

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Town East Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3617 O'Hare Dr Mesquite, TX 75150	
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 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>49640</p> <p>Based on interview and record review, the facility failed to promote the residents' right to receive mail, for all facility residents, in that,</p> <p>The facility failed to distribute mail to residents on Saturdays.</p> <p>This failure could place residents at risk of not receiving mail in a timely manner and could result in a decline in resident's psychosocial well-being and quality of life.</p> <p>Findings include:</p> <p>During a confidential group interview on 07/10/24 at 10:02 am, 5 of 5 residents stated that mail was only delivered Monday through Friday, when the facility's business office was opened and not on weekends.</p> <p>An interview with the [NAME] Director on 07/10/24 at 2:34 pm, revealed she distributed mail Monday-Friday, and the weekend Receptionist distributed the mail on weekends. She stated the Mail Carrier might leave the mail in a lock box outside which required a key to unlock. She said she had a key to unlock the lock box but was unsure if the Receptionist had a key.</p> <p>An interview with the Administrator on 07/10/24 at 11:20 am, revealed she wasn't aware residents weren't receiving mail on weekends. She stated the weekend receptionist did not have a key to the lockbox outside where mail was delivered. She stated mail was not retrieved and distributed on Saturdays.</p> <p>Record review of the facility's Mail and Electronic Communication: Policy Interpretation and Implementation, revised May 2017, revealed, Mail and packages will be delivered to the resident within twenty-four (24) hours of delivery on premises or to the facility's post office box (including Saturday deliveries).</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42971</p> <p>Based on observation, interview, and record review, the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 (Resident #66, Resident #80) of 8 residents reviewed for quality of life.</p> <p>The facility failed to ensure:</p> <p>1- Resident #66 had his fingernails cleaned and trimmed.</p> <p>2- Resident #80 had his fingernails cleaned and trimmed.</p> <p>This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life.</p> <p>Findings include:</p> <p>1. Record review of Resident #66's Quarterly MDS assessment dated [DATE] reflected Resident #66 was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included cerebral infarction (occurs because of disrupted blood flow to the brain due to problems with the blood vessels that supply it), need for assistance with personal care, and cognitive communication deficit. Resident #66 had a BIMS score of 00 which indicated Resident #66 was unable to complete the interview , which indicated Resident #66's cognition was severely impaired. Resident #66 required assistance with personal hygiene.</p> <p>Review of Resident #66's Comprehensive Care Plan, revised 04/22/24, reflected the following: Problem: [Resident #66] has an ADL self-care performance deficit related to cerebral infarction. Goal: [Resident #66] will maintain current level of function. Interventions: . check nails' length and trim and clean on bath day and as needed. Report any changes to the nurse.</p> <p>An observation on 07/09/24 at 10:40 AM revealed Resident #66 was lying in his bed. His right hand was contracted, and the nails were approximately 0.7 cm. The nails on the left hand were approximately 0.3 centimeter in length extending from the tip of his fingers and the underside had dark brown colored residue. Resident #66 was unable to answer questions.</p> <p>2. A record review of Resident #80's Quarterly MDS assessment dated [DATE] reflected Resident #80 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included dementia, lack of coordination, and muscle weakness. Resident #80 had a BIMS score of 10 which indicated Resident #80's cognition was moderately impaired. He required moderate assistance with personal hygiene.</p> <p>A record review of Resident #80's Comprehensive Care Plan, revised 02/24/24, reflected the following: Focus: [Resident #80] has an ADL self-care performance deficit. Goal: [Resident #80] will improve current level of function in through the review date. Interventions: . check nails' length and trim and clean on bath day and as needed. Report any changes to the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation and interview on 07/09/24 at 10:58 AM revealed Resident #80 was laying in his bed. The nails on both hands were approximately 0.3 centimeter in length extending from the tip of his fingers and the underside had dark brown colored residue. Resident #80 did not like his fingernails long and dirty.</p> <p>In an interview with LVN A on 07/09/24 at 11:00 AM, he stated both CNAs and LVNs were responsible for nail care. He stated if a resident had diabetes, only nurses were allowed to trim resident's nails. He stated the risk for not performing nailcare was increased risk of infection and skin break down. He offered to clean and trim both residents' fingernails after the interview.</p> <p>In an interview on 07/11/24 at 8:50 AM with the DON revealed her expectation was that nail care should be provided every shower day and as needed. She stated that both CNAs and Nurses were responsible for doing nail care on all residents; except Nurses were responsible for nailcare if resident had diagnosis of diabetes. She also stated that as the DON she conducted spot checks and daily rounds for monitoring. The DON stated residents who had dirty fingernails could be an infection control issue.