STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLUMBIA HEALTHCARE CENTER	621 W COLUMBIA ST EVANSVILLE, IN 47710

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00440519, IN00440582, IN00441713, and IN00445070. Complaint IN00440519 - No deficiencies related to the allegations are cited. Complaint IN00440582 - No deficiencies related to the allegations are cited. Complaint IN00441713 - No deficiencies related to the allegations are cited. Complaint IN00445070 - No deficiencies related to the allegations are cited. Survey dates: October 24, 25, 28, 29, 30, 31 and November 1, 2024. Facility number: 000129 Provider number: 155224 AIM number: 100266780 Census Bed Type: SNF/NF: 111 Total: 111 Census Payor Type: Medicaid: 93 Other: 18 Total: 111 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 13, 2024.	F 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. Columbia Healthcare desires this Plan of Correction to be considered the facility's Allegation of Compliance.	

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

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F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on interview and record review, the facility failed to notify the physician of blood glucose levels outside of parameters for 1 of 2 residents reviewed for insulin administration. (Resident 59) Finding includes: On 10/29/24 at 12:59 P.M., Resident 59's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 9/29/24, indicated Resident 59 was not assessed for cognitive impairment because the resident was rarely or never understood and the resident received insulin 7 days during the 7-day lookback period. Physician orders included, but were not limited to: Accu-check (a blood glucose monitoring system) once a day - Notify physician if Accu-check is below 60 milligram per deciliter (mg/dL) or greater than 400 mg/dL, dated 4/22/20 A risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus care plan, dated 4/7/20 and reviewed 9/25/24, included an intervention to document abnormal findings and notify the physician. A vital sign report, dated 7/6/24 at 10:06 A.M., indicated the blood glucometer read "HI" (blood glucose level greater than 600 mg/dL). The July 2024 MAR indicated the physician was not notified of Resident 59's elevated blood	F 0580	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #59 was treated for infection. Blood sugar is now within normal range. No other residents affected by alleged deficient practice. Resident is receiving appropriate care per MD order for elevated blood glucose levels **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents with daily glucose monitoring have the potential to be affected by the alleged deficient practice. An audit for all residents with orders for daily glucose monitoring was completed to ensure physician orders were followed. Nurses were in-serviced on change of condition and when/how to report by the DNS/Designee **What measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur?**	11/29/2024

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	glucose level on 7/6/24. A Nursing progress note, dated 7/6/24 at 11:01 P.M., indicated the lab called the facility at 6:00 P.M. to report Resident 59 had a critical blood glucose level of 526 mg/dL. The NP was texted and called by Licensed Practical Nurse (LPN) 6 about critical lab value. A response was not received. The clinical record lacked documentation of follow up with the physician about Resident 59's critical blood glucose level between 7/6/24 at 11:01 P.M. and 7/7/24 at 8:54 A.M. A Nursing progress note, dated 7/7/24 at 8:54 A.M., indicated the nurse attempted to contact the NP again for the critical blood glucose level. During an interview with the Nurse Practitioner (NP) on 11/1/24 at 9:00 A.M., the NP indicated staff texted her and if there was no response after 15 to 30 minutes, they would call her. If she still didn't respond, they were to call the on-call physician. On 11/1/24 at 11:33 A.M., the Administrator provided a current Blood Glucose Monitoring policy, dated 2/2015, that indicated "The physician will be notified when the resident's blood glucose is outside the physician stated parameters or if the resident is experiencing signs or symptoms of high or low blood sugars". On 11/1/24 at 2:06 P.M., the Administrator provided a current Resident Change of Condition policy, dated 12/17, that indicated "It is the policy of this Community that changes in resident condition will be communicated to the physician and family/responsible party, and that		Inservice for nursing staff on Change of Condition, Head to Toe Assessments with Documentation Guidelines, and Procedures for Out-of-Range Blood Sugars. DNS/Designee will review facility activity report daily to monitor for out-of-range blood sugars and to ensure MD is notified per parameters. **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** The DNS/Designee will be responsible for the completion of the Timely Notification and Documentation When Blood Sugar Out of Range QA tools weekly x 4 weeks, monthly x 6, then quarterly x 2 until continued compliance is maintained for 2 consecutive quarters. The results of the audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed.	

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	appropriate, timely, and effective intervention occurs ... All nursing actions, physician contacts, and resident assessment information will be documented in the Progress Notes ... Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation ... If unable to contact attending physician timely, the resident will be transferred for emergency services ... Documentation will include time and family/physician response". 3.1-5(a)(3)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on record review and interview the facility failed to ensure a resident had a care plan implemented related to frequent urinary tract infections (UTI) with multidrug resistant organisms for 1 of 1 residents reviewed for UTI. (Resident 85) Finding includes: On 10/25/24 at 10:58 A.M. Resident 85 indicated that they got frequent urinary tract infections because staff did not clean her properly. The clinical record was reviewed on 10/28/24 at 2:49 P.M. Resident 85 had diagnoses that included but was not limited to urinary tract infection. A Quarterly MDS (Minimum Data Set) Assessment, dated 9/24/24, indicated the resident was cognitively intact, used a wheel chair,	F 0656	**How will the corrective action be accomplished for residents found to be affected by deficient practice?** Resident #85 current care plans were reviewed and updated to include a care plan for frequent Urinary Tract Infections. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected An audit of residents with 2 or more UTI's have been reviewed and care plans have been added. IDT will review orders during	11/29/2024

