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| F 000 | INITIAL COMMENTS<br><br>A complaint investigation was conducted from 11/6/2024 to 11/7/2024. Event ID # OT9911. The following intakes were investigated NC00223417, NC00223354, NC00223186, NC00222523, NC00222059, and NC00221958. One of the eight complaint allegations resulted in a deficiency. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. | F 550 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Electronically Signed | | 11/24/2024 |

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| F 550 | Continued From page 1<br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to treat a resident in a dignified manner for one (Resident #4) of three residents reviewed for dignity. Findings included:<br><br>Resident #4 had a diagnosis of Alzheimer's disease and resided on a locked dementia unit in the facility.<br><br>Documentation on the most recent quarterly Minimum Data Set assessment dated 9/24/2024 coded Resident #4 as severely cognitively impaired with no moods or behaviors.<br><br>An interview was conducted with Medication Aide (Med Aide) #3 on 11/7/2024 at 9:56 AM. Med Aide #3 stated on 9/28/2024 he was in the hallway after the evening meal with a view visible into the day room of the dementia unit. Med Aide #3 stated Resident #4 was standing up and he witnessed Nurse Aide (NA) #1 grab the shirt of Resident #4 and push Resident #4 into the chair telling her to sit down. Med Aide #3 stated NA #1 pushed Resident #4 harder than necessary making the chair hit the wall. Med Aide #3 revealed he heard Resident #4 state, "I'm telling" | F 550 | Past noncompliance: no plan of correction required. | |

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|---|---|---|---|---|
| F 550 | Continued From page 2 | F 550 | | |

and NA #1 responded, "Go ahead." Med Aide #3 confirmed he went to the Nurse to report what he witnessed on behalf of Resident #4.

NA #1 did not respond to requests for an interview.

The facility Administrator was interviewed on 11/6/2024 at 2:03 PM. The Administrator stated she was notified immediately of what Med Aide #3 witnessed on the dementia unit on 9/28/2024. The Administrator stated she interviewed NA #1 about what had occurred. The Administrator revealed she was told by NA #1, she forcibly put Resident #4 into the chair because she was going to get up and bother other residents. The Administrator stated she felt like NA #1 was admitting to treating Resident #4 disrespectfully and NA #1 could not have known what Resident #4 was going to do as she routinely just walked around the unit not bothering anyone.

The facility provided the following corrective action plan with a completion date of 10/4/2024: The immediate actions taken for the resident found to have been affected:

Resident #4, a resident in the dementia unit, was treated disrespectfully on 9/28/2024 by NA #1. Med Aide #3 observed NA #1, "grab a resident by her shirt, forcing her into the day room and pushing her into her chair hard." Med Aide #3 immediately told the nurse what he observed. Resident #3 was assessed by the nurse and there were no visible signs of injury per the nursing assessment. Resident #4 was assessed by the nurse for pain and for emotional distress. Resident #4 did not display any signs or symptoms of discomfort, anxiety, or being upset.

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|---|---|---|---|---|
| F 550 | Continued From page 3 | F 550 | | |

The nurse immediately notified the Charge Nurse who called the Director of Nursing and Administrator. NA #1 was immediately suspended and escorted from the facility due to her disrespectful behavior with the resident. An abuse investigation was immediately begun, and the incident was reported to the state agency. The nurse notified the physician and the family member of Resident #4.

Identification of other residents having the potential to be affected:

The facility determined the behavior of NA #1 was inappropriate and resulted in failure to treat Resident #4 with dignity and respect. All residents are at risk for a negative impact if they are not treated with dignity and respect.

Actions taken/systems put into place to reduce the risk of future occurrences:
Resident interviews were initiated on 9/28/2024 and 100% of cognitively intact residents in the facility were interviewed by the Social Worker. No additional issues with inappropriate undignified behavior, abuse, or neglect were identified.

The Nursing Staff initiated skin assessments on 9/28/2024 and 100% of all cognitively impaired residents, to include the residents on the dementia unit, were assessed. There were no issues identified.