</p> <p>Record Review of the facility policy titled Fingernails/Toenails Care of revised February 2018 reflected, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections 1. Nail care includes daily cleaning and regular trimming</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427</b></p> <p>Based on observations, interviews, and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 (Resident #2) of 6 residents reviewed for quality of care.</p> <p>1.The facility failed to promptly test Resident #2 for COVID 19 when nurse practitioner ordered the test on [DATE] until [DATE].</p> <p>2. The facility failed to follow nurse practitioner order for nasal spray for Resident #2 on [DATE], [DATE], and [DATE].</p> <p>These failures could place residents at risk for not receiving or experiencing a delay in treatment or not having health conditions identified promptly.</p> <p>Findings included:</p> <p>Review of Resident #2's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was cognitively intact with a BIMS score of 15 and diagnoses of unspecified sequelae of unspecified cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain), hypertension (high blood pressure), and hyperlipidemia (high levels of fats in blood).</p> <p>Review of Resident #2's progress notes revealed a Physician Progress Note by the Nurse Practitioner (NP) L with a date of service of [DATE] reflected resident had nasal congestion and there was a new order for Flonase.</p> <p>Review of Resident #2's orders revealed an order with an order date of [DATE] and start date of [DATE] by communication method Prescriber Written reflected, Please test to rule out COVID. One time only for 3 days.</p> <p>Review of Resident #2's orders revealed an order dated [DATE] with a start date of [DATE] by communication method Prescriber Written reflected, Fluticasone Propionate Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) 1 application in both nostrils one time a day for nasal congestion for 7 days.</p> <p>Review of Resident #2's July TAR reflected no order for nasal spray for Resident #2.</p> <p>Review of Resident #2's July MAR reflected an order for nasal spray for Resident #2 with a start date of [DATE] and showed not given on date [DATE] or [DATE] and initialed as given by CMA I on [DATE].</p> <p>Interview and observation on [DATE] at 11:09 AM revealed Resident #2 sitting in a wheelchair in her room and stated she was not feeling well; she had some nasal congestion and a slight cough. Resident #2 stated she thought she had a cold.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on [DATE] at 1:24 PM with LVN A stated he was not sure if Resident #2 had an order for a COVID test or if she had been given the test yet. LVN A looked at the orders for Resident #2 and stated that there was an order dated [DATE] and it was categorized incorrectly under laboratory services and should have been under nursing services which meant it was not added automatically to the TAR. LVN A stated that the order expired on [DATE] so he still had time to complete the order. LVN A stated there was not a risk to residents by not having completed the test yet because there was no COVID on the hall.</p> <p>Interview on [DATE] at 1:30 PM with Resident #2 revealed she was not tested for COVID-19.</p> <p>Interview on [DATE] at 2:55 PM with CMA I revealed he saw the nasal spray order for Resident #2 in the MAR but he could not give nasal spray to residents; only a nurse could. So he did not give it to the resident and told a nurse; could not remember which nurse. CMA I stated that he did not give any doses of nasal spray to Resident #2.</p> <p>Interview on [DATE] at 3:12 PM with NP L revealed she was the pulmonary nurse practitioner and recently started working at the facility. NP L stated she saw Resident #2 on [DATE] and ordered the COVID-19 test and nasal spray because the resident complained of nasal congestion and had a slight cough. NP L stated she entered the orders in herself. She stated she expected the COVID-19 test to be done the same day it was ordered and for the nasal spray order to be followed as ordered. NP L stated the risk to residents of not following the order promptly was spread of illnesses or a resident might not be provided prompt treatment.</p> <p>Interview on [DATE] at 3:50 PM with the DON revealed CMAs were not allowed to give nasal sprays, only eye drops, and the order should be in the TAR not in the MAR. The DON stated she did not know Resident #2 had an order for a COVID test until [DATE] and she immediately tested the resident. The DON stated NP L started working at the facility in June of 2024 when the DON was on maternity leave and when NP L put the orders in for Resident #2 she selected the wrong categorization which resulted in the order for COVID-19 test not transferring over to the MAR or TAR. The DON stated NP L also categorized the nasal spray order incorrectly which resulted in it showing up in the MAR instead of the TAR. The DON stated that NP L started working at the facility when she was on maternity leave, and she typically educated all new nurse practitioners personally and was not sure why NP L had not been informed of the proper process. The DON stated she immediately educated NP L on the correct way to enter orders in their system. The DON stated that she also educated the two ADON's to ensure they knew to educate all new nurse practitioners of the proper process for entering orders at their facility if the DON was not at the facility to do it herself.