| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155226 | A. BUILDING 00<br>B. WING | 06/03/2024 |

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| NORTH CAPITOL NURSING & REHABILITATION CENTER | 2010 N CAPITOL AVE<br>INDIANAPOLIS, IN 46202 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00433435 and IN00430020.<br><br>Complaint IN00433435 - Federal/State deficiencies related to the allegations are cited at F677.<br><br>Complaint IN00430020 - No deficiencies related to the allegations are cited.<br><br>Survey dates: May 28, 29, 30, 31, and June 3, 2024<br><br>Facility number: 000131<br>Provider number: 155226<br>AIM number: 100274910<br><br>Census Bed Type:<br>SNF/NF: 60<br>Total: 60<br><br>Census Payor Type:<br>Medicare: 53<br>Medicaid: 2<br>Other: 5<br>Total: 60<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on June 6, 2024 | F 0000 | | |
| F 0554<br>SS=D<br>Bldg. 00 | 483.10(c)(7)<br>Resident Self-Admin Meds-Clinically Approp<br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined | | | |

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

Roland Todd Mann | Executive Director | 06/21/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | that this practice is clinically appropriate.<br>Based on observation, interview and record review, the facility failed to have the Interdisciplinary team (IDT) determine and document a self medication assessment was clinically appropriate for 1 of 1 residents randomly observed with medications by their side in a common area. (Resident 18)<br><br>Findings include:<br><br>A random observation of Resident 18 was made on 5/28/24 at 11:12 a.m. Resident 18 was sitting in the common area/lounge on the second floor and on a table beside her was a medication cup with pills in it. The cup had several unidentified medication tablets in it. Resident 18 indicated, she questioned the number of medications in the cup and did not want to take medications without knowing what she was given.<br><br>An interview with Licensed Practical Nurse (LPN 22) conducted on 5/28/24 at 11:17 a.m. indicated, she had given Resident 22 her morning medications and believed she had placed them in her mouth prior to leaving the resident. LPN 22 indicated, Resident 18 must have spit them out back into the cup after she left the resident.<br><br>An interview with Resident 18 conducted on 5/28/24 at 11:19 a.m. indicated, she had not spit her medications out into the cup. She indicated, she had not attempted to take the medications as she was concerned with what medications they were.<br><br>Resident 18's clinical record was reviewed on 5/29/24 at 1:21 p.m. Resident 18's diagnoses included, but not limited to, paranoid schizophrenia, anxiety disorder, and major | F 0554 | **F tag: 554**<br><br>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice<br>**Resident 18 continues to reside in the facility and will receive all medications by licensed staff per plan of care and medication administration policy. Resident 18 has had no recent changes in condition and the plan of care is up to date.**<br>how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken<br>**All residents have the potential be affected**<br>**All residents will be reviewed for the need of self-administration of medications and all care plans will be updated as indicated from the review by DNS/Designee**<br>**All residents that self-administer will be reviewed by IDT and all appropriate assessments will be completed and documented as needed per policy.**<br><br>**Licensed nursing staff will be in serviced by the DNS/Designee regarding** | 07/05/2024 |

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| | depressive disorder. The clinical record for Resident 18 did not contain a Self-Administration of Medication assessment.<br><br>A Quarterly Minimum Data Set dated 3/28/24 indicated, Resident 18 had a moderate cognitive deficit.<br><br>Resident 18's care plan reviewed at the same time as her clinical record did not contain a care plan regarding her being able to self-administer any medications.<br><br>A Self-Administration of Medication policy received on 5/29/24 at 1:06 p.m. from Nurse Consultant indicated, "Procedure: Alert residents will be informed of their right to self-administer medications upon admission. If a resident desires to participate in self-administration, the Interdisciplinary Team will assess the competence of the resident to participate by completing the 'Self-Administration of Medication Assessment' observation. A physician order will be obtained specifying the resident's ability to self-administer medications and, if necessary, listing which medication will be included in the self-administration plan...The resident will be assessed for continued self-administration of medications quarterly and with any significant change of condition. The resident's care plan will be updated to include self-administration."<br><br>3.1-11(a) | | **policy/procedure for self-administration of medications**<br>what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.<br>**Licensed nursing staff will be in serviced by the DNS/Designee regarding policy/procedure for medication administration**<br><br>**The medication administration tool will be used by the licensed nurse to verify that self-medication administration assessment observation has been completed per policy.**<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.<br><br>**To ensure compliance, the DNS/Designee is responsible for the completion of the Self-Medication Administration QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the** | |