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	required substantial to maximum assistance with bathing and personal hygiene, was incontinent of bowel and bladder, had a primary diagnosis of COPD (chronic obstructive pulmonary disease), had a urinary tract infection within the last 30 days, had an intravenous catheter, had been on intravenous medications, required isolation precautions, and was on antibiotics. Current physician orders included but was not limited to: Urine is colonized with ESBL (Extended-spectrum beta-lactamase, causes problems in efficacy of antibiotics making infection resistant to treatment) dated, 9/6/22. On 11/1/24 at 9:45 A.M., the DON (Director of Nursing) indicated that she would have expected Resident 85 to have an ongoing careplan related to recurrent urinary tract infections and colonization of ESBL in the resident's urine. A policy provided by the Administrator on 11/1/24, at 11:33 A.M., titled IDT Comprehensive Care Plan Policy, indicated "it is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented based on the Resident Assessment Instrument process. The care plan must include measurable goals and resident specific interventions based on the resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial well-being." 3.1-35(a) 3.1-35(b)(1)		Morning Meeting that require new or updated care plans related to frequent UTIs. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** In-service include IDT Care Plan Pathways and Care Plan Libraries related to UTIs. All care plans of residents with 1 or more urinary tract infections will be audited to ensure a care plan has been developed to meet the medical needs of the resident by the DNS/Designee. **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** The MDS/Designee will be responsible for the completion of the Comprehensive Care Planning in Place for Chronic UTI QA tool weekly x 4 weeks, monthly x 6, then quarterly x 2 until continued compliance is maintained for 2 consecutive quarters. The results of the audits will be reviewed by the QAPI committee overseen by the ED. If a 100% is not achieved, an action plan will be developed.	
F 0684 SS=G	483.25 Quality of Care			

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Bldg. 00	Based on interview and record review, the facility failed to ensure effective services to treat elevated blood glucose levels were provided in accordance with the physician and Nurse Practitioner (NP) orders for 1 of 2 residents reviewed for insulin administration. (Resident 59) This deficient practice resulted in the resident requiring emergent transport to an acute care hospital intensive care unit for the treatment of diabetic ketoacidosis (DKA) (a life-threatening complication of diabetes that occurs when the body doesn't have enough insulin to use blood sugar for energy.) Finding includes: On 10/29/24 at 12:59 P.M., Resident 59's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. The most recent comprehensive Significant Change Minimum Data Set (MDS) Assessment, dated 3/21/24, indicated Resident 59 was not assessed for cognitive impairment because the resident was rarely or never understood and the resident received insulin 6 days during the 7-day lookback period. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 9/29/24, indicated Resident 59 was not assessed for cognitive impairment because the resident was rarely or never understood and the resident received insulin 7 days during the 7-day lookback period. A risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus care plan, dated 4/7/20 and reviewed 9/25/24,	F 0684	**How will the corrective action be accomplished for residents found to be affected by deficient practice?** Resident 59 was treated for infection. Blood glucose level is now within normal range. No other residents affected by alleged deficient practice. Resident is receiving appropriate care per MD order for elevated blood glucose levels **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All Residents with daily glucose monitoring have the potential to be affected. An audit for all residents with orders for daily glucose monitoring was completed to ensure physician orders were followed by DNS/Designee. Nursing staff educated on Resident Change of Condition Policy, Change of Condition-When to Report, and Head to Toe Assessment protocol by DNS/Designee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	11/29/2024

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	included an intervention to document abnormal findings and notify the physician. The July 2024 Physician's order recapitulation included, but was not limited to, orders for staff to administer 20 units of insulin glargine (a long-acting insulin) once daily at bedtime, measure the resident's blood glucose once daily, and notify the physician if Accu-check result is below 60 milligram per deciliter (mg/dL) or greater than 400 mg/dL. A vital sign report, dated 7/2/24 at 10:14 A.M., indicated Resident 59's blood glucose level was 490 mg/dL. The July 2024 Medication Administration Record (MAR) indicated the physician was notified of the elevated blood glucose level on 7/2/24. The Progress notes, medication administration notes, and event forms, dated 7/2/24, lacked documentation to determine the physician responded to or the facility staff made attempts to follow-up with the physician to address the elevated blood glucose level. The progress notes, assessments, monitoring/evaluation tools, physician orders, and medication administration notes lacked documentation to indicate a physician response was received or the facility staff followed up with the physician between 7/2/24 at 10:14 P.M. and 7/6/24 at 1:55 P.M. A vital sign report, dated 7/6/24 at 10:06 A.M., indicated the blood glucometer read "HI" (blood glucose level greater than 600 mg/dL). The July 2024 MAR indicated the physician was		**practice does not recur?** Nursing Staff will be in-serviced on Resident Change of Condition Policy, Change of Condition-When to Report, and Head to Toe Assessment protocol. Daily audit by DNS/Designee for all residents with physician orders for insulin/daily glucose monitoring are followed. DNS/Designee will review facility activity report daily to monitor for out of range blood sugars and to ensure MD is notified per parameters. **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** The DNS/Designee will be responsible for the completion of the Quality of Care and Documentation of Notifications to include medication administration observation during medication pass with immediate notification for out of range blood sugar QA tool weekly x 4 weeks, monthly x 6, then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed.	

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	not notified of Resident 59's elevated blood glucose level on 7/6/24. The progress notes, assessments, monitoring/evaluation tools, physician orders, and medication administration notes lacked documentation to indicate the physician was contacted between 7/6/24 at 10:06 A.M. and 7/6/24 at 1:55 P.M. A Physician Communication note, dated 7/6/24 at 1:55 P.M., indicated the physician was notified the resident was not acting like herself. The resident did not want to eat, refused to drink her fluids, was not walking according to her baseline, and was urinating a large amount. The note indicated the resident had an increased heart rate of 119 beats per minute (bpm) and respirations of 24 respirations per minute (rpm). A Physician/NP order, dated, 7/6/24 at 2:09 P.M., indicated orders were received for staff to immediately (STAT) obtain blood draws for a complete blood count (CBC) (a laboratory test to measure the number and type of cells in blood and a comprehensive metabolic panel (CMP) (a laboratory test that measures 14 substances in your blood to provide information about your metabolism and chemical balance). . A Nursing progress note, dated 7/6/24 at 11:01 P.M., indicated the lab called the facility at 6:00 P.M. to report Resident 59 had a critical blood glucose level of 526 mg/dL. The NP was texted and called by Licensed Practical Nurse (LPN) 6 about critical lab value. A response was not received. A message screenshot, dated 7/6/24 at 6:50 P.M., indicated staff texted the critical blood glucose		This facility requests IDR for this citation due to evidence provided not included in 2567 and admission to the hospital was due to infection resulting in DKA.	

