STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675963	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Pointe Nursing and Rehabilitation	7804 Virgil Anthony Blvd Watauga, TX 76148

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405 Based on observation, interview, and record review, the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 3 of 5 residents (Residents #1, #6, and #7) reviewed for quality of care, in that: 1. The facility failed to prevent Resident #1's wound from increasing in size. Resident #1's Stage 3 coccyx wound measured 5 cm x 1.5 cm x 0.1 cm on 09/03/24 and increased in size to 12 cm x 10 cm x 0.1 cm when last seen by the WMD on 09/10/24. 2. The facility failed to ensure that Resident #6's low air loss mattress pump was plugged in. 3. The facility failed to ensure that Resident #7's low air loss mattress pump had the correct settings. These failures placed residents at risk of developing new or worsening pressure ulcers. Findings included: RESIDENT #1 A record review of Resident #1's Quarterly MDS Assessment, dated 08/25/24, revealed a [AGE] year-old female who admitted on [DATE]. Resident #1 had a history and diagnoses of Cerebral Infarction, uns. ([ischemic stroke] is when there's some kind of blockage that keeps blood from reaching all areas of the brain); T2DM (a chronic condition that affects the way the body processes glucose [blood sugar]); Vascular Dementia (a brain condition that affects thinking, memory, and behavior, and is caused by damaged blood vessels in the brain); Pressure Ulcer of Sacral Region (made up of the sacrum, a triangular bone at the base of the spine, and the coccyx [tailbone]), Stage 3; Anxiety and MDD (a mood disorder that causes a persistent feeling of sadness and loss of interest). A BIMS score of 9 suggested Resident #1 had a moderate cognitive decline. Resident #1 required maximal assistance from staff for ADLs. Resident #1 was always incontinent of bowel and bladder. The Quarterly MDS reflected Resident #1 had a pressure ulcer/injury, was at risk of developing pressure ulcers/injuries, and had one or more unhealed pressure ulcers/injuries. Resident #1 was transferred to the hospital on 09/15/24 for a non-wound related issue. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #1's comprehensive care plan, last care plan review completed 07/12/24 reflected: [Resident #1] has Diabetes Mellitus and is at risk for complications. (Initiated: 06/27/23). Interventions included Check all of body for breaks in skin and treat promptly as ordered by doctor; Monitor/document/report to MD PRN for s/sx of infection to any open areas: Redness, Pain, Heat, swelling or pus formation; and Notify the charge nurse for open areas, sores, pressure areas, blisters, edema or redness to the feet. [Resident #1] has a potential for pressure ulcer development/alteration in skin integrity r/t impaired mobility requiring assist, obesity, incontinence, DM. Resident has wounds to coccyx [tailbone] and left heel. (Initiated: 06/27/23). Interventions included Assess/record/monitor wound healing at least weekly; Follow facility policies/protocols for the prevention/treatment of skin breakdown; and Notify nurse immediately of any new areas of skin breakdown; . needs assistance to turn/reposition. A record review of Resident #1's Order Summary Report printed 09/21/24 reflected: Order date 08/28/24: Clean left heel with NS, pat dry, paint with betadine and leave open to air r/t DTI (a type of pressure ulcer that occurs when soft tissue is damaged by prolonged pressure or shear forces) daily and PRN. Order date 09/03/24: Cleanse stage 3 pressure wound to coccyx with NS, pat dry, apply calcium silver alginate, and cover with gauze island with border. One time a day for stage 3 pressure wound to coccyx for 30 days. [Discontinued 09/10/24] Order date 09/10/24: cleanse unstageable (due to necrosis) to the coccyx with 1/4% Dakin's Solution, gently pack wound using 1/4% Dakin's wet to moist Keflex gauze, apply ABD pad, and cover with border gauze island dressing daily and PRN soilage/dislodgement. One time a day for Unstageable pressure wound to coccyx for 30 days. Record review of Resident #1's September 2024 TAR revealed the orders were implemented as written. Record review of Resident #1's WMD visit notes reflected: Date: 08/20/24. Resident #1 was seen for wounds on left heel; coccyx. Stage 3 pressure wound, coccyx - Resolved on 08/20/24. Date: 09/03/24. Resident #1 was seen for wounds on left heel; coccyx. Stage 3 pressure wound, coccyx. Duration greater than 1 day. Objective healing/maintain healing. Wound size: 5 cm x 1.5 cm x 0.1 cm. Exudate: Moderate Serous. 100% granulation tissue. Dressing Treatment Plan: Apply Alginate calcium with silver. Cover with gauze island with border dressing. Apply zinc ointment to peri wound. Once daily. Recommendations: Off-load wound; Reposition per facility protocol. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Date: 09/10/24. Resident #1 was seen for wounds on coccyx; left heel. Unstageable (due to necrosis) pressure wound, coccyx. Duration greater than 8 days. Objective healing/maintain healing. Wound size: 12 cm x 10 cm x 0.1 cm. Odor. Exudate: Moderate Serosanguinous. Thick adherent devitalized necrotic tissue (70%), Sough (10%), Granulation tissue (20%). Wound progress: Exacerbated. Dressing Treatment Plan: Apply sodium hypochlorite solution (Dakin's). Use 1/4% Dakin's solution wet to moist Keflex gauze to loosely pack wound. Cover with ABD pad. Apply zinc ointment to peri wound. Once daily. Recommendations: Off-load wound; Reposition per facility protocol. RESIDENT #6 A record review of Resident #6's Quarterly MDS Assessment, dated 8/19/24, revealed a [AGE] year-old male who admitted on [DATE]. Resident #6 had a history and diagnoses of T2DM (a chronic condition that affects the way the body processes glucose [blood sugar]); Muscle wasting and Atrophy; and Pressure Ulcer of Sacral Region, Stage 4. A BIMS score of 12 suggested Resident #6 had a moderate cognitive decline. Resident #6 had a suprapubic indwelling urinary catheter ([SPC] placed 07/19/24) and was frequently incontinent of bowel. A record review of Resident #6's comprehensive care plan, initiated 03/30/23, next review date 11/06/24, reflected: [Resident #6] has an actual pressure ulcer and the potential for pressure ulcer development/alteration in skin integrity r/t impaired mobility, cognitive impairment, Diabetes, nutritional deficits, and occasional bowel incontinence. Stage 4 pressure ulcer to sacral area. Interventions included Administer protein supplements as ordered; Administer treatments as ordered and monitor for effectiveness; Administer Vitamin C as ordered; Assess/record/monitor wound healing at least weekly; Follow facility protocols for the prevention/treatment of skin breakdown; and requires the use of an air mattress. A record review of Resident #6's Order Summary Report printed 09/21/24 reflected: Order date 08/08/24: Ensure LAL mattress is on and inflated every shift for wound care. Record review of Resident #6's September 2024 TAR revealed the orders were implemented as written with nurse responses of on, yes, or ok. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 09/22/24 at 1:57 PM, Resident #6 was in a semi-side-lying (left lateral and back) position on a LAL mattress with a digital pump placed at the foot of the bed. The pump's power button was dim and in the ON position, the weight setting in lbs knob pointed towards 150 (lbs.), there was no sound, and the mattress did not appear to be inflated. The pump's plug was noted on the floor, under the bed, not inserted into a power outlet. Resident #6 had a SPC in place at the lower midline abdominal area below the belly button and above the pubic bone. A 4 x 4 split gauze was secured over the SPC insert site. There was no indwelling urinary catheter strap in place to prevent pulling or tugging. The SPC tubing laid across Resident #6's right leg connected to a closed system drainage bag that hung on the bed rail. Resident #6 was pleasant and willingly participated in an interview. Resident #6 was alert and oriented to person, place, time of day, and situation. Resident #6 said his bed was not on, it has been off. Resident #6 could not say how long the mattress was not inflated. Resident #6 denied current pain related to the non-functioning mattress. RESIDENT #7 A record review of Resident #7's Quarterly MDS Assessment, dated 06/18/24, revealed a [AGE] year-old female who admitted on [DATE]. Resident #7 had a history and diagnoses of Arthritis; Alzheimer's Disease; Malnutrition; Anxiety Disorder; and Depression. A BIMS score of 9 suggested Resident #7 had a moderate cognitive decline. Resident #7 was always incontinent of bowel and bladder. Resident #7 MDS assessment reflected a risk of developing pressure ulcers/injuries. A pressure reducing device for bed reflected as skin and ulcer/injury treatments in place. A record review of Resident #7's comprehensive care plan, last reviewed 06/12/24, reflected: [Resident #7] has a potential for pressure ulcer development. Resident has abscess to left chest (Initiated: 05/29/24; Revision: 09/17/24). Interventions included Administer treatments as ordered and monitor for effectiveness (Initiated: 09/18/24); assess/record/monitor wound healing at least weekly (Initiated: 09/18/24); Follow facility policies/protocols for the prevention/treatment of skin breakdown; and Resident has a low air loss mattress (Initiated: 08/16/24). A record review of Resident #7's Order Summary Report printed 09/21/24, reflected in part: Start date 09/04/24: Cleanse wound to coccyx with NS, pat dry, apply zinc ointment daily and PRN soilage/dislodgement two times a day for wound to coccyx for 30 days. [discontinued 09/17/24] A record review of Resident #7's Order Summary Report printed 09/22/24, reflected in part: Start date 09/22/24: Low air loss mattress. Nurse to check for proper functioning and settings every shift to promote wound healing. Record review of Resident #7's weight summary revealed last weight on 09/09/24 at 4:26 PM was 98.1 pounds. During an observation on 09/21/24 at 3:40 PM, Resident #7 laid on her back on a LAL mattress with a digital pump placed at the foot of the bed. The pump's power button was in the ON position and the weight setting in lbs knob pointed towards 280 (lbs.). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/21/24 at 2:37 PM, the WCN said that Resident #1 was seen by the WMD for a Stage 3 coccyx wound on 09/03/24 that was resolved on 08/20/24. The WCN said that the wound had visibly increased and was documented by the WMD 09/10/24. The WCN said that she tried to monitor Resident #1 throughout the day during the week, because Resident #1 could not reposition herself and wanted to make sure Resident #1 needed to keep the coccyx wound offloaded. The WCN said she did not work on 09/11/24 or 09/12/24. The WCN said when she returned on 09/13/24 the wound length had increased, there was some slough over the wound, and a slight odor. The WCN said that Resident #1 was discharged from the facility when she returned to work on Monday, 09/16/24. During an interview on 09/21/24 at 3:55 PM, LVN B said that she made sure the LAL digital pumps worked by making sure the pump was turned on. LVN B said that she felt the mattress to make sure it was inflated. LVN B could not verbalize what the appropriate settings should be on Resident #7's pump. LVN B said that the maintenance workers determined the settings when the bed was delivered to the room. During an interview on 09/22/24 at 3:06 PM, RN C said that she was the weekend supervisor. RN C said that she only worked at the facility every other weekend. RN C said that her responsibility was to oversee that nurses and CNAs provided care and services to residents to prevent skin breakdown and promote wound healing by providing incontinent care, turning, and repositioning, every two hours and as needed. RN C said that she performed wound care on the weekends unless she had to fill in for a nurse or medication aide that called in or did not show up for work. RN C said that she performed wound care for Resident #1 on Sunday, 09/08/24. RN C said that she did not recall a sign of infection. RN C said that she performed treatment as the order was written, did not measure the wound, or compared past documentation for changes. RN C said that she did not perform wound care on Saturday, 09/07/24 because she filled in for a medication aide who called off. RN C said the nurse was responsible for their assigned residents wound care. During an interview on 09/22/24 at 3:15 PM, LVN B said that she did not know that Resident #6's LAL mattress pump was not plugged in. LVN B pushed the power button to ON to OFF and back to the ON position. LVN B turned the weight setting knob between numbers. LVN B said she did not know what was wrong. Resident #6 spoke up and said, it does not work. LVN B followed the pumps plug when prompted and saw that the plug was not connected to the electrical outlet. LVN B said, I guess when the CNAs pulled the bed away from the wall to assist the resident, they probably pulled the plug out of the wall. LVN B did not plug the pump into the wall during the surveyor's presence. LVN B said that she learned the weight setting was the resident's current weight. During an interview on 09/22/24 at 4:00 PM, the DON said that she expected nurses to follow facility protocols for pressure ulcer prevention and skin management. The DON said that nurses should know the appropriate settings for a resident's LAL mattress digital pump. The DON said that the LAL mattress assisted with off-loading pressure to the resident to prevent wounds and avoid pre-existing wounds from worsening. The DON said that an in-service was initiated with all nursing staff on LAL mattress digital pump settings. Record review of the facility's Skin Integrity Management policy, revised 10/05/16, reflected: Reposition residents at risk for pressure sore or with pressure sores at least every two (2) hours, if unable to turn themselves. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Use pillows or foam wedges to keep bony prominences from direct contact . The presence of a pressure reducing device/specialty bed does not negate the need to turn/reposition the resident at least every two (2) hours in order to prevent pulmonary and renal complications as well as pressure sores . If eschar or necrotic tissue is present, debridement may be indicated. Physicians do surgical debridement only. Record review of the facility's Physician's Orders undated policy reflected: Purpose: To monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405 Based on observation, interview, and record review, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services for 3 of 3 residents (Residents #6, #8, and #9) reviewed for quality of care. 1. The facility failed to ensure Resident #6, Resident #8, and Resident #9 had an indwelling urinary catheter strap in place to prevent pulling or tugging on 09/22/24. 2. The facility failed to provide Resident #6, Resident #8, and Resident #9 a privacy cover for the indwelling urinary catheter drainage bags on 09/22/24. 