Education was initiated by the Director of Nursing on 9/28/2024 for all nursing staff members. The subject of the education was treating residents with dignity, prevention of abuse and neglect, resident protection, and reporting.

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|---|---|---|---|---|
| F 550 | Continued From page 4<br>How the corrective actions will be monitored to ensure deficient practice will not reoccur:<br><br>Daily rounds were initiated on 9/28/2024 by the senior management team for 10 % of the resident population to ensure that residents are treated with dignity and respect always. In the event there are areas of concern identified; immediate action will be taken to protect the residents. Daily rounding results will be reviewed in the monthly Quality Assurance Performance Improvement committee meetings to identify on-going issues and opportunities for improvement.<br><br>The corrective action plan completion date was 10/4/2024.<br><br>The facility's corrective action plan was verified on 11/07/2024 by the following:<br><br>Interviews and record review verified Resident #4 was assessed for pain, injury, or emotional distress on 9/28/2024. Record review revealed all cognitively impaired residents were assessed for injury while cognitively intact residents were interviewed for any mistreatment including incidents involving dignity issues. Interviews with nursing staff revealed they were educated on treating residents with dignity and reporting violations of resident mistreatment. Record reviews and interviews confirmed daily rounds by the senior management team were being completed to ensure residents were treated with dignity. The compliance date of 10/4/2024 was validated. | F 550 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii) | F 686 | | 11/24/24 |

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| F 686 | Continued From page 5<br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews, and wound care physician interview the facility failed to accurately document a resident's admission skin assessment, initiate treatment for a pressure ulcer, complete a weekly assessment, and administer treatments as ordered according to the care plan for one (Resident #6) of three residents reviewed for pressure sore care.<br>Findings included:<br><br>Resident #6 was originally admitted to the facility on 9/25/2024 and discharged back to the hospital on 10/6/2024. Resident #6 had multiple diagnoses some of which included type 2 diabetes mellitus, severe quadriparesis/neuropathy, coronary artery disease, congestive heart failure, tracheostomy status, percutaneous gastrostomy tube, cerebral vascular accident, dysphagia, and pressure sore injury to sacrum and left buttock.<br><br>Documentation on the hospital discharge summary for Resident #6 dated 9/24/2024 | F 686 | Immediate action(s) taken for the resident(s) found to have been affected include:<br>The facility failed to accurately document the admission skin assessment, initiate treatment for a pressure ulcer, complete a weekly assessment of the pressure ulcer and administer treatments as ordered according to the plan of care for resident # 6.<br><br>Resident # 6 was discharged from the facility on 11/9/24.<br><br>Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents with pressure ulcers have the potential to be affected when facility staff members fail to follow the facility wound care policies. | |