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	level to the NP and requested orders, but did not receive a response. A laboratory report, dated 7/6/24 at 4:53 P.M., indicated Resident 59 had a blood glucose level of 526 mg/dL. An untimed handwritten note on the report, signed by the Director of Nursing (DON) indicated the NP was notified on 7/7/24. The report did not include sufficient documentation to determine the facility notified the physician or the NP, between 7/6/24 at 4:54 P.M. and 7/7/24 at 8:53 A.M., of the elevated blood glucose level. A Nursing progress note, dated 7/7/24 at 8:54 A.M., indicated the nurse attempted to contact the NP again for the critical blood glucose level. The July 2024 Physician's recapitulation dated 7/7/24 at 9:39 A.M., indicated the following order was received: Humalog (insulin lispro) KwikPen - insulin lispro (a short-acting insulin) - Give per Sliding Scale subcutaneous, three times a day, If Blood Sugar is less than 60 mg/dL, call physician. If Blood Sugar is 0 to 199, give 0 Units. If Blood Sugar is 200 to 249, give 1 Units. If Blood Sugar is 250 to 299, give 2 Units. If Blood Sugar is 300 to 349, give 3 Units. If Blood Sugar is 350 to 399, give 4 Units. If Blood Sugar is 400 to 499, give 5 Units. If Blood Sugar is greater than 500, call physician. A vital sign report, dated 7/7/24 at 12:24 P.M., indicated Resident 59's blood glucose level was 548 mg/dL. The July 2024 Medication Administration Record			

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	(MAR) indicated no insulin lispro was administered to Resident 59, on 07/07/24, to treat the blood glucose level of 548 mg/dL. A vital sign report, dated 7/7/24 at 4:25 P.M., indicated Resident 59's blood glucose level was 582 mg/dL. The progress notes, medication administration notes, monitoring/evaluation tools, and physician orders, dated 7/7/24, did not include documentation to indicate the physician was notified of the elevated blood glucose levels or new orders were received to treat the blood glucose levels of 548 mg/dL or 582 mg/dL. The July 2024 MAR indicated Resident 59's 8:00 A.M. dose of insulin lispro on 7/8/24 was given by Registered Nurse (RN) 15, but did not indicate the blood glucose was measured prior to administration, how much insulin was given, or the body site where the insulin was given. Progress notes and the vital sign report, dated between 7/7/24 at 4:25 P.M. and 7/8/24 at 11:25 A.M., lacked documentation to indicate a blood glucose level was obtained. A nursing progress note, dated 7/9/24 at 9:04 A.M., indicated Resident 59 became unresponsive during a meal, staff performed a sternal rub, and a blood glucose check was conducted. The Accu-check measured the blood glucose as, "HI", the heart rate was 123 bpm the respirations were 22 rpm, and the resident was panting. The progress note indicated the resident had no recent fluid intake. The note indicated the NP was notified and orders were received to send the resident to the Emergency Room (ER) for evaluation and treatment.			

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	A hospital admission assessment, dated 7/9/2024 at 9:54 A.M., identified the resident had a urinary tract infection (UTI). The assessment included, but was not limited to, the following laboratory results: The blood glucose measured 742 mg/dL with a reference range of 70 - 99 mg/dL. The white blood cell count measured 21.2 thousands per microliter (THOUS/uL) with a reference range of 4.0 - 10.3 THOUS/uL. The urinalysis measured positive for greater than 1000 mg/dL glucose with a reference range of negative. The assessment indicated Resident 59 was admitted to the Intensive Care Unit (ICU) for treatment of diabetic ketoacidosis (DKA). Hospital discharge papers, dated 7/15/24 at 10:14 A.M., indicated Resident 59 was discharged back to the facility after being admitted to the hospital for acute metabolic encephalopathy (ME) (a condition that occurs when the body lacks oxygen, glucose, or vitamins), DKA, and UTI. During an interview with the DON on 10/30/24 at 11:59 A.M., she indicated all notifications to the physician was documented as a progress note. During an interview with the Director of Nursing (DON) on 10/30/24 at 1:44 P.M., she indicated the nurse called the NP for the blood sugars over 500 mg/dL on 7/7/24. The NP said to give five units over the maximum units on the sliding scale. The documentation system would not let her input that she gave 10 units, so she put she gave zero units. She did not document the notification to the NP, the new order, or the insulin administration amount in a progress note or as a medication administration note, but she should have. At that time, the DON was unable to provide documentation to indicate the nurse gave 10 units			

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	of insulin. During an interview with the DON on 10/30/24 at 1:59 P.M., she indicated Licensed Practical Nurse (LPN) 6 did not remember if she gave the 8 A.M. dose of insulin lispro or not. The DON was unsure what Resident 59's blood glucose was at 8:00 A.M. on 7/8/24 at 8:00 A.M., or how many units of insulin lispro were given if any. During an interview, on 11/1/24 at 8:15 A.M., the Administrator indicated text messages were not part of the clinical record. During an interview with the Administrator on 11/1/24 at 8:51 A.M., she indicated staff texted the NP and didn't need to document all communication in the progress notes. During an interview with the Nurse Practitioner (NP) on 11/1/24 at 9:00 A.M., the NP indicated staff texted her and if there was no response after 15 to 30 minutes, they would call her. If she still didn't respond, they were to call the on-call physician. She did not have a record of being contacted on 7/2/24 in relation to Resident 59's elevated blood glucose level. She indicated she would have advised staff to recheck the blood sugar in an hour and call back if it was still high. The NP indicated she was unable to find a recheck of blood glucose levels for Resident 59 on 7/2/24. The NP indicated the sliding scale insulin order was for one week on a trial basis and then the resident would be re-evaluated. At that time, the NP was unable to provide documentation that the insulin order was on a trial basis and when the resident was to be re-evaluated. The NP indicated she did not have documentation of being contacted on 7/7/24 in relation to Resident 59's elevated blood glucose level. She indicated she			