3. The facility failed to ensure Resident #8's indwelling urinary catheter was kept off the floor on 09/22/24. These failures could place residents at risk for discomfort, urethral trauma, loss of dignity and urinary tract infections. Findings included: RESIDENT #6 A record review of Resident #6's Quarterly MDS Assessment, dated 8/19/24, revealed a [AGE] year-old male who admitted on [DATE]. Resident #6 had a history and diagnoses of CKD, uns. (kidneys have mild to moderate damage) and severe sepsis secondary to UTI, uns. (a bacterial infection that occurs when bacteria enter the urethra [the hollow tube that lets urine leave the body] and infect the urinary tract). A BIMS score of 12 suggested Resident #6 had a moderate cognitive decline. Resident #6 had a suprapubic catheter ([SPC] placed 07/19/24) and was frequently incontinent of bowel. A record review of Resident #6's comprehensive care plan, initiated 03/30/23, next review date 11/06/24, reflected: [Resident #6] has a suprapubic catheter r/t obstructive uropathy and urinary retention (Initiated: 03/30/23; Revision: 09/06/24). Interventions included . position catheter bag and tubing below the level of the bladder and in a privacy bag (Initiated: 09/01/2024; Revision: 09/06/24); ensure catheter strap in place and holding so that tubing is not pulling on the urethra (Initiated: 07/25/23; Revision: 08/09/23); and ensure foley bag is in privacy bag while in wheelchair (Initiated 07/25/23). A record review of Resident #6's Order Summary Report printed 09/21/24 reflected: Order date 12/12/20: Ensure foley bag was in privacy bag while in bed or wheelchair. Order date 06/07/22: Ensure catheter strap in place and holding every shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Order date 09/03/24: Cleanse suprapubic insertion site with normal saline, pat dry then cover with split 4 x 4 gauze dressing daily/PRN soilage/dislodgement. Order date 09/04/24: UA with C&S one time only for UTI. Order date 09/06/24: suprapubic catheter insertion site culture. One time only for yellow drainage from suprapubic site. Order date 09/09/24: Cephalexin oral capsule 500 mg. Give 500 mg by mouth every 12 hours for UTI until 09/19/24. Record review of Resident #6's September 2024 TAR revealed the orders were implemented as written and the Cephalexin 500 mg antibiotic treatment for UTI was completed on 09/19/24. During an observation and interview on 09/22/24 at 1:57 PM, Resident #6 was in a semi-side-lying (left lateral and back) position in bed. Resident #6 had a SPC in place at the lower midline abdominal area below the belly button and above the pubic bone. A 4 x 4 split gauze was secured over the SPC insert site. There was no indwelling urinary catheter strap in place to prevent pulling or tugging. The SPC tubing laid across Resident #9's right leg connected to a closed system drainage bag that hung on the bed rail. The drainage bag did not have a privacy cover. Resident #9 willingly participated in an interview. Resident #9 was pleasant and cooperative with direct care staff. Resident #9 was alert and oriented to person, place, time of day, and situation. Resident #9 said that the SPC was placed about 2 months ago. Resident #9 said that he used to have an indwelling urinary catheter that was inserted into the urethra (the duct by which urine is conveyed out of the body from the bladder). Resident #9 said that he just finished antibiotics for an UTI a couple days ago (record review indicated Thursday, 09/19/24). Resident #9 said that the nurse came in every morning to clean around his stomach (the SPC insert site) and placed a new dressing over it. Resident #9 denied pain or discomfort at the SPC insert site or symptoms of an UTI. RESIDENT #8 A record review of Resident #8's Entry MDS Assessment, dated 09/06/24, revealed a [AGE] year-old male readmitted on [DATE]. Resident #8 had diagnoses of Bladder Diverticulum (a thin-walled pouch that protrudes from the bladder wall); Retention of Urine; and Pressure Ulcer of Sacral region. Resident #8 had an indwelling urinary catheter and was incontinent of bowel. A record review of Resident #8's comprehensive care plan, initiated 08/12/24 to present, reflected: [Resident #8] has indwelling catheter to promote wound healing (Initiated: 08/12/24; Revision: 09/18/24). Interventions included . position catheter bag and tubing below the level of the bladder and in a privacy bag (Initiated: 08/12/2024; Revision: 09/18/24) and ensure tubing is anchored to the resident's leg or linens so that tubing is not pulling on the urethra (Initiated: 08/12/24; Revision: 09/18/24). A record review of Resident #8's Order Summary Report printed 09/21/24 reflected: Order date 09/07/24: Ensure foley bag was in privacy bag while in bed or wheelchair. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Order date 09/07/24: Ensure catheter strap in place and holding every shift. Every shift change and as needed. Order date 09/07/24: Provide catheter care every shift. Record review of Resident #8's September 2024 TAR revealed the orders were implemented as written. During an observation on 09/22/24 at 2:29 PM, Resident #8 appeared to be asleep in a supine (on back) position in bed. Resident #8 did not have a catheter strap in place to prevent pulling or tugging. Resident #8's drainage bag did not have a privacy cover and the drainage bag rested on the floor beside the bed. RESIDENT #9 A record review of Resident #9's Admission MDS Assessment, dated 8/01/24, revealed a [AGE] year-old male who admitted on [DATE]. Resident #9 had a history and diagnoses of paraplegia with contractures; Neuromuscular dysfunction of Bladder, uns.; UTI; and Candida Auris ([MDRO] a multidrug-resistant organism). A BIMS score of 