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| F 686 | Continued From page 6<br>included physician orders for a sacral pressure injury, left medial buttock tissue loss as well as left knee pressure injury. The wound care physician orders included in part the following: sacrum and left buttock: start Santyl ointment with [gauze dressing] to wound bed, Cleanse with normal saline during each dressing change, apply Santyl "nickel thick" to entire wound base, followed by moist dressing within wound margins, cover with [foam] sacral border dressing upside down, change daily and [as needed] drainage/soilage. Santyl ointment is a prescription medication that removes dead tissue from wounds so they can start to heal.<br><br>Documentation on the care plan dated as initiated on 9/25/2024 revealed Resident #6 had a focus area for a Stage 4 pressure ulcer on her sacrum relative to deconditioning, immobility, and activity intolerance. Some of the interventions listed on the care plan were to administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing at least every week and as needed, measure length, depth where possible, assess and document status of wound perimeter, wound bed, and healing progress, report improvements and declines to the medical doctor, and refer to wound specialist.<br><br>Documentation on the nursing admission screening dated 9/25/2024 revealed Resident #6 was assessed by Nurse #2 as having, "unstageable to sacrum, red open area to right buttock, trach (tracheostomy) stoma, PEG (percutaneous gastrostomy) tube incision intact." There were no measurements of length, width, or depth of the wounds. There was no description of the perimeter of the wounds or the wound bed. | F 686 | Actions taken/systems put into place to reduce the risk of future occurrence include:<br><br>Nursing personnel including Registered Nurses (RNs) Licensed Practical Nurses (LPNs), and Treatment Nurse and the Treatment Aide were immediately in-serviced by the Director of Nursing (DON) following the complaint survey ending 11/7/24. This in-service included:<br>-Administering treatments, including treatments for pressure ulcers, as ordered by the physician, and according to the plan of care.<br>-Accurate and timely documentation in the electronic medical record.<br>-Accurately documenting admission assessments, including skin assessments<br><br>On 11/21/24 the Chief Clinical Officer (CCO) audited all facility admissions from October and November 2024 for adherence with facility policy and procedures related to wound management. Findings were presented in a meeting with facility senior leadership including the Director of Nursing, Administrator, Corporate Nurse Consultant and Chief Clinical Officer and Chief Operating Officer on 11/22/24. Corrective actions taking following this meeting included:<br><br>-11/22/24 facility leaders including the Director of Nursing, Administrator and RN Supervisor completed skin assessments on 100% of the residents in the facility. Findings were documented, skin referrals | |

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| F 686 | Continued From page 7<br><br>Documentation on a skin observation tool dated 9/25/2024 revealed Resident #6 was assessed by Nurse #2 with, "unstageable wound to sacrum, open area to right buttock, bruises to abdomen, PEG tube sit, [and] trach stoma to neck." There were no measurements of length, width, or depth of the wounds. There was no description of the perimeter of the wounds or the wound bed.<br><br>Documentation on a weekly observation tool initiated by Nurse #2 dated 9/25/2024 was blank and did not include any information regarding the wounds of Resident #6.<br><br>Documentation in an Admission nursing note written by Nurse #2 revealed Resident #6 had an "Unstageable wound noted to sacrum, dressing in place. Open area noted right buttock, dressing in place."<br><br>An interview with Nurse #2 was conducted on 11/7/2024 at 12:54 PM. Nurse #2 stated she asked the Director of Nursing (DON) to help her assess the wounds on Resident #6 upon admission. Nurse #2 stated she observed the wound on the sacrum of Resident #6 to be a small, light brown wound covered in necrotic tissue and the area on the right buttock to be a small, reddened area. Nurse #2 recalled that both wounds had bandages.<br><br>An interview was conducted with the DON on 9/25/2024 at 11:42 AM. The DON stated she observed the sacral pressure area on admission along with Nurse #2 on 9/25/2024. The DON explained on admission the sacral wound was about the size of a lemon slice, with adherent brown necrotic tissue that was dry with no | F 686 | and treatments were initiated for any resident needing further intervention.<br><br>-11/22/24 the Director of Nursing audited treatment records including 100% of resident treatment records (TARs) and notes from the facility consulting wound physician to ensure that all resident TARs ensure that all physician orders had been implemented. The DON reviewed findings with the facility treatment nurse on 11/22/24 and corrective actions were taken to resolve all discrepancies noted.<br><br>-Nursing personnel (RNs, LPNs, including the Treatment Nurse) were in-serviced again 11/22/24 through 11/23/24 by the Director of Nursing (DON) and the Corporate Nurse Consultant regarding the facility wound care policies and procedures. This in-service included:<br>Facility Wound Protocols<br>Accurately documenting admission assessments, including skin assessments<br>Initiating treatment for treatments, including pressure ulcers<br>Completing weekly skin assessments and wound assessments timely<br>Administering treatments, including treatments for pressure ulcers, as ordered by the physician, and according to the plan of care.<br>Accurate and timely documentation in the electronic medical record.<br><br>-11/23/24 the CCO meet with DON, Administrator review the plan of correction, audits and education records. Needed adjustments were made to the | |