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	would have ordered four units of insulin above the highest number on the sliding scale to be given, making the total insulin nine units for that administration time. She indicated four units of insulin above the highest number on the sliding scale for a blood glucose level over 400 mg/dL should have been a standing order from that point on. The NP indicated that she was not contacted by a nurse on 7/8/24 about Resident 59's blood glucose level, insulin, or a missed dose. The NP was unsure what Resident 59's blood glucose was at 8:00 A.M. on 7/8/24 or how many units of insulin lispro were given. On 11/1/24 at 11:33 A.M., the Administrator provided a current Blood Glucose Monitoring policy, dated 2/2015, that indicated, " ...The physician will be notified when the resident's blood glucose is outside the physician stated parameters or if the resident is experiencing signs or symptoms of high or low blood sugars ...". On 11/1/24 at 2:06 P.M., the Administrator provided a current Resident Change of Condition policy, dated 12/2017, that indicated, " ...It is the policy of this Community that changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs ... All nursing actions, physician contacts, and resident assessment information will be documented in the Progress Notes ... Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation ... If unable to contact attending physician timely, the resident will be transferred for emergency services ... Documentation will include time and			

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	family/physician response ..." On 11/1/24 at 2:06 P.M., the Administrator provided a current General Dose Preparation and Medication Administration policy, dated 4/30/24, that indicated " ...Document necessary medication administration/treatment information (e.g. when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application site) on appropriate forms ..." On 11/1/24 at 2:06 P.M., the Administrator provided a current Authorization and Communication of Orders policy, dated 6/1/24, that indicated " ...Facility should ensure that the authorized person receiving a verbal order immediately records it in the resident's chart or electronic order system, including the date and time of the order, the name of physician/prescriber, the signature of the person recording the order and other information as permitted by and in accordance with applicable law ..." The article, "About Diabetic Ketoacidosis," dated 5/15/24, was retrieved on 11/5/24 from the Center for Disease Control and Prevention (CDC) website at https://www.cdc.gov/diabetes/about/diabetic-ketoacidosis.html#:~:text=also%20develop%20DKA.-,DKA%20develops%20when%20your%20body%20doesn't%20have%20enough%20insulin,dangerous%20levels%20in%20your%20body. The guidance included: " ...DKA is a serious complication of diabetes that can be life-threatening. DKA is most common among people with type 1 diabetes. People with type 2 diabetes can also develop DKA. DKA develops when your body doesn't have			

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	enough insulin to allow blood sugar into your cells for use as energy. Instead, your liver breaks down fat for fuel, a process that produces acids called ketones. When too many ketones are produced too fast, they can build up to dangerous levels in your body ..." The article, "Metabolic Encephalopathy", dated 7/10/24, was retrieved on 11/5/24 from the Cleveland Clinic website at https://my.clevelandclinic.org/health/diseases/metabolic-encephalopathy. The guidance included: "...Metabolic encephalopathy is a brain dysfunction caused by an underlying condition. Many possible conditions can cause metabolic encephalopathy, but these mainly target your metabolism. Your metabolism is the chemical process that converts the things you eat and drink into energy. Brain dysfunction can affect your mood, thinking and memory or cause a loss of consciousness (coma). All metabolic encephalopathies require medical attention. If left untreated, they can be life-threatening or cause permanent brain damage ..." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on interview and record review, the facility failed to ensure a resident did not develop an avoidable pressure ulcer by monitoring skin for 1 of 3 residents reviewed for facility acquired pressure ulcers. (Resident 89) Finding includes: During an interview on 10/24/24 at 2:22 P.M., Resident 89 indicated she had pressure injuries on	F 0686	**How will the corrective action be accomplished for residents found to be affected by deficient practice?** Resident #89 no longer has a knee immobilizer. The pressure ulcer was healed on 10/30/24. **How will the facility identify**	11/29/2024

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	her right leg from her knee immobilizer not being monitored. On 10/28/24 at 2:40 P.M., Resident 89's clinical record was reviewed. Diagnoses included, but were not limited to congestive heart failure and diabetes mellitus. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 8/7/24, indicated resident 89 was cognitively intact, was fully dependent on staff for transfers, required substantial assistance from staff (staff do more than half the work) for toileting and bathing, and did not have any unhealed pressure ulcers. Current physician orders included, but were not limited to: Right calf: cleanse wound with wound cleanser, pat dry; wound to be packed by wound NP (nurse practitioner) with skin sub, cover with silicone dressing, then steri-strips, then cover with a dry dressing. Change 1x weekly by Wound NP. Outer dressing to be changed PRN if soiled/dislodged. Once a day on Wednesday, Start date 10/2/24. Current care plans included, but were not limited to: Impaired mobility related to: right nondisplaced fracture medial tibial plateau; Assess and document skin condition weekly and as needed. Date initiated 6/12/24. The care plan did not specify to remove the immobilizer and check skin under the immobilizer. A nursing progress note, dated 6/12/24 at 10:14 P.M. indicated Resident 89 returned from a hospital stay, from 6/8/24 through 6/12/24 due to fall with fracture in facility that occurred on 6/8/24,		**other residents having the potential to be affected by the same deficient practice?** All Residents with external device have the potential to be affected by the alleged deficient practice. An audit was completed to identify any resident with orders for an external device and to ensure physician orders were followed and that appropriate care plans are established to include routine skin assessments. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** DNS/Designee to educate and in-service all Nurses on splinting device application and Weekly Skin Assessments Daily audits will be completed by DNS/designee to ensure physician orders for all devices and skin assessments are followed for any resident with order for external device. **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** The DNS/Designee will be responsible for the completion of	

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	with a knee immobilizer to the right leg. A nursing progress note, dated 7/23/24 at 2:33 P.M., indicated Resident 89 had returned from an orthopedic appointment with orders to discontinue the knee immobilizer on Resident 89's right leg. An IDT (interdisciplinary team) note, dated 7/26/24 at 9:48 A.M., indicated Resident 89's right lateral calf noted to have two unstageable pressure wounds related to the knee immobilizer. A skin and wound note, dated 7/31/24 at 6:45 P.M., indicated Resident was assessed by the wound NP due to a deep tissue injury to the right posterior leg caused by right leg brace, measured at 4.8 centimeters (cm) by 1.3 cm by 0.1 cm. The clinical record, including assessments, observations, events, progress notes, and documents, lacked skin assessments completed during the following weeks while Resident 89 had a right knee immobilizer in place: 6/12/24-6/18/24 6/20/24-7/2/24 7/4/24-7/23/24 During an interview on 11/1/24 at 2:09 P.M., the Director of Nursing indicated there were not skin assessments completed during the missing weeks in June and July. On 11/1/24 at 11:36 A.M., the Administrator provided a policy titled Skin Management Program, revised 5/22, that indicated the purpose of the policy was "To promote the prevention of pressure/ulcers/injury development. Avoidable pressure ulcer/injury: means that the resident		the Weekly Skin Assessment Summary, Weekly Skin Assessments Reflect Alterations in Skin Integrity and IDT Documentation reflects the Risk Factors Present Prior to Wound Development.QA tool weekly x 4 weeks, monthly x 6, then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed.	