15 suggested Resident #9 was cognitively intact. Resident #9 had a right- and left-side percutaneous nephrostomy ([PCN] a tube that lets urine drain from the kidney through an opening in the skin on the back), an indwelling urinary catheter, and was frequently incontinent of bowel. A record review of Resident #9's comprehensive care plan, initiated 07/26/24, reflected: [Resident #9] has bladder incontinence (Initiated: 07/26/24). Interventions included Incontinent care at least every 2 hours and apply moisture barrier after each episode. (Initiated 07/26/24; Revision: 08/13/24); Monitor/document for s/sx UTI. [Resident #9] has Urinary Tract Infection (Initiated: 09/06/24; Revision: 09/10/24). Interventions included Give antibiotic therapy as ordered and provide incontinence care as needed. The care plan did not reflect a focus or interventions for percutaneous nephrostomies or indwelling urinary catheter. A record review of Resident #9's Order Summary Report printed 09/21/24, reflected in part: Start date 07/25/24, Empty nephrostomy drainage bag bilateral; Empty the left and right nephrostomy tube and enter the output every shift; Enhanced Barrier Precautions every shift; Ensure catheter strap in place and holding every shift change as needed; Ensure foley bag is in privacy bag while in bed or wheelchair every shift; Provide catheter care; and Foley urinary catheter 16 FR/10 mL to gravity drainage every shift. Record review of Resident #9's September 2024 TAR revealed the orders were implemented as written and Ciprofloxacin 500 mg antibiotic treatment for UTI was completed on 09/17/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 09/22/24 at 2:30 PM, Resident #9 was sitting up in bed. Resident #9 had an indwelling urinary catheter in place. There was no indwelling urinary catheter strap in place to prevent pulling or tugging. The catheter tubing laid across Resident #9's right leg connected to a closed system drainage bag that hung on the bed rail. The drainage bag did not have a privacy cover. Resident #9 was pleasant and willingly participated in an interview. Resident #9 was alert and oriented to person, place, time of day, and situation. Resident #9 said that he had nephrostomy tubes to his right and left kidney. Resident #9 said that he also had an indwelling urinary catheter inserted into the urethra (the duct by which urine is conveyed out of the body from the bladder). Resident #9 said that he had a follow up appointment with his urologist in October. Resident #9 said that the staff never placed a strap to prevent the catheter tubing from getting pulled or tugged. Resident #9 said that he just finished antibiotics for an UTI a few days ago (record review indicated Tuesday, 09/17/24). Resident #9 said that the nurse provided catheter care every morning and the CNAs emptied the drainage bag before the shift change. Resident #9 denied pain or discomfort at the SPC insert site or symptoms of an UTI. During an interview on 09/22/24 at 2:39 PM, CNA E said that she reviewed facility training videos on catheter care and it had been covered during in-services. CNA E said that she would empty the drainage bag when providing peri-care to a resident and would report how much, if the urine had an odor, and if dark in color because of a possible UTI to the nurse. CNA E said that there should be a blue cover on the catheter drainage bags for privacy and dignity. CNA E said it was the nurse and the CNAs responsibility to ensure a privacy cover was on the drainage bags. CNA E could not explain why Residents #6, #8, and #9 did not have privacy covers or why she did not retrieve a privacy cover and place on the drainage bag. During an interview on 09/22/24 at 3:15 PM, LVN B said she worked weekend double shifts (6A -2P; 2P - 10P). LVN B said she provided catheter care based upon standards of practice, physician orders, and the care plan. LVN B said that she was observed for catheter care competency during new hire training and orientation. LVN B said that she checked for placement, for signs of infection such as redness, discharge, or swelling at insert site, and urine characteristics when she provided catheter care daily. LVN B said residents with catheters should have a leg support strap in place to prevent trauma or the catheter tubing from being pulled out. LVN B said that catheter drainage bags should have a privacy cover. LVN B could not explain why Resident's #6, #8, and #9 did not have a catheter stabilization device in place or a privacy cover on the drainage bag. LVN B said that all direct care staff were responsible for making sure a privacy cover was on the catheter drainage bag. LVN B said that she was the primary responsible person when assigned to the resident. LVN B said that she would place privacy covers on the drainage bags and ensure a leg support strap was in place. LVN B said that Resident #8's drainage bag probably rested on the floor because [Resident #8] bed must remain in the lowest position when in bed. Walking rounds revealed LVN B followed through with privacy covers and stabilization devices were in place and Resident #8's bed was raised slightly enough to prevent the catheter bag from resting on the floor. (continued on next page)