</p> <p>Review of the facility's medication and treatment orders policy titled Medication and Treatment Orders, dated 2001 and revised [DATE], reflected Orders for medications and treatments will be consistent with principles of safe and effective order writing.</p> <p>Review of the facility's administering medications policy titled Administering Medications, dated 2001 and revised [DATE], reflected Medications are administered in a safe and timely manner, and as prescribed . 21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>42971</p> <p>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 (Nurses cart hall 400) of 4 medication carts reviewed for pharmacy services.</p> <p>The facility failed to ensure LVN B, responsible for Nurses Cart Hall 400, removed medications in unsecure containers from the Nurses Cart.</p> <p>This failure could place residents at risk of not having the medication available due to possible drug diversion and at risk of not receiving the intended therapeutic benefit of the medication.</p> <p>Findings Included:</p> <p>Record review and observation on 07/09/24 at 9:27 AM of Nurses Cart Hall 400, with LVN B revealed the blister pack for Resident #55's lorazepam 1 mg tablet (controlled medication used for anxiety) had 1 blister seal broken and the pill still inside the broken blister and tapped over. Also, the blister pack for Resident #75's tramadol 50 mg tablet (controlled medication used for pain) had 1 blister seal broken and the pill still inside the broken blister.</p> <p>In an interview on 07/09/24 at 9:35 AM, LVN B stated the count was done at shift change and the count was correct. She stated she did not check the blister packs during the count. She stated she was unaware when the blister pack seal was broken, and she was not aware of who might have damaged the blister. She stated the risk would be a potential for drug diversion. She stated the nurses and med aides were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated when a broken seal was observed, she would report it to the DON and would discard the pill with another nurse.</p> <p>In an interview on 07/11/24 at 8:50 AM, the DON stated she expected if a blister pack medication seal was broken, the pill should be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened. The DON stated the risk would be potential for drug diversion and infection control issue. She stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADON and the DON were supposed to check the carts weekly.</p> <p>Record review of the facility's policy Medication Labeling and Storage revised February 2023, reflected the following: . 3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .</p> <p>49427</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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**</b> 48560</p> <p>Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen in that:</p> <p>The facility failed to ensure potato rolls in the walk-in refrigerator had expiration date.</p> <p>The facility failed to ensure Dietary Aide F and Assistant Dietary Manager used appropriate hair restraints in the kitchen.</p> <p>These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination.</p> <p>Findings included:</p> <p>Observation on 7/9/24 at 9:41 AM of facility's walk-in refrigerator revealed a packet of potato rolls that did not had an expiration date.</p> <p>Observation on 7/10/24 at 11:30 AM of the lunch meal service revealed Dietary Aide F and Assistant Dietary Manager failed to wear appropriate hair restraint inside the kitchen prep and serving area. Dietary Aide F had long hair with braids. Dietary Aide F had hair restraint on half of his head, which exposed his braids and were not secured under the restraint. Observation revealed Dietary Aide F performed tasks in the kitchen prep area that included handling washed utensils with improper hair restraint. The Assistant Dietary Manager had a hair restraint covering her head partially with strands of hair in the back loose without securing it properly under the hair restraint. It was observed that the assistant dietary manger was scooping up potato salad in individual bowls with improper hair restraint.</p> <p>In an interview on 7/10/24 at 12:07 PM with Dietary Aide F revealed he had worked in the facility for three years. He stated that hair restraints should be worn in the kitchen to prevent hair from falling in the food. He stated that he had long hair and braided it. He stated he knew that all the hair should be appropriately restrained within the hair restraint, and he may have missed it to tuck his braids under the hair restraint. He stated that he should have checked if all his hair was tucked under the hair net and failure to do so could lead to hair in resident's food causing cross contamination and possibly of residents getting sick.</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 - Some</p>	<p>In an interview on 7/10/24 at 12:15 PM with [NAME] G stated that everyone who worked in the kitchen should wear appropriate hair restraint. She stated that she had often seen Dietary Aide F and the Assistant Dietary Manager not wearing hair restraints in a manner that covered all the hair. She stated failure to wear appropriate hair restraints in the kitchen could lead to cross contamination and the possibility of getting residents sick. She stated that it was the responsibility of the cooks, the assistant dietary manager, and the dietary manger to date all food items. She stated it was her first day back in the kitchen after a two-day break and did not know about undated potato rolls. She stated that she usually dated food items with expiry date in the kitchen walk-in refrigerator and had received Inservice about the same.