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	developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions." 3.1-40(a)(1)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on interview, observation, and record review, the facility failed to administer non-pharmalogical or pharmalogical interventions for pain prior to performing wound care for 1 of 2 residents observed for wound care. (Resident 104) Finding includes: On 10/29/24 at 9:46 A.M., Resident 104's clinical record was reviewed. Diagnoses included, but were not limited to, malignant neoplasm of lymph nodes of head, face, and neck and squamous cell carcinoma of skin of scalp and neck. A Significant Change MDS (Minimum Data Set) Assessment, dated 9/3/24, indicated Resident 104 was cognitively intact, was completely dependent on staff for transfers required substantial assistance from staff (staff does more than half the work) for toileting and bathing, received as needed pain medication in the last five days and had not received non-medication intervention for pain in the past five days. Current physician orders included, but were not limited to:	F 0697	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Audit of resident 104's MAR was completed to ensure pain medication is being administered per providers orders and that any PRN pain medication is given as ordered when requested by resident prior to wound care. Education given to Nurse 12 on Pain Management Policy **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents with pain medication order receiving wound care have the potential to be affected by the alleged deficient practice. An audit has been conducted to ensure that residents with wounds have adequate pain	11/29/2024

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	hydrocodone-acetaminophen schedule II tablet 5-325 mg; oral every four hours as needed, start date 9/10/24. Betadine (povidone-iodine) solution; 10%; 1 application; topical. Special Instructions: Betadine wash to left heel once a day, start date 8/28/24. Care plans included, but were not limited to: Resident is at risk for pain. Offer non pharmacological interventions such as quiet environment, rest, shower, back rub, reposition. Administer medications as ordered. Start date 8/5/24. During an observation on 10/30/24 at 10:56 A.M., RN 12 entered Resident 104's room and told Resident 102 she was going to start the wound treatment on his foot. Resident 104 requested pain medication before RN 12 started the wound treatment. RN 12 started to perform wound care and Resident 102 began grimacing and stating he was in pain and would like pain medication before wound care. RN 12 yelled into the hall for another nurse; RN 10 entered Resident 104's room and RN 12 handed RN 10 the medication cart keys and asked her to get a narcotic pain medication for Resident 102. RN 12 continued cleaning Resident 102's wound and painted the left heel with Betadine. Resident 104 continued to grimace and request pain medication. RN 10 returned to Resident 104's room and handed RN 12 a medication cup. RN 12 spoon the medication and applesauce slurry into Resident 104's mouth. RN 12 did not offer to reposition Resident 104 or to postpone the wound treatment. During an interview on 11/1/24 at 1:42 P.M., Resident 104 indicated he does not receive routine		control. Daily audit will be completed by DNS/designee to ensure pain medication administration is being completed as ordered for routine and PRN pain medication per resident request for all residents with pain medication orders receiving wound care. **What measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur?** All Nurses in-serviced on Pain Management Policy. Daily audit will be completed by DNS/designee to ensure pain medication administration is being completed as ordered for routine and PRN pain medication per resident request for all residents with pain medication orders receiving wound care. **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** The DNS/Designee will be responsible for the completion of the Pain Assessed Prior to Wound Care and Wound Care Held Until Pain Manageable QA tools weekly x 4 weeks, monthly x 6, then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the audits will be reviewed by	

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	pain medications and that staff never give the pain medication time to take effect before beginning wound treatments. On 11/1/24 at 11:36 A.M., the Administrator provided a policy titled Pain Management, revised 7/24, that indicated "It is the policy to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, including pain management. A plan of care will be written with the initiation of pain medication and individualization to the resident.. and alternative pain relief techniques." 3.1-37(a)		the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation, interview, and record review, the facility failed to ensure medications were administered according to manufacture and professional standard for 1 of 5 residents observed during medication pass. (Resident 89) Two medication errors were observed during 26 opportunities for error in medication administration. This resulted in a 7.69% error rate. (Resident 89) Findings include: During a medication administration on 10/25/24 at 7:55 A.M., LPN (Licensed Practical Nurse) 13 prepared Glargine Insulin 30 Units SQ (Subcutaneous) bid (two times a day) and Lispro 10 units SQ tid (three times a day) and did not prime the two insulin injection pens with two units prior to administering.	F 0759	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 89 received the correct insulin dosage as ordered during the medication pass. There were no negative effects for resident 89 by the deficient practice. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents receiving insulin by injection pen have the potential to be affected by this alleged deficient practice. DNS/ designee conducted	11/29/2024