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	675963	A. Building B. Wing	09/23/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/22/24 at 4:00 PM, the DON said that the implementation of care plan interventions was reviewed every morning during the clinical meeting. The DON said that a preceptor observed and monitored nurses for competency skills and would sign off on the competency skills check off when successfully met. The DON said that nurses who were successfully checked off for catheter care competencies and skill sets were allowed to insert, provide care for, and remove indwelling urinary catheters. The DON said that nephrostomy tube care should be included in nurse competency skills checkoffs but was not sure. The DON said that she was employed for less than 3 months and was not familiar with all the trainings provided to nurses. The DON said that residents were assessed and evaluated if indwelling catheters were clinically indicated. The status of residents' catheter needs was discussed during IDT meetings. The DON said that Resident #6 and Resident #9 had a history of recurring, persistent, or chronic UTIs related to their kidney functions. The DON said that interventions in place for residents with indwelling catheters included water intake, supplements, and catheter care every shift. The DON indicated that residents were at risk of UTI development if the catheter was not changed or managed appropriately. During an interview on 09/22/24 at 5:50 PM, the NFA provided procedures related to catheter insertion. The NFA could not provide a specific policy and procedure related to catheter care. The NFA said that catheter drainage bags should have a privacy cover always applied for resident's dignity; should never be placed on the floor and must remain below the bladder to prevent the backflow of urine into the bladder, which could cause an infection. A specific policy about Catheter Care and Maintenance was requested from the NFA on 09/22/24 at 3:54 PM. A policy on indwelling catheter insertion was provided. The NFA did not have a specific policy as requested. Record review of Catheter Care and Maintenance (2017) reviewed the DO's and DON'Ts of indwelling urinary catheter care and maintenance. The Agency for Healthcare Research and Quality (AHRQ) outlined strategies to prevent catheter-associated urinary tract infections. Guidelines reflect stabilization of the catheter tubing with a special fastening device; keep the drainage bag below level of bladder to drain urine by gravity; and always keep the drainage bag off the floor to keep the catheter clean and free of germs. Catheter Care and Maintenance. Content last reviewed March 2017. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/hai/quality/tools/cauti-ltc/modules/implementation/education-bundles/indwelling-urinary-catheter-use/catheter-care/slides.html

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43815 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 17 residents (Residents #2, #3, #4, and #5) reviewed for infection control. 1. The facility failed to ensure LVN A, MA, and Activity Director monitored residents to ensure they were not exposed to infections during lunch service when Resident #2 was serving lemonade and coffee to residents without proper hand sanitation. 2. The facility failed to ensure Resident #5 did not move around the dining room as he asked other residents for their dinner rolls. This failure placed residents at an increased risk of exposure to infections to include COVID- 19, decreased quality of life, or hospitalization s. Finding included: Review of Resident #2's face sheet dated 9/17/24 reflected he was admitted on [DATE] with diagnoses of Cerebral Infraction due to Embolism (type of stroke that occurs when a blood clot or other blockage travels to the brain and blocks blood flow), Vascular Dementia (brain damage caused by multiple strokes), Type 2 Diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), and Aphasia (language disorder that affects a person's ability to communicate). A record review of Resident #2's Quarterly MDS Assessment, dated 06/23/24, reflected a [AGE] year-old male who admitted on [DATE]. Resident #2 had a history and active diagnoses of stroke, Diabetes Mellitus, Hyperlipidemia, Seizure Disorder, and a BIMS score of 11 suggested Resident #2 had a moderate cognitive impaired. A review of Resident #2's Care Plan dated 09/17/24 did not reflect Resident #2 assisting in the dining room during meals. Review of Resident #3's face sheet dated 9/17/24 reflected he was admitted on [DATE] with diagnoses of Anoxic Brain Damage (occurs when the brain is deprived of oxygen), Type 2 Diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), Gastro-Esophageal Reflux (a digestive disease in which stomach acid or bile irritates the food pipe lining), Hypertension (a condition in which the force of the blood against the artery walls is too high). A record review of Resident #3's Quarterly MDS Assessment, dated 06/27/24, reflected a [AGE] year-old male admitted on [DATE]. Resident #3 had a history and active diagnosis of Traumatic Brain Dysfunction, Hypertension, Diabetes Mellitus, and a BIMS score of 13 suggested Resident #2 was cognitively