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| | | | **ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.** | |
| F 0677 SS=D Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>Based on observation, interview, and record review, the facility failed to provide dependent residents with oral care, complete bed bath, hair care, and emptying of a bedside commode for 3 of 6 residents reviewed for activities of daily living (ADLs). (Resident D, Resident E, and Resident F)<br><br>Findings include:<br><br>1. The clinical record for Resident D was reviewed on 5/31/24 at 3:05 p.m. The diagnoses included, but were not limited to, hypertension, congestive heart failure, diabetes mellitus, and muscle weakness.<br><br>A care plan for skin integrity, dated 5/21/24, indicated Resident D had impaired skin integrity. He was on bedrest, limited in his ability to change positions, and a problem for shear and friction related to required maximum assistance with bed mobility.<br><br>A physician order, dated 5/17/24, indicated to perform oral care three times a day.<br><br>An observation conducted of Resident D, on 5/29/24 at 9:56 a.m., of a white coated substance to his tongue. | F 0677 | **F tag**: **677**<br><br>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice<br>**Resident's D, E, and F continue to reside in facility with no negative outcomes or changes in conditions. Resident D is receiving oral care three times per day, Resident E bedside commode is being changed as needed, and Resident F is receiving a full bath per protocol**<br>how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.<br>**All Dependent residents who receive ADL care by staff have the potential to be affected.**<br><br>**All nursing staff will be in serviced by the DNS/designee on ADL Care for Dependent** | 07/05/2024 |

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| | An observation conducted of Resident D, on 5/29/24 at 10:43 a.m., of a white coated substance to his tongue.<br><br>An observation conducted of Resident D, on 5/30/24 at 11:45 a.m., of a white coated substance to his tongue along with foam on the inside of his mouth.<br><br>A skills competency form, review date of 03/2023, was provided by the Director of Nursing (DON) on 5/31/24 at 2:30 p.m. The form indicated to check teeth, mouth, tongue, and lips for odor, cracking, sores, bleeding, and discoloration.<br><br>2. The clinical record for Resident E was reviewed on 5/31/24 at 10:31 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, tracheostomy status, dependence on ventilator, muscle weakness, morbid obesity, and diabetes mellitus.<br><br>An ADL care plan, dated 8/4/22, indicated Resident E required assistance with ADLs including bed mobility, transfers, and toileting related to chronic respiratory failure, anxiety disorder, depression, and debility. An approach was listed to assist with toileting and/or incontinence care as needed.<br><br>A quarterly minimum data set (MDS) assessment, dated 4/4/24, indicated Resident E was cognitively intact, needed substantial/maximal assistance with toileting hygiene and personal hygiene, and supervision/touching assistance with toilet transfer.<br><br>An observation conducted of Resident E, on 5/28/24 at 12:15 p.m., of a yellow liquid present in | | **Residents on or before DNS/Designee observed all residents to ensure residents were receiving oral care as needed, commodes were emptied and residents were receiving bad baths per protocol**<br><br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.<br><br>**All nursing staff will be in serviced by the DNS/designee on ADL care for dependent residents**<br>**DNS/Designee will conduct rounds each shift to ensure ADL is provided as needed and per resident preference**<br><br>how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place<br><br>**To ensure compliance, the DNS/Designee is responsible for the completion of the ADL Care for Dependent Residents QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The** | |

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| | the bedside commode in Resident E's room. Upon interviewing Resident E, she indicated she got up around 6:00 a.m. on 5/28/24 to utilize the bedside commode and it was not emptied at that time.<br><br>An observation conducted of Resident E, on 5/28/24 at 2:25 p.m., of a yellow liquid still present in the bedside commode of Resident E's room.<br><br>3. The clinical record for Resident F was reviewed on 5/31/24 at 10:03 a.m. The diagnoses included, but were not limited to, respiratory failure, diabetes mellitus, obesity, tracheostomy status, gastrostomy status, and dependence on ventilator.<br><br>An admission MDS assessment, dated 4/1/24, indicated Resident F was dependent for ADLs, totally incontinent of bowel, and an indwelling catheter.<br><br>An ADL care plan, dated 3/28/24, indicated Resident F required assistance with ADLs including bed mobility, transfers, eating, and toileting related to mobility deficits, respiratory failure, obesity, ventilator status, and muscle weakness. The approach listed to assist with bathing as needed, assist with bed mobility as needed, and assist with toileting and/or incontinent care as needed.<br><br>An observation conducted of Resident F, on 5/28/24 at 11:23 a.m., of a bed bath being provided by Certified Nursing Aide (CNA) 6. CNA 6 obtained a basin containing soapy water. She started utilizing a washcloth to Resident F's arms, abdomen, and frontal perineal area. CNA 6 obtained a basin of more water to continue to provide a bed bath to Resident F. CNA 6 positioned Resident F to the right side and | | **results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.** | |

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| | proceeded to utilize the washcloth to the back, buttocks, and posterior thighs. CNA 6 indicated she completed the bed bath after placing a gown on Resident F and covering her up with a blanket. CNA 6 did not wash Resident F's face, hair, or both legs below the knees, and feet. Resident F's hair appeared greasy and unkept. CNA 6 indicated she attempted to provide all residents on the unit with a bed bath daily, but Tuesdays were Resident F's bathing days.<br><br>An observation conducted of Resident F, on 5/29/24 at 10:38 a.m., noted her hair appeared greasy.<br><br>An observation conducted of Resident F, on 5/31/24 at 2:00 p.m., noted her hair appeared greasy.<br><br>Documents titled "shower report" were reviewed and indicated the last time a staff member checked to indicate Resident F had shampoo to their hair was 5/10/24.<br><br>A skills competency form, dated 03/2023, was provided by the DON on 5/31/24 at 2:30 p.m. The form indicated to wash, rinse, and pat dry the face, neck, ears, behind ears, shoulder, underarm, arm, hand, fingers, abdomen, leg, foot, toes, neck, back, buttocks, and anal area.<br><br>This citation relates to Complaint IN00433435.<br><br>3.1-38(a)(2)(A)<br>3.1-38(a)(2)(C)<br>3.1-38(a)(3)(A)<br>3.1-38(a)(3)(B)<br>3.1-38(a)(3)(C) | | | |