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	On 10/25/24 at 1:45 P.M., Resident 89's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and Systemic Lupus erythematosus. Physician orders included, but were not limited to, Insulin Glargine-insulin pen; 100 unit/mL (Milliliters) (3 mL); amt (amount): 30 units; subcutaneous. Special Instructions: Give half dose of insulin if BS (Blood Sugar) < (Less Than)120, Twice A Day, 8:00 A.M. and 8:00 P.M, dated 10/24/24. Lispro Insulin pen; 100 unit/mL; amt: 10 units; subcutaneous. Special Instructions: Do not administer if BS is below 100. Give Three Times A Day, 8:00 A.M., 12:00 P.M., and 5:00 P.M. dated 9/10/24. During an interview on 10/25/24 at 8:00 A.M., LPN 13 indicated she was unaware of priming the insulin prior to administering. On 10/25/24 at 12:59 P.M., the Administrator provided a current, non-dated "Patient Information Insert for Humalog Kwik Pen". The insert indicated "...turn the knob to 2 units...priming ensures the Pen is ready and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too much or too little insulin..." 3.1-48(c)(1)		insulin injection pen skills validations with all licensed nursing staff. Education provided to Nurse 13 on proper technique of priming insulin injection pens. **What measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur?** DNS/Designee will conduct in-service with licensed nursing staff on Insulin Pen Administration DNS/Designee will round to ensure insulin pen administration is completed per protocol **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** The DNS/Designee will be responsible for the completion of the Insulin Administration Observation During Med Pass with No Procedure Error. QA tool weekly x 4 weeks, monthly x 6, then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the audits will be reviewed by the QAPI committee overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed.	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record	F 0761	**How will corrective action be**	11/29/2024

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	review, the facility failed to ensure medications were properly dated, labeled, and not expired in 5 of 5 medication carts and 2 of 2 treatment carts. (1500 Hall Medication Cart, 1400 Hall Medication Cart, Memory Care Medication Cart, 2300/2400 Hall Medication Cart, 2500 Hall Medication Cart, First Floor Treatment Cart, Second Floor Treatment Cart) Findings include: 1. On 10/24/24 at 8:45 A.M., 1500 Hall Medication Cart was observed to with the following: RN (Registered Nurse) 12 indicated each resident had their own glucometer (Instrument to measure blood sugars) and insulin is kept in the pouches. [Resident Name]106's insulin pouch had the following: 1 vial of opened Humulin R (Regular) insulin with no open date 2 Glargine Insulin Pen with no label [Resident Name] insulin pouch had the following: Glargine Insulin pen with no open date 1 bottle of Nasal Saline for [Resident Name] expired 7/24 1 bottle of Liquid Protein no label During an interview on 10/24/24 at 8:45 A.M., RN 12 indicated medication bottles should have an open date and label. There should not be anything expired in the carts. 2. On 10/24/24 at 9:02 A.M., the 1400 Hall Medication cart was observed with the following: 1 bottle of Sterile Water with an expiration of		**accomplished for those residents found to have been affected by the deficient practice?** All opened items with no open date, loose medications, medications with no label and expired items were destroyed and replaced. Resident 106 Humulin and Glargine insulin pen were discarded Other Glargine insulin pen was discarded Nasal saline which was expired is discarded 1400 hall med cart the expired sterile water was discarded, First floor treatment cart Betadine was discarded Memory Care medication cart – Clonidine pill and Miralax was discarded. Non medication items were removed from the cart. 2400/2300 hall medication cart – orange pill, white pill and Miarlax was discarded 2nd floor treatment cart – Nystatin antifungal cream, Ketoconazole shampoo, hydrophile, bag balm, were discarded. The cart was cleaned. 2200 hall undated Miralax was discarded Medication Refrigerator – Mary's Magic Cream with no open date was discarded No residents had any negative effects due to the alleged deficient	

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	10/6/24 3. On 10/24/24 at 9:08 A.M., the Treatment Cart for the First Floor was observed to have: 1 opened bottle of Betadine (Antiseptic Cleaner) labeled with [Resident Name] in black Sharpee without and open date. During an interview on 10/24/24 at 9:10 A.M., RN 12 indicated when a resident is discharged the medication will be returned or destroyed. 4. On 10/24/24 at 9:20 A.M., the Medication Cart for the Memory Care Unit was observed with the following: In the top drawer of the medication cart: 1 silver colored necklace 1 silver colored ring 1 silver colored with blue stones watch 1 unopened 0.1 mg (Milligrams) Clonidine pill package 1 Bottle of MiraLAX (laxative) with no label During an interview on 10/24/24 at 9:25 A.M., RN 16 indicated there should not be any jewelry in the medication drawer and it should be labeled 5. On 10/24/24 at 9:30 A.M., the 2400/2300 Hall Medication Cart was observed with the following: 1 small white oblong pill 1 opened bottle of Nitroglycerin (Antianginal) for [Resident name] with no date 6. On 10/24/24 at 9:49 A.M., the 2500 Medication Cart was observed with the following: 1/2 small round orange pill 1 small round white pill # 49 3 opened bottles of MiraLAX with no open date		practice. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected by this practice. An audit was completed on all carts and medication rooms to ensure proper storage of medications and treatment supplies to ensure meds were properly dated, labeled and not expired and clean, and non-medication items were removed **What measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur?** The DNS/Designee will audit the medication and treatment cart daily. Results of the audits will be taken to the morning clinical meeting and discussed with the IDT. DNS/Designee to in-service licensed nursing staff and QMA's on Medication Storage and the importance of proper labeling and storage. **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** The DNS/Designee will be responsible for the completion of the Medication Storage QA tool	

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	7. On 10/24/24 at 10:15 A.M., the Second Floor Treatment Cart was observed with the following: 1 bottle of Nystatin Powder for [Resident Name] no open date 1 bottle of antifungal cream no label or date open 1 bottle of Ketoconazole shampoo that expired in 4/24 3 tubes of open hydrophile for [Resident Name] no open date 9 bottles of Ketoconazole shampoo with [Resident's Names] that were not dated when opened 1 opened container of Bag Balm (ointment) that had no label or open date There was a sticky white substance on a drawer of the treatment cart During an interview on 10/24/24 at 10:20 A.M., LPN (Licensed Practical Nurse) 13 indicated the Bag Balm should be labeled and dated. LPN 13 also indicated that she would date any tubes that were opened. During an interview on 11/1/24 at 12:29 P.M., the DON (Director of Nursing) indicated antifungals were stock medications until they were opened at which time they would be assigned to a resident and require a label. 8. On 10/24/24 at 10:27 A.M., the 2200 Hall Medication Cart was observed with the following: 2 opened bottles of MiraLAX for [Resident Named] no open date 9. On 10/24/24 at 10:40 A.M., the Medication Refrigerator in the Medication Storage room was observed with the following: 1 container of Mary's Magic cream for [Resident		weekly x 4 weeks, monthly x 6, then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed.	