intact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's face sheet dated 9/17/24 reflected she was initially admitted [DATE] and readmitted [DATE] with diagnoses of End Stage Renal Disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), Chronic Kidney Disease (a condition that occurs when the kidneys are damaged and cannot filter blood properly), Type 2 Diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), Dysphasia (a condition that affects your ability to produce and understand spoken language), and Bacteremia (the presence of bacteria in the blood). A record review of Resident #4's Quarterly MDS Assessment, dated 08/24/24, reflected a [AGE] year-old female who admitted on [DATE] and readmitted [DATE]. Resident #4 had a history and active diagnoses of Anemia, Hypertension, Renal insufficiency, Diabetes Mellitus, Hyperlipidemia, Cerebrovascular Accident, Hemiplegia, and a BIMS score of 13 suggested cognitively intact. Review of Resident #5's face sheet dated 9/17/24 reflected he was admitted [DATE] with diagnoses of Alzheimer's Disease (a brain disorder that gradually destroys memory and thinking skills and eventually the ability to perform daily tasks), Metabolic Encephalopathy (a brain dysfunction caused by a chemical imbalance in the flood that affects the brain), Chronic Kidney Disease (a condition that occurs when the kidneys are damaged and cannot filter blood properly), and Dysphagia (a condition that makes it difficult to move food from the mouth to the esophagus during swallowing). A record review of Resident #5's Quarterly MDS Assessment, dated 06/20/24, reflected an [AGE] year-old female who admitted on [DATE]. Resident #5 had a history and active diagnoses of Non-Traumatic Brain disfunction, Anemia, Hypertension, Renal insufficiency, Alzheimer's Disease, Cerebrovascular Accident, Malnutrition, Anxiety Disorder, Depression, and a BIMS score of 13 suggested cognitively intact. Observation on 09/17/24 at 12:06 PM revealed the Activity Director, LVN-A, and MA were in the dining room assisting residents with meals. At 12:10 Resident #3 raised his glass while looking at Resident #2, Resident #2 went to the table where Resident #3 was sitting and took the glass from him. Resident #2 then went to the ice chest in the dining room and opened the chest, picked up the ice scoop located inside the ice chest and filled the glass with ice, then he put lemonade in the glass and returned the glass to Resident #3. The Activity Director was observed talking to Resident #2 who then left the dining room. Observation on 09/17/24 at 12:25 PM revealed Resident #2 returned to the dining room, Resident #4 called Resident #2 to the table and handed him her coffee cup. Resident #2 took the coffee cup and proceeded to the coffee pot and poured coffee in the cup and handed the cup back to Resident #4. The Activity Director walked over and talked to Resident #2, and he left the dining room. Observation on 09/17/24 at 12:33 PM revealed Resident #5 was rolling around the dining room to all the tables asking other residents if they wanted their dinner roll and received the rolls from other residents. The LVN did not discourage the resident from receiving the rolls from the other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/17/24 at 1:34 PM with the MA revealed LVN-A was responsible for monitoring the residents when they were eating in the dining room. She stated Resident #2 had been asked several times not to hang around in the dining room if he was not eating. She stated Resident #2 did not eat in the dining room, he ate in his room. She stated she had received training on infection control, and she learned the best way to prevent the spread of infection or disease was to wash hands or use hand sanitizer. She stated when Resident #2 passed out drinks to the other residents, they were at risk of receiving drinks that were not on their diet. She stated the residents could have received a regular drink instead of a drink intended for them which could spread infection. Interview on 09/17/24 at 1:44 PM with LVN-A revealed he was responsible for monitoring the residents when they ate in the dining room. He stated Resident #2 was independent and he should not serve other residents drinks in the dining room. He stated Resident #2 had been talked to about getting things for the other residents. He stated he did not know if it had been addressed in Resident #2's Care Plan . He stated when the staff spoke to Resident #2 about getting the drinks, Resident #2 would become confrontational. He stated he had continued to deter Resident #2 from touching the ice and drinks. He stated he had received training on infection control and learned the best way to prevent the spread of infection or disease was to wash hands or use hand sanitizer. He stated the residents had been at risk of infection or disease. Interview on 09/17/24 at 1:52 PM with the Activity Director revealed she learned from a family member of Resident #2 that he had previously worked in a diner or kitchen before he came to live at the facility. She stated Resident #2 had been told he was not supposed to get in the ice. She stated the last time he was told not to get in the ice, he yelled at the person who talked to him. She stated the other