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| F 0686 SS=D Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<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>Based on observation, interview, and record review, the facility failed to ensure a low air loss mattress was functioning for 2 of 2 residents reviewed for pressure ulcers. (Resident D and Resident 45)<br><br>Findings include:<br><br>1. The clinical record for Resident D was reviewed on 5/31/24 at 3:05 p.m. The diagnoses included, but were not limited to, hypertension, congestive heart failure, diabetes mellitus, and muscle weakness.<br><br>A care plan for skin integrity, dated 5/21/24, indicated Resident D had impaired skin integrity. He was on bedrest, limited in his ability to change positions, and a problem for shear and friction related to required maximum assistance with bed mobility. An approach was listed to utilize a pressure reducing/redistribution mattress on the bed/low air loss (LAL) mattress. | F 0686 | **F tag: 686**<br><br>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice<br>**Resident D and resident 45 continue to reside in the facility and have had no negative outcomes related to treatment/SVCS to prevent/heal pressure ulcers.** Resident D and Resident 45 low air loss mattresses are functioning per manufacturers instructions.<br><br>how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken | 07/05/2024 |

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| | An observation conducted of Resident D, on 5/29/24 at 9:56 a.m., laying on a mattress with a pump to the foot board. There were no lights on the pump to indicate it was on and functioning.<br><br>An observation conducted of Resident D, on 5/29/24 at 10:43 a.m., laying in bed with the LAL mattress pump to the foot board not having lights on to indicate it was on and functioning.<br><br>An observation conducted of Resident D, on 5/30/24 at 9:35 a.m., laying in bed with the LAL mattress pump remained without lights on to indicate it was on and functioning.<br><br>An observation conducted of Resident D, on 5/30/24 at 11:45 a.m., laying in bed with the LAL mattress pump remained without lights on to indicate it was on and functioning.<br><br>An interview conducted with Respiratory Therapist (RT) 5, on 5/30/24 at 12:10 p.m., indicated there are times where the lights would flicker and indicate the generator was activated. When that occurs, he would check resident rooms to ensure all items were working. RT 5 went to the outlet that the LAL mattress was plugged into, but it appeared that it wasn't plugged in entirely into the outlet. RT 5 placed the plug entirely into the outlet and the lights came on for Resident D's LAL mattress. The mattress was observed to be rising when the LAL mattress pump had lights on to indicate it was operational.<br><br>2. The clinical record for Resident 45 was reviewed on 5/31/24 at 10:09 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, congestive heart failure, tracheostomy status, gastrostomy status, reduced mobility, muscle | | **Residents who have a LAL mattress are at risk.**<br><br>**All staff will be in serviced by the DNS/Designee regarding this deficiency**<br>**DNS/Designee observed all air loss mattresses to ensure mattresses were operating properly**<br><br>what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.<br><br>**All staff will be in-serviced by ED/DNS/Designee on managing LAL/SVCS**<br><br>**~~All staff~~Care companion/designee will observe and monitor the function of LAL mattresses and notify the supervisor along with proper follow up.**<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.<br><br>**To ensure compliance, the ED/DNS/Designee is responsible for the completion of the Treatment/SVCS to prevent/heal pressure ulcers QAPI tool weekly times 4** | |

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| | weakness, and epilepsy.<br><br>A significant change minimum data set (MDS) assessment, dated 2/22/24, indicated Resident 45 was dependent on staff for activities of daily living care.<br><br>A physician order, dated 3/27/24, indicated the utilization of a LAL mattress to Resident 45's bed.<br><br>A care plan for skin integrity, revised 5/28/24, indicated Resident 45 had a history of impaired skin integrity/pressure injury to their left hip that had healed previously and a history of multiple pressure ulcers. A pressure reducing mattress/LAL mattress was listed as an approach.<br><br>An observation conducted of Resident 45, on 5/29/24 at 10:33 a.m., with the LAL mattress pump, located on the foot board to the bed, was without lights to indicate it was on and functioning.<br><br>An interview with RT 5, on 5/29/24 at 10:35 a.m., indicated that the plug came undone that connected to the pump of the LAL mattress. RT 5 plugged the cord into the pump and the lights came on to indicate the pump was on. Resident 45's mattress proceeded to raise after the cord was plugged back into the pump.<br><br>A policy titled "Skin Management Program", dated 5/22, was provided by the Director of Nursing (DON) on 5/31/24 at 2:30 p.m. The policy indicated the following, " ...PROCEDURE FOR WOUND PREVENTION ...3. Interventions to prevent wounds from developing and/or promote healing will be initiated based upon the individual's risk factors to include but not limited to the following ...All residents will have a pressure redistribution mattress ...If resident | | **weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.** | |