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	Name] with no open date. On 10/25/24 at 12:59 P.M., the Administrator provided a current policy " Storage and Expiration Dating of Medications and Biologicals" revised on 8/1/24. The policy indicated "...facility should ensure that medications and biologicals that: have an expired dated on the label and have been retained longer than the recommended manufacturer or supplier guidelines.... until destroyed...Once any medication or biological is opened...facility staff should record the date opened on the primary container...." 3.1-25(j) 3.1-25(o)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 1 of 2 residents reviewed for insulin use. (Resident 59) Finding includes: On 10/29/24 at 12:59 P.M., Resident 59's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 9/29/24, indicated Resident 59 was not assessed for cognitive impairment because the resident was rarely or never understood and the resident received insulin 7 days during the 7-day lookback period. The July 2024 Physician's recapitulation orders dated 7/7/24 at 9:39 A.M., indicated the following	F 0842	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Provider Notification Documentation for Resident #59 is being completed and accurately documented. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected by this practice. All Nursing staff were in-serviced on Documentation Guidelines by DNS/Designee **What measures will be put into**	11/29/2024

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	order was received: Humalog (insulin lispro) KwikPen - insulin lispro (a short-acting insulin) - Give per Sliding Scale subcutaneous, three times a day, If Blood Sugar is less than 60 mg/dL, call physician. If Blood Sugar is 0 to 199, give 0 Units. If Blood Sugar is 200 to 249, give 1 Units. If Blood Sugar is 250 to 299, give 2 Units. If Blood Sugar is 300 to 349, give 3 Units. If Blood Sugar is 350 to 399, give 4 Units. If Blood Sugar is 400 to 499, give 5 Units. If Blood Sugar is greater than 500, call physician. A risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus care plan, dated 4/7/20 and reviewed 9/25/24, included an intervention to document abnormal findings and notify the physician. A vital sign report, dated 7/2/24 at 10:14 A.M., indicated Resident 59's blood glucose level was 490 mg/dL. The July 2024 Medication Administration Record (MAR) indicated the physician was notified of the elevated blood glucose level on 7/2/24. The Progress notes, medication administration notes, and event forms, dated 7/2/24, lacked documentation to determine the physician responded to or the facility staff made attempts to follow-up with the physician to address the elevated blood glucose level. A Physician/NP order, dated, 7/6/24 at 2:09 P.M., indicated orders were received for staff to immediately (STAT) obtain blood draws for a complete blood count (CBC) (a laboratory test to		**place or systematic changes made to ensure that the deficient practice will not reoccur?** The Nursing staff was in-serviced and educated on Documentation Guidelines All resident MAR's have been audited to ensure documentation has been completed. The DNS/Designee will complete daily audits for all residents receiving insulin to ensure that documentation is accurate and complete **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** The DNS/Designee will be responsible for the completion of the Provider Notification Documentation QA tool weekly x 4 weeks, monthly x 6, then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed.	

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	measure the number and type of cells in blood and a comprehensive metabolic panel (CMP) (a laboratory test that measures 14 substances in your blood to provide information about your metabolism and chemical balance). A Nursing progress note, dated 7/6/24 at 11:01 P.M., indicated the lab called the facility at 6:00 P.M. to report Resident 59 had a critical blood glucose level of 526 mg/dL. The NP was texted and called by Licensed Practical Nurse (LPN) 6 about critical lab value. A response was not received. A message screenshot, dated 7/6/24 at 6:50 P.M., indicated staff texted the critical blood glucose level to the NP and requested orders, but did not receive a response. A vital sign report, dated 7/7/24 at 12:24 P.M., indicated Resident 59's blood glucose level was 548 mg/dL. The July 2024 Medication Administration Record (MAR) indicated no insulin lispro was administered to Resident 59, on 07/07/24, to treat the blood glucose level of 548 mg/dL. A vital sign report, dated 7/7/24 at 4:25 P.M., indicated Resident 59's blood glucose level was 582 mg/dL. The July 2024 Medication Administration Record (MAR) indicated no insulin lispro was administered to Resident 59, on 07/07/24, to treat the blood glucose level of 582 mg/dL. The July 2024 MAR indicated Resident 59's 8:00 A.M. dose of insulin lispro on 7/8/24 was given by Registered Nurse (RN) 15, but did not indicate			

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	the blood glucose was measured prior to administration, how much insulin was given, or the body site where the insulin was given. During an interview with the Director of Nursing (DON) on 10/30/24 at 1:44 P.M., she indicated the nurse called the NP for the blood sugars over 500 mg/dL on 7/7/24. The NP said to give five units over the maximum units on the sliding scale. The documentation system would not let her input that she gave 10 units, so she put she gave zero units. She did not document the notification to the NP, the new order, or the insulin administration amount in a progress note or as a medication administration note, but she should have. At that time, the DON was unable to provide documentation to indicate the nurse gave 10 units of insulin. During an interview with the DON on 10/30/24 at 1:59 P.M., she indicated Licensed Practical Nurse (LPN) 6 did not remember if she gave the 8 A.M. dose of insulin lispro on 7/8/24 or not. The DON was unsure what Resident 59's blood glucose was at 8:00 A.M. on 7/8/24 at 8:00 A.M., or how many units of insulin lispro were given if any. During an interview, on 11/1/24 at 8:15 A.M., the Administrator indicated text messages were not part of the clinical record. During an interview with the Administrator on 11/1/24 at 8:51 A.M., she indicated staff texted the NP and didn't need to document all communication in the progress notes. During an interview with the Nurse Practitioner (NP) on 11/1/24 at 9:00 A.M., the NP indicated that she did not have a record of being contacted on 7/2/24 in relation to Resident 59's elevated blood			

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	glucose level. She indicated she would have advised staff to recheck the blood sugar in an hour and call back if it was still high. The NP indicated she was unable to find a recheck of blood glucose levels for Resident 59 on 7/2/24. The NP indicated the sliding scale insulin order was for one week on a trial basis and then the resident would be re-evaluated. At that time, the NP was unable to provide documentation that the insulin order was on a trial basis and when the resident was to be re-evaluated. The NP indicated she was not contacted by a nurse on 7/8/24 about Resident 59's blood glucose level, insulin, or a missed dose. The NP was unsure what Resident 59's blood glucose was at 8:00 A.M. on 7/8/24 or how many units of insulin lispro were given. On 11/1/24 at 2:06 P.M., the Administrator provided a current General Dose Preparation and Medication Administration policy, dated 4/30/24, that indicated "Document necessary medication administration/treatment information (e.g. when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application site) on appropriate forms". On 11/1/24 at 2:06 P.M., the Administrator provided a current Authorization and Communication of Orders policy, dated 6/1/24, that indicated "Facility should ensure that the authorized person receiving a verbal order immediately records it in the resident's chart or electronic order system, including the date and time of the order, the name of physician/prescriber, the signature of the person recording the order and other information as permitted by and in accordance with applicable law".			