</p> <p>In an interview on 7/10/24 at 12:22 PM with the Assistant Dietary Manager revealed she had been working in the facility for the last [AGE] years. She stated she was aware that appropriate hair restraints were always needed in the kitchen. She stated that she had long hair with bangs and thought she covered most of her hair but did not checked to see that the back of her hair was let loose and not properly secured under the hairnet. She said she should have ascertained that all her hairs were secured under the hair restraint while prepping and serving food because it could pose a risk to the resident by cross contamination. She stated that everyone in the kitchen was responsible for dating food items. She stated that the breads were usually dated with an expiration date. However, she was not aware why the potato rolls in the walk-in refrigerator was not dated with an expiration date. She stated the risk of not dating the foods in the kitchen appropriately could risk the residents being sick with food borne illness.</p> <p>In an interview on 7/10/24 at 12:32 PM with the Dietary Manager revealed that it was his expectation that all kitchen staff should be wearing hair restraints appropriately while working in the kitchen. He stated he will provide in-service to kitchen staff about wearing appropriate hair restraints. He also stated that everyone working in the kitchen, especially cooks, were responsible for dating food items, and it was his expectation that all facility policies regarding food dating and labeling were followed. He stated potato rolls were received frozen and were pulled to thaw and placed in the refrigerator . He stated the cooks should had dated the Potato rolls with a pull date (the date when food items are taken out of the freezer and placed in the refrigerator to thaw) as well as an expiration date. He stated failure to wear appropriate hair restraint and date food items with the expiration date, both could cause risk to the residents by cross contamination of foods and possible food borne illness.</p> <p>Record review of the facility policy titled Food Safety and Sanitation dated 2019, reflected, Policy: All local, state and federal standards and regulations will be followed in order to assure a safe and sanitary food and nutrition services department .Employees are required to have their hair styled so that it does not touch the collar, and to wear clean aprons, clothes and shoes Hair restraints are required and should cover all hair on the head. [NAME] nets are required when facial hair is visible .</p> <p>Record review of the facility policy titled Food Storage dated 2019, reflected, . Food should be dated as it is placed on the shelves if required by state regulation.</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>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47690 49427</p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for the residents in the facility.</p> <p>1) The facility failed to implement the measure stated in their Water Management Program policy to prevent the Legionella bacteria growth in their water system.</p> <p>2) The facility failed to ensure CNA H put on appropriate PPE before entering and exiting Resident #48's room, who was on isolation precautions for COVID-19.</p> <p>These failures placed residents at risk for contacting Legionella bacterial infection through the water system, and could place residents at risk for illness and infection.</p> <p>Findings include:</p> <p>1) Record review of the facility monthly water maintenance dated June 2024 and July 2024 revealed there was no testing for legionella bacteria growth in the facility water system. Interview with the Administrator and the facility Operational Director on 07/10/24 at 7:46 AM revealed there was no water testing for legionella bacteria growth in the facility water system. The Administrator and the Operational Director stated the Water Management Program consisted of flushing the water pipelines to prevent water stagnation in none used water outlets in the facility.</p> <p>On 07/10/2024 at 07:56 AM interview with the Operating Director and the Administrator revealed if there was a vacant room, the maintenance staff would run the water for about one minute. The Administrator stated there was a risk of the growth of Legionella in the water system. She stated residents could get sick if they contacted legionella bacterial infection and could send residents to hospital. The Operating Director stated in order further to prevent Legionella bacteria growth in the water pipes in the facility, the facility implemented flushing and running water in vacant rooms to prevent water stagnation. The Operating Director stated no test had been done to make sure that there was no growth of Legionella.</p> <p>Review of the Facility Water Management Program (WMP) dated June 2024 and July 2024 revealed a monthly log of the areas the maintenance staff ran the water in for one minute. On July 01, 2024, it was done in 200 Hall soiled Utility Hopper, and the laundry room hopper. On June 14, 2024, it was done in 200 Hall soiled Utility Hopper, the laundry room hopper, and rooms 111, 405, 212, 306.</p> <p>Review of the facility Policy titled Legionella Water Management Program revised July 2017 revealed:</p> <p>3. The purposes of the Water Management Program are to identify areas in the water system where legionella bacteria can grow and spread, and to reduce the risk of Legionella's disease.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Town East Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3617 O'Hare Dr Mesquite, TX 75150	