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| NORTH CAPITOL NURSING & REHABILITATION CENTER | 2010 N CAPITOL AVE<br>INDIANAPOLIS, IN 46202 |

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| | prefers to utilize a mattress or cushion not provided by the facility this will be addressed in the residents care plan ...."<br><br>3.1-40(a)(2) | | | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, interview, and record review, the facility failed to ensure flooring was in good condition to prevent accident hazards for a resident that had tripped on loose flooring and had fallen for 1 of 2 residents reviewed for accidents. (Resident E)<br><br>Findings include:<br><br>The clinical record for Resident E was reviewed on 5/31/24 at 10:31 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, tracheostomy status, dependence on ventilator, muscle weakness, morbid obesity, and diabetes mellitus.<br><br>An ADL care plan, dated 8/4/22, indicated Resident E required assistance with ADLs including bed mobility, transfers, and toileting related to chronic respiratory failure, anxiety disorder, depression, and debility. An approach was listed to assist with toileting and/or | F 0689 | **F 689**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>The flooring in the room occupied by Resident E was repaired.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents residing in the facility have the potential to be affected by this deficient practice<br>An audit will be conducted to identify any other rooms with missing floor tiles. All identified areas of concern will be addressed | 07/05/2024 |

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| | incontinence care as needed.<br><br>A quarterly minimum data set (MDS) assessment, dated 4/4/24, indicated Resident E was cognitively intact, needed substantial/maximal assistance with toileting hygiene and personal hygiene, and supervision/touching assistance with toilet transfer.<br><br>An interview conducted with Resident E, on 5/28/24 at 12:15 p.m., indicated there was a piece of flooring that was not level. She tripped due to her shoe being caught on the floor due to a piece of flooring that was missing. She went to sit on the bed, that was not locked at that time, and she twisted and fell onto her bottom. She was able to see the subfloor due to the missing flooring. An observation conducted during the interview, noted a piece of wood flooring that was present underneath Resident E's wheels to the foot of her bed that were mismatched. Resident E indicated they put that newer flooring down after she fell.<br><br>A fall event, dated 3/26/24, indicated Resident E had fallen onto the floor while transferring from wheelchair to bed. Resident E stated she tripped on a piece of impaired floorboard and the floorboard was loose. Maintenance was made aware of loose flooring, and they immediately fixed that floorboard.<br><br>An interdisciplinary team (IDT) note, dated 3/27/24, indicated the root cause of Resident E falling was loose flooring.<br>An interview conducted with Registered Nurse 2, on 5/30/24 at 11:40 a.m., indicated the flooring had been coming up throughout the unit. It started on the 4th floor and now it's on the unit that Resident E resided on. For some reason the floorboard came up and Resident E tripped on it causing her | | immediately.<br>Any Inservice will be conducted with all staff on reporting any maintenance concerns timely.<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>Any Inservice will be conducted with all staff on reporting any maintenance of housekeeping concerns timely.<br>ED/Designee will round to ensure floor tiles are in place<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>To ensure compliance the ED/Designee will complete a Free of accident Hazards CQI audit tool for six months with audits being completed once daily for one month, and then monthly for 5 months by a nurse manager or designee. This CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this | |

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| | to fall.<br><br>A policy titled "Fall Management", revised 8/2022, was provided by the Executive Director on 5/31/24 at 8:52 a.m. The policy indicated the following, " ...It is the policy of [name of company/corporation] to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls ...."<br><br>3.1-45(a)(1) | | practice will result in disciplinary action up to and or including termination of the responsible employee. | |
| F 0690 SS=D Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services | | | |

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| | to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained during incontinence care and ensure follow-up regarding changes in urinary output from an indwelling urinary catheter for 1 of 2 residents reviewed for urinary catheter. (Resident F)<br><br>Findings include:<br><br>The clinical record for Resident F was reviewed on 5/31/24 at 10:03 a.m. The diagnoses included, but were not limited to, respiratory failure, diabetes mellitus, obesity, tracheostomy status, gastrostomy status, dependence on ventilator, and neuromuscular dysfunction of bladder.<br><br>An admission MDS assessment, dated 4/1/24, indicated Resident F was dependent for ADLs, totally incontinent of bowel, and had an indwelling catheter.<br><br>An ADL care plan, dated 3/28/24, indicated Resident F required assistance with ADLs including bed mobility, transfers, eating, and toileting related to mobility deficits, respiratory failure, obesity, ventilator status, and muscle weakness. The approach listed to assist with bathing as needed, assist with bed mobility as needed, and assist with toileting and/or | F 0690 | **F tag: 690**<br><br>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice<br>**Resident F continues to reside in the facility and has had no negative outcomes related to maintaining infection control during incontinence care/urinary catheter management.**<br>**Resident F is receiving catheter care per protocol.**<br><br>how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:<br><br>**Residents with a urinary catheter and residents that are incontinent are at risk.**<br><br>**All staff will be in serviced by the DNS/Designee on this deficient practice** | 07/05/2024 |