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	3.1-50(a)(1) 3.1-50(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation and interview, the facility failed to ensure infection control practices were in place for 2 of 2 residents during incontinence care and 1 of 1 resident during wound care. Staff failed to sanitize hands and change gloves between soiled to clean tasks, as well as failed to use enhanced barrier precautions during wound care. (Resident 64, Resident 85, and Resident 86) Findings included: 1. On 10/24/24 at 10:43 A.M., CNA (Certified Nurses Aide) 3 went into Resident 64's room. CNA 3 donned gloves, checked the resident's brief to see if they were incontinent, started to act upon changing the soiled brief but then indicated they would go get another staff member to assist. CNA 3 touched the resident's remote to their bed, and bedside table with soiled gloves before removing them then did not sanitize or wash hands. On 10/29/24, at 11:44 A.M., Resident 64's clinical record was reviewed. The Annual MDS (Minimum Data Set) Assessment on 8/5/24 indicated the resident was not cognitively intact, required substantial or maximum assistance with toileting and personal hygiene, was always incontinent of bowel and bladder, and had a diagnosis that included but was not limited to dementia. 2. On 10/25/24 at 10:58 A.M. Resident 85 indicated that they got frequent urinary tract infections	F 0880	**How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** Residents 64, 85, and 86 had no negative effects by the alleged deficient practice. Residnet 64 and 85 are receiving incontinent care per infection control protocol Resident 86 is receiving wound care per infection control protocol **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected by this practice. CNA's 3/7, QMA 5 and LPN 4 all educated on the proper donning and doffing PPE and Enhanced Barrier Precaution Procedures **WWhat measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur?** DNS/Designee to in-service all nursing staff on Infection Control Policy and Enhanced Barrier Precautions to include glove	11/29/2024

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	because staff did not clean her properly. The clinical record was reviewed on 10/28/24 at 2:49 P.M. A Quarterly MDS (Minimum Data Set) Assessment, dated 9/24/24, indicated the resident was cognitively intact, used a wheel chair, required substantial to maximum assistance with bathing and personal hygiene, was incontinent of bowel and bladder, had a primary diagnosis of COPD (chronic obstructive pulmonary disease), had a urinary tract infection within the last 30 days, had an intravenous catheter, had been on intravenous medications, required isolation precautions, and was on antibiotics. On 10/31/24, at 9:22 A.M., while peri care and linen change was performed for Resident 85 CNA (Certified Nurses Aide) 7 stopped QMA (Qualified Medication Aide) 5 to remind them to change their gloves before proceeding after the resident's soiled incontinence brief was removed and skin was cleansed. QMA 5 took off soiled gloves and put on clean gloves, did not wash or sanitize hands. CNA 7 did not change their gloves, wash or sanitize hands, after removing soiled bed pan from underneath the resident before continuing with care, including assisting the resident with washing their face. 3. On 10/29/24 at 10:15 A.M., Resident 86's clinical record was reviewed. Diagnoses included, but were not limited to, stage 4 pressure ulcer of sacral region. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 10/11/24, indicated Resident 86 had no cognitive impairment, required substantial to maximal assistance of staff (staff does more than half) for all Activities of Daily Living (ADLs), and had one stage 4 pressure ulcer on admission to the facility.		change, proper PPE and hand washing/sanitizing. Observational rounds will be completed by DNS/Designee to ensure proper PPE and handwashing/sanitizing techniques are being used prior to and during resident care. **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** The DNS/Designee will be responsible for the completion of the Proper PPE, Hand Washing/Sanitizing and Enhanced Barrier Procedures QA tool weekly x 4 weeks, monthly x 6, then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed.	

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	The most current wound assessment, dated 10/23/24, indicated Resident 86 had a pressure ulcer on the sacrum that measured 8.8 centimeters (cm) in length, 8 cm in width, and 1.3 cm in depth. Care plans included, but were not limited to: Resident is at risk of transferring or becoming colonized with an MDRO (multi-drug resistant organism) and requires enhanced barrier precautions due to an indwelling medical device and a chronic wound that requires a dressing, dated 9/16/24. Interventions included, but were not limited to, enhanced barrier precautions and wear gown and gloves prior to high contact resident care activities. The clinical record lacked physician orders for EBP. On 10/30/24 at 9:40 A.M., Licensed Practical Nurse (LPN) 4 was observed performing wound care for Resident 86. LPN 4 was not wearing a gown while performing the wound care. A sign indicating Resident 86 was on Enhanced Barrier Precautions (EBP) was observed hanging on the wall by the gloves in the room. On 10/31/24 at 10:44 A.M., the Infection Preventionist (IP) indicated that residents with wounds automatically got placed on EBP. Staff should wear gown and gloves while performing any major care for the resident on EBP. On 10/31/24 at 10:56 A.M., the Administrator provided a current undated Enhanced Barrier Precautions policy that indicated "Enhanced Barrier Precautions expands the use of PPE (personal protective equipment) beyond situations in which exposure to blood and body fluids is anticipated, it refers to the use of gown			

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	and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Enhanced barrier precautions are used for: Resident(s) with chronic wounds and/or indwelling medical devices, regardless of their MDRO status ...". 3.1-18(b)(2) 3.1-18(l)			