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| F 686 | Continued From page 8<br>drainage. The DON said the wound on the right buttock was a very small red open stage 3 pressure area. The DON explained the facility did not know Resident #6 had wounds prior to her coming to the facility and an air mattress was obtained for her on 9/26/2024.<br><br>There were no physician orders for a wound care treatment for the right buttock initiated on 9/25/2024.<br><br>There was no documentation on the treatment administration record (TAR) of wound care for the right buttock wound from 9/26/2024 to 10/2/2024.<br><br>Documentation in the physician orders dated as initiated on 9/26/2024 and discontinued on 10/02/2024 revealed Resident #6 was to have 250 units/gram of Santyl external ointment (Collagenase) applied to her sacral area topically every day shift for wound care.<br><br>Documentation on the treatment September administration record (TAR) revealed the treatment record was blank on 9/26/2024 for the wound care order for the sacral wound of Resident #6.<br><br>Review of the daily nursing schedule for 9/26/2024 revealed Nurse #7 was assigned to perform treatments for the hallway which Resident #6 resided.<br><br>Nurse #7 was interviewed on 11/7/2024 at 12:27 PM. Nurse #7 revealed he did not recall if he provided a wound care treatment to the sacral area of Resident #6 on 9/26/2024 and he did not recall what the wound looked like when Resident #6 was first admitted. | F 686 | plan of correction, and on-going audit schedules were established.<br><br>-11/23/24 the CCO, DON and Administrator met with the RN Supervisor who assumed the duties of the treatment nurse effective 11/23/24 to discuss the plan of correction, auditing schedules and expectations of wound care program management.<br><br>How the corrective action(s) will be monitored to ensure the practice will not recur:<br><br>The DON or designee will complete an audit of all admissions for the previous day to ensure that admission assessments reflect complete documentation of any wounds noted, TARs accurately reflect physician orders for treatment orders and enhanced barrier precautions have been initiated for all residents with wounds. This audit will occur daily for four (4) weeks.<br><br>The DON or designee will review all skin referrals with the treatment nurse as a part of the daily clinical meeting to ensure timely and accurate follow up.<br><br>The DON or designee will complete an audit of all treatment records using the missed treatment report in the electronic medical record to ensure that all treatments have been completed and documented as ordered. This audit will occur daily for four (4) weeks | |

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| F 686 | Continued From page 9<br><br>Documentation on an initial wound evaluation and management summary dated 10/1/2024 written by the facility consultant wound care physician revealed the sacral and right buttock wounds of Resident #6 were assessed and the following information was provided. The wound care physician documented the Stage 4 sacral wound to be 7 centimeters (cm) in length, 8 cm in width, and 1.5 cm in depth with heavy serous exudate and 100% necrotic tissue. The sacral wound was debrided, and the nonviable tissue was removed. The dressing treatment plan was for Dakin's solution to be applied twice daily for 30 days, packed with Kling dressing soaked in ¼ strength Dakin's solution twice a day, covered with a superabsorbent gelling fiber with silicone foam border dressing. The wound care physician documented the Stage 3 pressure wound on the right buttock of Resident #6 to be 2 cm in length, 1.5 cm in width, and 0.2 cm in depth with light serous exudate and 100 % slough. The wound care physician surgically removed the nonviable tissue on the Stage 3 pressure wound on the right buttock. The dressing treatment plan for the stage 3 pressure wound on the right buttock was for Alginate calcium silver with a gauze island border dressing applied once daily.<br><br>The Admission Minimum Data Set (MDS) assessment dated 10/2/2024 coded Resident #6 as having one Stage 3 present on admission and one stage 4 present of admission. The assessment also coded Resident #6 as having a pressure reducing devise for the bed, nutrition/hydration interventions, pressure injury/ulcer care, and application of nonsurgical dressings. Resident #6 was also coded as requiring substantial or total dependence for | F 686 | The DON or designee will audit weekly skin observations and weekly wound assessments to ensure timely completion. This audit will occur weekly for four (4) weeks.<br><br>The Chief Clinical Officer or Corporate Nurse Consultant will review all audits and monitoring systems weekly for four (4) weeks.<br>Audit records will be also reviewed biweekly by the Quality Assessment Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee.<br><br>Corrective action completion date: Nov 24, 2024. | |

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|---|---|---|---|---|
| F 686 | Continued From page 10 | F 686 | | |

assistance with mobility.