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| | incontinent care as needed.<br><br>A care plan for indwelling urinary catheter, dated 3/28/24, indicated the approach of position the bag below the level of the bladder and report signs and symptoms of a urinary tract infection (UTI) that would include, but was not limited to, fever, foul odor, concentrated urine, or blood in urine.<br><br>An observation conducted of Resident F, on 5/28/24 at 11:23 a.m., of a bed bath being provided by Certified Nursing Aide (CNA) 6. CNA 6 obtained a basin containing soapy water. She started utilizing a washcloth to Resident F's arms, abdomen, and frontal perineal area. CNA 6 proceeded to wipe Resident F's perineal area from front to back but did it back-to-back and utilized the same part of the washcloth both times. CNA 6 took the urinary catheter bag and placed it in between Resident F's legs and had the urinary catheter bag above the level of the bladder before placing the urinary catheter bag in between Resident F's legs. CNA 6 proceeded to turn Resident F to her right side, continued with the bed bath, and placed the urinary catheter bag above the level of the bladder and returned the urinary catheter bag back to the bed frame to where it was secured to the frame. The tubing to the urinary catheter bag contained a liquid that was milky and gray in color.<br><br>An observation conducted of Resident F, on 5/29/24 at 10:38 a.m., of the tubing to the urinary catheter bag contained a liquid that was cloudy and dark yellow in color.<br><br>An observation conducted of Resident F, on 5/31/24 at 2:00 p.m., noted Resident F's urinary catheter tubing did not contain liquid but | | What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.<br><br>**All nursing staff will be in-serviced by ED/DNS/Designee on urinary catheter care and incontinence care**<br>**All nursing staff will follow infection control practices while providing incontinence care.**<br><br>**All licensed nurses will observe catheter output and follow up accordingly with the proper documentation and notification as needed.**<br><br>**DNS/designee will observe ADL care for resident with catheters to ensure protocol is followed.**<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.<br><br>**To ensure compliance, the ED/DNS/Designee is responsible for the completion of the Bowel and Bladder Catheter/UTI QAPI tool weekly times 4 weeks, monthly times 6** | |

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| | contained clumps of a white substance. Registered Nurse (RN) 2 was present and indicated it appeared that there were clumps of sediment in Resident F's catheter tubing. The urinary catheter bag contained a darker yellow liquid with sediment located at the bottom. RN 2 indicated there was sediment within the tubing in clumps along with sediment within the urinary catheter bag. RN 2 indicated she was going to reach out to Resident F's physician to see about an order for irrigation to the urinary catheter. RN 2 stated there seems to be an issue with sediment occurring within the residents who have an indwelling urinary catheter for long periods of time.<br><br>The most recent progress note in Resident F's clinical record, dated 5/21/24 at 6:09 p.m., indicated the urinary catheter was patent and flowing clear, yellow urine.<br><br>A policy titled "Change of Condition Policy", revised 11/2018, was provided by the Director of Nursing (DON) on 5/31/24 at 2:30 p.m. The policy indicated the following, " ...that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place ...."<br><br>3.1-41(a)(2) | | **and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.** | |
| F 0695 SS=D Bldg. 00 | 483.25(i) Respiratory/Tracheostomy Care and Suctioning<br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, | | | |

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| | is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>Based on observation, interview, and record review, the facility failed to assess a resident with a tracheostomy (trach) after providing trach care for 1 of 1 residents reviewed for death; ensure infection control practices were maintained during tracheostomy care (Resident D), and oxygen tubing/tracheostomy mask were changed as ordered (Resident E) for 2 of 3 residents reviewed for respiratory care. (Resident 60)<br><br>Findings include:<br><br>1. An observation was conducted of tracheostomy (trach) care for Resident D, on 5/30/24 at 11:45 a.m., by Respiratory Therapist (RT) 4 and RT 5. The bedside table was noted with a tracheostomy kit that was unopened. RT 4 and RT 5 donned personal protective equipment (PPE) that included clean gloves, gown, and a facemask. RT 5 removed the inner cannula with his clean gloves and discarded of such in the trash can. RT 4 prepared to suction Resident D. RT 4 connected the suction catheter to the suction machine and proceeded to suction Resident D. Resident D started to cough and coughed up large amounts of mucous after being suctioned. Mucous was noted within Resident D's trach collar and his upper chest. RT 4 removed their gloves and performed hand hygiene. She removed the cover to the trach care kit and retrieved the sterile gloves. The cuffs of both gloves were sticking to the gloves. RT 4 proceeded to shake the gloves to get the cuff to loosen but the sterile part of the gloves were contacting her hands. Both gloves were donned, | F 0695 | **F 695**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>**Resident 60 no longer resides in the facility.**<br>**Resident D continues to reside in the facility and will receive trach care that adheres to all infection control procedures.**<br>**Resident E still resides in the facility and trach mask and tubing has been changed as ordered.**<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents who residing in the facility who receive trach care have the potential to be affected by this deficient practice<br>An in-service will be completed for all Respiratory Therapists regarding these deficient practices<br>A skills check off will be completed with all Respiratory Therapists to ensure that all trach care is consistent with professional standards of practice. | 07/05/2024 |