residents asked Resident #2 for help all the time. She stated he stood in the dining room to watch if the residents spilled something on the floor and he will get a napkin and pick up what was spilled. She stated if she was busy helping other residents, then Resident #2 would get drinks for the other residents. She stated she did not know if the dining issue of getting drinks for other residents had been discussed on Resident #2's Care Plan. She stated she had been trained on infection control. She stated she learned the best way to prevent the spread of infection or disease was to wash hands and use hand sanitizer. She stated the residents were at risk of contamination when served by Resident #2 who had not been properly trained to serve the residents. Interview on 09/17/24 at 2:05 PM with the Administrator revealed she was not aware Resident #2 had been assisting residents while in the dining room. She stated she had not seen him pass drinks when she was in the dining room. She stated this issue had not been addressed on Resident #2's care plan since she became the administrator of the facility in December of 2023. She stated she was sure the staff tried to discourage Resident #2 from assisting the other residents. She stated the residents were at risk of infection contamination because Resident #2 was not trained on serving drinks. She stated the staff had been in-serviced/trained on preventing infection and disease by washing their hands and using hand sanitizer. Interview on 09/17/24 at 2:13 PM with Resident #3 revealed Resident #2 did assist him with drinks during meals. He stated Resident #2 had given him drinks in the dining room several times. He stated when Resident #2 was in the dining room, he asked Resident #2 to get his drinks, he did not ask the staff. He stated there were staff in the dining room during meals. He stated the staff had told Resident #2 he should not be handing out drinks, but Resident #2 did not listen to what the staff said to him. He stated he had never been sick as a result of drinks he received from Resident #2. He stated he drank regular drinks he did not need any special type of drink. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/17/24 at 2:21 PM with Resident #2 revealed he helped in the dining room to get the residents their drinks. He stated he did not know he was not supposed to help the other residents with their drinks. He stated there was nothing wrong with him assisting the other residents with their drinks. He stated, he was the cleanest person in the building including the nurses. He stated the staff told him not to give drinks, but he gave drinks because he wanted to give drinks. He stated he knew which residents could have regular drinks and those were the only residents he gave drinks. Interview on 09/17/24 at 2:27 PM with Resident #5 revealed he asked the other residents for their rolls when they did not eat them. He stated he liked the rolls. He stated the other residents were not going to eat their rolls. He stated the staff had never told him he could not ask the other residents for their uneaten rolls. He stated when he collected the rolls, he would take them to his room, and he would eat them later. He stated Resident #2 normally went around the dining room and helped other residents with drinks. He stated he never saw the staff tell Resident #2 not to get drinks. He stated he thought Resident #2 was a paid employee. Interview on 09/17/24 at 2:30 PM with Resident #4 revealed Resident #2 helped in the dining room every day. She stated she asked Resident #2 to refill her coffee. She stated she asked Resident #2 most of the time for a refill her drinks instead of the staff. She stated the staff had told Resident #2 he should not get drinks for the other residents, but he got angry and got the drinks anyway. She stated when he got angry, he yelled at the staff, but he would leave the dining room. She stated Resident #2 never got physical with the staff when they told him not to get drinks. Record review of facility Infection Control In-Service Training dated 02/08/24 reflected MA had been trained on proper hand washing technique. Record review of facility Infection Control In-Service Training dated 05/20/24 reflected LVN-A and the Activity Director had been trained on cleaning the medication cart and disinfecting shower chairs. Record review of facility Dietary Services Policy & Procedure Manual, dated 2012, reflected: Nursing Responsibilities at Meal Service Procedure: Nursing Service associates should follow these guidelines regarding meal service: .15. If the facility elects to use volunteers, family members, and other individuals to pass out trays the facility should provide training to those individuals. 16. Individuals providing assistance should also receive hands-on training regarding such topics as various feeding techniques, the proper use of adaptive equipment and in providing/coordinating emergency services should a resident experience a problem while eating. Record review of facility undated Hand Hygiene policy reflected, Except for situations where hand washing is specifically required, antimicrobial agents such as ABHR are also appropriate for cleaning hands and can be used for direct resident care.