There was no weekly observation tool in the electronic medical record of Resident #6 dated 10/2/2024.

Documentation on a physician's orders revealed Resident #6 had an order initiated on 10/2/2024 for the sacrum wound to be cleansed with quarter strength Dakin's solution then pack with Dakin's moistened Kling twice a day, every day shift and night shift.

Documentation on physician orders revealed Resident #6 had an order initiated on 10/3/2024 for the right buttock to be cleaned with normal saline or wound cleaner, calcium alginate with silver applied, and a border gauze dressing to be completed every day.

Documentation on the October TAR revealed Resident #6 did not receive wound care as ordered for the daily right buttock treatment or the twice daily treatment for the sacrum on 10/4/2024 and 10/5/2024.

Review of the daily nursing schedule for 10/4/2024 revealed Nurse #7 on the 7:00 AM to 3:00 PM shift and Nurse #5 on the 3:00 PM to 11:00 PM shift was assigned to provide wound care treatments for the hallway which Resident #6 resided.

Review of the daily nursing schedule for 10/5/2024 revealed Nurse #7 on the 7:00 AM to 3:00 PM shift and Nurse #9 on the 3:00 PM to 11:00 PM shift was assigned to provide wound care treatments for the hallway which Resident #6 resided.

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| F 686 | Continued From page 11 | F 686 | | |

Nurse #7 was interviewed on 11/7/2024 at 12:50 PM. Nurse #7 stated if he did not check off the treatment as being completed for Resident #6 then he would have passed it off to the next nurse shift nurse. Nurse #7 could not recall what the wound looked like on 10/4/2024 and 10/5/2024 but he recalled when he provided wound care treatments to Resident #6 on the morning of 10/6/2024, the wound had a lot of necrotic tissue and smelled very bad.

Nurse #5 was interviewed on 11/7/2024 at 1:07 PM. Nurse #5 stated she did not recall doing wound care for Resident #6 on 10/4/2024 and did not recall Nurse #7 telling her the wound care treatments were not completed on the morning shift on 10/4/2024. Nurse #5 explained she had just returned from an absence from the facility, and she was working as a hall nurse on 10/4/2024. Nurse #5 further explained she was the wound care nurse at the facility, and she would have completed the treatments for Resident #6 if she had been asked by Nurse #7 to do so.

Nurse # 9 was interviewed on 11/7/2024 at 1:43 PM. Nurse #9 stated she did not recall if she was asked by Nurse #7 to complete the wound care treatments for Resident #6 on 10/5/2024. Nurse #9 explained she was the MDS nurse who was "helping out on the floor" on 10/5/2024 but, she could not recall if she did wound care treatments for Resident #6 on that day.

An interview was conducted with the DON on 9/25/2024 at 11:42 AM. The DON stated the nurses were responsible for doing wound treatments on their assigned halls and all

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| F 686 | Continued From page 12<br>treatment orders should have been completed for Resident #6. The DON acknowledged the sacral wound of Resident #6 did deteriorate very quickly.<br><br>An interview was conducted with the facility Administrator on 11/7/2024 at 3:05 PM. The Administrator stated it was not best practice to not do treatments and not document treatments.<br><br>An interview was conducted on 11/7/2024 at 2:01 PM with the facility wound care consultant physician who completed the initial wound evaluation for Resident #6 on 10/1/2024. The wound care physician provided the following information. A deep tissue injury wound can deteriorate very quicky. The stage 4 pressure sore on the sacral area of Resident #4 could have had an unknown depth with damage that was previously done. | F 686 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and 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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections | F 880 | | 11/24/24 |