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| | and a drape was set up by the trach kit on the bedside table. RT 5 proceeded to remove the soiled gauze from around Resident D's trach collar with the same gloves utilized to remove the inner cannula. RT 4 took the supplies from the trach kit and placed on the drape located on the bedside table next to the trach kit. RT 4 touched Resident D's trach collar with her left hand that was now considered "clean". RT 4 took the saline gauze with her right hand and cleaned around the trach as well as the mucous that was hanging from the trach collar. RT 5 proceeded to remove the old trach collar since it was soiled with mucous and placed a new trach collar around Resident D's neck with the same gloves used for removing the inner cannula and removing the gauze around the trach site. RT 4 asked for the new inner cannula for Resident D's tracheostomy. RT 5 retrieved a new inner cannula by opening drawers to retrieve such, still in the package, and placed it on the bedside table, next to the trach kit with the same gloves worn. RT 4 took her sterile hand and grasped the package containing the inner cannula and asked RT 5 to open it for them. RT 5 opened the package of the inner cannula while RT 4 touched the inner cannula with her nonsterile right hand and placed the inner cannula into Resident D's tracheostomy.<br><br>An interview conducted with RT 5, on 5/30/24 at 12:10 p.m., indicated, if requested, then there could be two respiratory therapists conducting tracheostomy care.<br><br>A "Respiratory Care: Competency Assessment Form", undated, was provided by Nurse Consultant on 5/30/24 at 2:28 p.m. The document indicated "Tracheostomy Care On Ventilator Dependent Resident" in the following order: | | **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>An in-service will be conducted with all Respiratory staff regarding the deficient practice.<br>RT department manager/designee will observe trach care practices to ensure that all procedures are being adhered to and is consistent with professional standards of practice.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>To ensure compliance the RT manager/designee will complete a trach care/suctioning CQI audit tool for six months with audits being completed daily for one month, and then monthly for 5 months by the respiratory manager or designee. The trach care/suctioning CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this | |

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| | Verify physician's order,<br>Obtain all necessary equipment and supplies,<br>Identify resident/self,<br>Wash hands, practice universal precautions, and explain procedure,<br>Position resident,<br>Suction the trach, if necessary, using sterile technique, then wash hands,<br>Aseptically open the sterile saline/water and evenly dispense it in two containers,<br>Aseptically don sterile gloves,<br>Remove the inner cannula with non-dominant hand,<br>With dominant "clean" hand, insert the new disposable inner cannula,<br>Remove the dressing from around the trach and discard with non-dominant hand, &<br>Clean the area around the stoma by moistening the 4x4 gauze sponges with sterile saline/water.<br><br>The tracheostomy care competency form indicated the trach care task was not completed in order and with proper infection control practices related to removing the inner cannula with clean gloves, not inserting new inner cannula right after the previous one was removed, not changing gloves and performing hand hygiene after removing inner cannula, touching a soiled gauze sponge around the trach site, obtaining a new trach collar and apply such trach collar after removal of soiled trach collar, and not ensuring sterile technique during trach care with shaking of sterile gloves that made contact with the hands of the staff.<br><br>2. The clinical record for Resident E was reviewed on 5/31/24 at 10:31 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, tracheostomy status, dependence on ventilator, muscle weakness, morbid obesity, and diabetes | | practice will result in disciplinary action up to and or including termination of the responsible employee. | |

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| | mellitus.<br><br>A quarterly minimum data set (MDS) assessment, dated 4/4/24, indicated Resident E was cognitively intact, needed substantial/maximal assistance with toileting hygiene and personal hygiene, and supervision/touching assistance with toilet transfer.<br><br>A physician order, dated 1/9/23, indicated to change oxygen tubing once a week on Sundays.<br><br>An observation conducted of Resident E, on 5/28/24 at 12:15 p.m., noted a trach collar worn that was dated for 5/8.<br><br>An observation conducted of Resident E, on 5/28/24 at 2:25 p.m., noted with the same trach collar dated for 5/8. 3. The clinical record for Resident 60 was reviewed on 6/3/24 at 9:52 a.m. The diagnosis included, but was not limited to, tracheostomy.<br><br>A physician order dated 4/9/24 indicated Resident 60 was to receive "routine trach care."<br><br>A nursing progress note written by License Practical Nurse (LPN) 7 dated 4/11/24 at 7:12 a.m. "Res [resident] in bed resting peacefully...Trach intact, res was suctioned once this shift. Small white secretions obtained..."<br><br>An interview was conducted with LPN 7 on 6/3/24 at 11:04 a.m. She indicated on 4/11/24 approximately at 2:30 a.m., she was notified by the certified nursing assistant (CNA), Resident 60 had pulled out his trach. She then went in and placed the trach back in and his oxygen saturations were 96%. The resident was breathing fine for the rest of her shift which ended around 7:00 a.m. During | | | |