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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. The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE recommendations for developing a Legionella water management program 5 . e. Specific measures used to control the introduction and/or spread of Legionella ( e.g., temperature, disinfectants); f. The control limits or parameters that are acceptable and that are monitored; g. A diagram of where control measures are applied; h. A system to monitor control limits and the effectiveness of control measures; i. A plan for when control limits are not met and/or control measures are not effective; and j. Documentation of the program. 6. The Water Management Program will be reviewed at least once a year, or sooner if any of the following occur: a. The control limits are consistently not met; b. There is a major maintenance or water service change; .</p> <p>2) Review of Resident #48's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident was cognitively intact with a BIMS score of 15 and diagnoses of heart failure, type-2 diabetes (a condition that impacts the regulation of glucose), chronic obstructive pulmonary disease (lung disease that causes restricted airflow), dependence on supplemental oxygen, and hyperlipidemia (high fat levels in blood).</p> <p>Review of Resident #48's orders revealed an order start date of 07/08/2024 reflected was on airborne precautions for 10 days due to COVID-19 with an end date of 07/18/2024.</p> <p>Observation and interview with ADON J on 07/09/2024 at 11:08 AM revealed Resident #48's room had a sign on the door that indicated there were airborne infection precautions for the resident's room which included performing hand hygiene and putting on Personal Protective Equipment (PPE) which included gown, hair net, mask, face shield, gloves, and shoe coverings. ADON J stated Resident #48 was on airborne precautions and the purpose of wearing the PPE was to cut down on transmission of communicable diseases. She stated that there was a big risk to residents by not wearing the proper PPE because it could spread illness to other residents.</p> <p>Interview and observation on 07/09/2024 at 1:20 PM revealed CNA H entered Resident #48's room wearing a mask and gloves and set a black yeti cup on his bedside table then exited Resident #48's room and disposed of the gloves and sanitized her hands. CNA H stated that if she just was dropping off a cup of ice to a resident she did not have to put on all the PPE and would gown up if she provided direct care.</p> <p>Interview and observation on 07/09/2024 at 1:25 PM revealed Resident #48 was sitting up in bed, wearing a hospital gown and a nasal cannula with oxygen watching television. Resident #48 stated he had COVID-19 and staff wore PPE when they came in his room.</p> <p>In an interview on 07/10/2024 at 12:39 PM with ADON J she stated she put on all the PPE that was noted on the sign and that staff were expected put on all the PPE, including hair net, shoe coverings, face shield, gloves, gown, and mask. ADON J stated that all staff are told upon starting shift and during morning meetings of residents on isolation precautions and what the expectations were for staff. ADON J stated it was important to wear all the PPE to protect herself and other residents from communicable diseases, illness, and infection.</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>In an interview on 07/11/2024 at 10:35 AM CNA H stated that she had worked at the facility for about six months and did not recall any recent in-services about infection control or about residents on isolation precautions. CNA H stated she was wearing gloves and an N95 mask and took Resident #48's cup to get ice and made sure to never let the ice scoop touch the cup. CNA H stated that when she delivered food trays she put on all PPE including a gown, booties, mask, face shield, and gloves with assistance by other staff member to hand her the tray and would discard all the PPE before leaving the room. She stated she wasn't sure what the expectation was for staff when they entered a resident on isolation precautions if they weren't providing direct patient care. CNA H stated that she thought it was okay to enter Resident #48's room without putting on all the PPE noted on the sign to set a cup of ice at resident's bedside tray because it was a quick task and did not involve direct patient care.</p> <p>Interview on 07/11/2024 at 10:50 AM with the DON revealed she was the infection preventionist. The DON stated CNA H should have put on all the PPE noted on the sign before entering Resident #48's room and had been trained on isolation precautions. The DON stated that the team had a verbal reminder on 07/06/2024 about wearing PPE and did not have documentation because she did not have staff sign any sheets. The DON stated the cart with PPE by the resident's door and the sign on the door should have also indicated to CNA H what was expected and that all staff were required to follow the isolation protocol and gown up no matter what care they provided to the resident. The DON stated she would speak with CNA H immediately about PPE expectations.</p> <p>Review of CNA H employee file revealed document dated 01/04/2024 titled Subject: Nursing Services-Competency Evaluation for the skill of Isolation Care and signed by ADON J and CNA H that CNA H met all criteria.</p> <p>Review of the facility's infection control guidelines policy titled Infection Control Guidelines for All Nursing Procedures dated 2001 and revised August 2012 reflected .2. Transmission-Based Precautions will be used whenever measures are more stringent than Standard Precautions are needed to prevent the spread of infection .</p>		