloves she bandaged the elbow with then removed gloves. After returning from outside of the room to obtain a bandage from the supply cart, RN D hand sanitized hands and then applied gloves. RN D placed extra gloves on the resident's bed. After taking the old dressing off of the resident's leg, RN D did not change gloves between dirty dressing and clean dressing. RN D then reached into her pockets looking for a marker to date the bandage. RN D touched all four of her pockets on her scrubs with the same gloves. Without changing gloves RN D, touched her watch and, dated the dressing, then placed the marker and scissors back in her pockets.</p> <p>In an interview on 08/08/24 at 03:01 PM with RN D stated she thought she could have been more organized prior to her care but did not think she needed to change anything. RN D stated she does normally clean the bedside table with either Sani-wipes or Bleach wipes. RN D stated she was just nervous. After walking through the wound care she provided, RN D realized she did not change gloves or hand sanitize between glove changes. RN D stated this could be a concern for cross contamination.</p> <p>In an interview on 08/08/24 at 03:30 PM the ADON, who was present for the incontinent care, did not have a concern with the care RN D provided. After going through the wound care that was provided, the ADON acknowledged that RN D did not change gloves or hand sanitize. The ADON stated all items should be cleaned before and after use. The ADON stated all staff should be washing hands or using hand sanitizer before care, between glove changes, and after care .</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>Record review of the facility's policy titled Obtaining a fingerstick glucose level and dated October 2011 indicated in part: The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level. Equipment and supplies - The following equipment and supplies will be necessary when performing this procedure: Disinfected blood glucose meter (glucometer) with sterile lancet. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice.</p> <p>According to Center for Disease Control (CDC), Whenever possible, assign blood glucose meters to a person and do not share them. Dedicated meters should be cleaned and disinfected per the manufacturer's instructions and, at a minimum, anytime the device is reassigned to a different person. Dedicated meters should be stored in a manner that prevents cross-contamination and inadvertent use for the wrong patient. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per the manufacturer's instructions, to prevent the spread of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected, it should not be shared. Retrieved from <a href="https://www.cdc.gov/injection-safety/hcp/infection-control/index.html">https://www.cdc.gov/injection-safety/hcp/infection-control/index.html</a>. August 08, 2024 .</p>		