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| | her shift, she had administered medications and had taken his vitals. The resident was stable at that time.<br><br>The resident's clinical record did not indicate an assessment after trach care was provided to Resident 60 that included pertinent information: trach care had been provided due to removal, the resident's tolerance of the procedure, the appearance of stoma, redness, and/or any concerns with trach care.<br><br>An interview was conducted with the Director of Nursing on 6/3/24 at 11:23 a.m. She indicated she had been notified by LPN 7 via phone on 4/11/24, Resident 60 had removed his inner cannula of his trach, and she had to reinsert the inner cannula.<br><br>A tracheostomy are policy was provided by the Director of Nursing on 6/3/24 at 11:30 a.m. It indicated "...Documentation: document procedure, resident tolerance, and other pertinent information, including amount, color,, consistency of drainage, appearance of stoma, redness, tenderness, odors or other concerns..."<br><br>3.1-47(a)(4)<br>3.1-47(a)(6) | | | |
| F 0770<br>SS=D<br>Bldg. 00 | 483.50(a)(1)(i)<br>Laboratory Services<br>§483.50(a) Laboratory Services.<br>§483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.<br>(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. | | | |

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| | Based on interview and record review, the facility failed to timely obtain laboratory tests, as ordered by the physician, for 1 of 5 residents reviewed for unnecessary medications (Resident 5).<br><br>Findings include:<br><br>The clinical record for Resident 5 was reviewed on 5/29/24 at 11:10 a.m. The Resident's diagnosis included, but were not limited to, diabetes, hypertension, and epilepsy.<br><br>A care plan, initiated 10/29/18, indicated Resident 5 had ineffective tissue perfusion related to his diagnosis of hypertension, hyperlipidemia (high cholesterol), and history of stroke. The goal was for him to maintain adequate tissue perfusion as evidenced by blood pressure within normal limits for resident, no change in mental status, no complaints of dizziness/lightheadedness/syncope, and no edema. The interventions included, but were not limited to, obtain labs as ordered, initiated 10/29/18, and administer medications as ordered by the physician, initiated 10/29/18.<br><br>A physician's order, dated 3/28/24, indicated he was to have a CBC (complete blood count) with differential, CMP (complete metabolic panel), HgbA1c (long term blood sugar level), TSH (thyroid stimulating hormone), and a vitamin D alpha hydroxy 25 (vitamin D level) obtained on the 4th Friday of March and September. The start date was 3/29/24.<br><br>A physician's order, dated 3/28/24, indicated he was to have a valproic acid (antiseizure medication) level to be obtained on the 4th Friday of March, June, September, and December. The start date was 3/29/24. | F 0770 | **F tag: 770**<br><br>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice<br>**Resident 5 continues to reside in the facility and has had no negative outcomes related to laboratory services. Resident 5 is having labs drawn per MD order.**<br><br>how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:<br><br>**All residents in the facility are at risk.**<br>**DNS/Designee reviewed MD orders for labs to ensure all labs were completed as ordered.**<br><br>**All licensed nursing staff will be in serviced by the DNS/Designee on lab policies and procedures**<br><br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.<br><br>**All licensed nursing staff will be in-serviced by ED/DNS/Designee on lab policy** | 07/05/2024 |

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| | A physician's order, dated 3/28/24, indicated he was to have a lipid profile obtained on the 4th Friday of March. The start date was 3/29/24.<br><br>The clinical record did not contain laboratory results for 3/29/24.<br><br>During an interview on 5/30/24 at 1:29 p.m., the ADNS (Assistant Director of Nursing) indicated that the labs were not drawn on 3/29/24. She was unsure why the labs were not obtained.<br><br>During an interview on 5/31/24 at 2:10 p.m., Laboratory Associate 20 indicated the laboratory did not have a record that any labs had been ordered to be obtained on 3/29/24.<br><br>On 5/30/24 at 3:17 p.m., the Regional Nurse Consultant provided the Guidelines for Lab and Radiology Tracking, last reviewed April 2024, which read "...All lab and /or radiology orders will be entered into MatrixCare Physician Orders upon receipt of order...the nurse entering the order is responsible for notifying the lab provider of the lab order by their preferred method...If any lab and/ or radiology test ordered are not resulted as expected, investigate and take the necessary steps to obtain the results..."<br><br>3.1-49(a) | | **All licensed nursing staff will follow current laboratory policy and procedure with proper documentation and follow-up.**<br><br>**DNS/Designee will review orders for labs for all residents during morning clinical meeting to ensure residents are receiving labs per MD order.**<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.<br><br>**To ensure compliance, the ED/DNS/Designee is responsible for the completion of the Laboratory Services QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.** | |
| F 0812 SS=E | 483.60(i)(1)(2)<br>Food | | | |