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| F 880 | Continued From page 13 | F 880 | | |

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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|---|---|---|---|---|
| F 880 | Continued From page 14<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and staff interview the facility failed to follow their infection control policy and procedures for enhanced barrier precautions for one (Nurse #5) of three nursing staff members observed for infection control procedures. Findings included:<br><br>Review of the facility policy on enhanced barrier precautions, dated as implemented on 11/1/2024, revealed the following information. The facility will have the discretion on how to communicate to staff which residents require to use of enhanced barrier precautions (EBP), as long as staff are aware of which residents require to use of EBP prior to providing high-contact care activities. Personal protective equipment (PPE) for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room.<br><br>1. Resident #6 was readmitted to the facility on 10/31/2024 with diagnoses of Stage 4 pressure ulcer and presence of a tracheostomy tube.<br><br>Observation on initial tour on 11/6/2024 at 10:22 AM revealed Resident #6 did not have an enhanced barrier precaution sign on her door and | F 880 | Immediate action(s) taken for the resident(s) found to have been affected include:<br>Nurse #5 failed to follow the facility infection control policies and procedures for Enhanced Barrier Precautions (EBP) and Personal Protective Equipment (PPE).<br><br>Specifically, nurse #5 provided wound care to Resident #6 without donning appropriate personal protective equipment (PPE) and without ensuring that appropriate signage was in place on the door of the patient.<br>Upon notification of the incident the Director of Nursing (DON) immediately re-educated and counseled Nurse #5 on proper procedures for utilizing personal protective equipment and following the facility infection control policies while performing high-contact patient care activities.<br><br>The Director of Nursing also placed appropriate signage on the door of Resident #6. The DON also assessed the availability of PPE in close proximity to the | |

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| F 880 | Continued From page 15<br>did not have any personal protective equipment (PPE) on or near her door. Upon entering the room after knocking to request permission, Nurse #5 responded and stated she had just finished up providing wound care for Resident #6. Two additional staff members were in the room with Nurse #5. It was observed there was no PPE in the room of Resident #6.<br><br>An interview was conducted with Nurse #5 on 11/7/2024 at 9:49 AM. Nurse #5 acknowledged on the previous day, 11/6/2024, when she performed wound care for Resident #6, she and the two staff members assisting her did not wear gowns when performing wound care. Nurse #5 stated that when Resident #6 was first admitted there was an Enhanced Barrier Precautions sign and PPE on her door, but for some reason when her room was deep cleaned the sign was removed and not put back up. Nurse #5 stated she knew she needed to wear a gown when performing wound care for a chronic stage 4 pressure ulcer, but she had forgotten due to a lack of the sign.<br><br>An interview with the Director of Nursing (DON) was conducted on 11/7/2024 at 11:42 AM. The DON confirmed Nurse #5 should have worn a gown while she was providing wound care for Resident #6 on 11/6/2024. The DON confirmed an enhanced barrier precaution sign should have been on the door along with PPE supplies on the door so staff could wear a gown while performing resident care activities to include wound care, bathing, changing linens, and personal hygiene. The DON did not know when or why the sign was removed from the door of Resident #6. The DON explained the staff was trained in the requirements to wear gowns as enhanced barrier | F 880 | door of Resident #6 and made arrangements to immediately get ample personal protective equipment by the door of Resident #6 and all other residents that require enhanced barrier precautions.<br><br>Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all patients are at risk when the facility staff members fail to follow the facility infection control policies.<br><br>Actions taken/systems put in place to reduce the risk of future occurrence include:<br>Mandatory Infection Control in-services were held on the day of the survey and continued for all staff in all departments 11/21/24 through 11/23/24. The meetings were held on all shifts for staff members in all departments. The Director of Nursing (DON) conducted the training for all staff members in all departments regarding the facility infection control policies and she was assisted by the Corporate Nurse Consultant. The education sessions included appropriate use of personal protective equipment and infection control signage.<br><br>Additional containers were purchased and distributed closely to resident rooms that require EBP.<br>The corporate nurse consultant and the Director of Nursing audited the entire facility on 11/22/24 to ensure that appropriate infection control signage (per | |

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| F 880 | Continued From page 16<br>precautions for residents with wounds and the PPE was available on every hall. The DON further explained the nursing staff needed to be retrained on when enhanced barrier precautions were needed.<br><br>An interview was conducted with the Administrator on 11/7/2024 at 3:05 PM. The Administrator stated the facility policy was to have enhanced barrier precaution signs on the door of residents who require wound care and staff need to wear gowns when performing wound care and personal care for those residents. The Administrator stated someone removed the enhanced barrier precaution signs on the door of Resident #6 when her room was deep cleaned when she went to the hospital and the sign was not replaced. The Administrator indicated additional training was needed for the staff on enhanced barrier precautions.<br><br>2. Resident #8 had diagnoses of stage 4 pressure ulcer and Type 2 diabetes.<br><br>An observation of the door of Resident #8 on 11/7/2024 at 8:41 AM revealed a sign posted entitled, "Enhanced Barrier Precautions." The sign stated in part, "All Healthcare Personnel must: Wear gloves and gown for the following High-Contact Resident Car Activities:" One of the activities on the sign for which gloves and a gown were to be worn was for "wound care: any skin opening requiring a dressing." There were no visible gowns or gloves available in the hallway or on the door of Resident #8<br><br>Nurse #5, the wound care nurse, was observed approaching the room of Resident #8 on 11/7/2024 at 8:43 AM and prepared her supplies | F 880 | the facility policy) was placed on the door of every patient that requires EBP.<br><br>How the corrective action(s) will be monitored to ensure the practice will not recur:<br><br>Utilizing an updated and accurate listing of residents that require Enhanced Barrier Precautions, the senior team members (Director of Nursing, Administrator, Nursing Supervisors) will round daily to ensure that all residents have appropriate signage in place and that adequate linen is in place for all staff and all residents.<br><br>Week 1: Daily rounds will be completed for one (1) x per day for one (1) week.<br>Week 2: Rounding will be reduced to three (3) x per week for one (1) week.<br>Week 3 and 4: Rounding will be reduced to two (2) x per week for two (2) weeks.<br><br>The Director of Nursing or designee will complete random infection control audits observing hand hygiene, enhanced barrier precautions and the use of personal protective equipment (PPE) during high-contact patient care activities. Audits will occur weekly for four (4) weeks and monthly for two (2) months.<br>Problems with signage and PPE will be remedied immediately. Rounding will be documented and provided to the DON who will follow up daily.<br><br>The Corporate Infection Control Director will perform random infection control audits monthly for two (2) months to | |

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| F 880 | Continued From page 17<br>to perform wound care to include multiple pairs of gloves. Nurse #5 entered the room of Resident #8 and performed wound care without donning a gown.<br><br>Nurse #5 was interviewed directly after completion of the wound care for Resident #8 on 11/7/2024 at 8:52 AM. Nurse #5 acknowledged she did not wear a gown while she was performing wound care for Resident #8 as directed to do so on the enhanced barrier precaution sign on her door. Nurse #10, who was standing at her medication cart directly across the hallway, reminded Nurse #5 in that moment that a gown and gloves must be worn while caring for residents with wound care requiring a dressing, a central line, urinary catheter, feeding tube, and/or a tracheostomy. Nurse #5 said she was aware of the need for a gown while providing wound care, but she forgotten to do so.<br><br>An interview with the Director of Nursing was conducted on 11/7/2024 at 11:42 AM. The Director of Nursing confirmed Nurse #5 should have worn a gown while she was providing wound care for Resident #8. | F 880 | monitor hand hygiene and compliance with enhanced barrier precautions.<br><br>Audit records will be reviewed biweekly by the Quality Assessment Performance Improvement (QAPI) Committee until such time consistent substantial compliance has been achieved as determined by the committee.<br><br>Corrective action completion date: Nov 24, 2024. | |