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| Bldg. 00 | Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation, interview, and record review, the facility failed to properly store foods in the kitchen. This affected of 60 residents in the facility who eat food from the kitchen.<br><br>Findings include:<br><br>An initial tour of the kitchen was conducted on 5/28/24 at 10:11 a.m. with Registered Dietician (RD). During the initial tour the following was observed:<br><br>In the walk-in fridge:<br>- On a shelf in the fridge was a metal pan which contained a package of meat. RD indicated, at the time of the observation, the meat in the pan was thawing and should have been labeled with the | F 0812 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>Unlabeled meat found in refrigerator was discarded. Two unopened expired half gallon milks were discarded. Milk containers that were found sitting on the floor were removed and properly stored on the shelving. Unlabeled milk and juice found sitting on the tray were also discarded. The dietary manager's beard guard was corrected immediately and properly worn. | 07/05/2024 |

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| | kind of meat it was and a date indicating when it was taken out of the freezer to ensure its use within 72 hours of thawing.<br><br>- Two unopened half gallons of lactose free milk where found to be expired. The expiration dates on the containers of lactose free milk were May 12, 2024 and May 11, 2024 respectively.<br><br>- Sitting on the floor of the fridge in a milk crate were two unopened gallon jugs of milk. According to the RD at the time of the observation, no food items should be stored on the floor of the fridge.<br><br>- On a multi-shelf rack within the fridge, a tray contained 2 glasses of pre-poured milk and 3 glasses of orange juice. The tray was labeled with a use by date of 5/20 and the glasses of milk and juice were not labeled.<br><br>During the initial tour, it was observed that the Dietary Manager's (DM) mustache was not covered by a hair net and his mustache was more than a 1/4 inch long. DM indicated at the time of the observation, he was unaware of the need to also cover his mustache when wearing a beard net.<br><br>During the initial tour, it was observed that a large trash can that was not in current use did not have a lid on it.<br><br>A Food Storage policy received on 5/28/24 at 4 p.m. from RD indicated, "Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored at an appropriate temperature and by methods designed to prevent contamination...6. Food is stored a minimum of 6 inches above the floor...on clean racks or other clean surfaces and protected from | | **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents who receive milk, juice from the kitchen, or food prepared by the dietary manager have the potential to be affected by the alleged deficient practice.<br>Culinary manager/designee observed food storage in the kitchen to ensure properly stored.<br>An in-service will be completed for all dietary staff addressing the deficiency.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>An in-service will be conducted with all dietary staff to address the deficient practice.<br>When food deliveries arrive, the Dietary Manager will audit each item to ensure that all items are labeled correctly.<br>All items in the refrigerator will be checked daily ~~x 30 days~~ to ensure that all items are stored and labeled correctly.<br>ED/designee will round the kitchen daily ~~x 30 days~~ to ensure that staff are adhering to proper infection control procedures.<br><br>**How the corrective action(s)** | |

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| | contamination...The food must clearly be labeled with the name of the product, the date it was prepared, and marked to indicated the date by which the food shall be consumed or discarded...Refrigerated, ready-to-eat, potentially hazardous food purchased from approved vendors shall be clearly marked with the date the original container is opened and the date by which the food shall be consumed or discarded. This opened food can be held at 41 degrees Fahrenheit or less for no more than 7 days and the date marked may not exceed the manufacturer's use-by-date...11. Refrigeration...f. All foods shall be covered or wrapped tightly, labeled, and dated...12...d. Items that have been frozen and thawed should be used with 72 hours of being thawed, unless otherwise specified by the manufacturer.<br><br>The Retail Food Establishment Sanitation Requirements Refuse, Recyclables and Returnables Section 392 indicated, "(a) Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered: (1) inside the retail food establishment if the receptacles and units:<br>(A) contain food residue and are not in continuous use..."<br><br>3.1-21(i)(3) | | **will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>To ensure compliance the ED/Designee will complete a dietary CQI audit tool for six months with audits being completed daily for one month, and then monthly for 5 months by a nurse manager or designee. The _____CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. | |
| F 0880<br>SS=D<br>Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<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. | | | |

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| | §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 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 §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility | | | |

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| | 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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<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. | | | |
| | Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained during medication administration, while providing a bed bath (Resident F), and ensure personal protective equipment (PPE) was available to utilize prior to entering a room on transmission-based precautions (TBP) (Residents' 6, 21, 22, 41 and 56).<br><br>Findings include:<br><br>1. The clinical record for Resident F was reviewed on 5/31/24 at 10:03 a.m. The diagnoses included, but were not limited to, respiratory failure, diabetes mellitus, obesity, tracheostomy status, gastrostomy status, and dependence on ventilator. | F 0880 | **F tag: 880**<br><br>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice<br>**Resident's 6, 21, 22, 41, and 56 continue to reside in the facility and have had no negative outcomes related to infection control and prevention practices.**<br>**Resident F is receiving bed bath per protocol. CNA 6 has been inserviced by DNS/Designee regarding bathing a resident. Resident 22,** | 07/05/2024 |

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| | An admission MDS assessment, dated 4/1/24, indicated Resident F was dependent for ADLs, totally incontinent of bowel, and an indwelling catheter.<br><br>An ADL care plan, dated 3/28/24, indicated Resident F required assistance with ADLs including bed mobility, transfers, eating, and toileting related to mobility deficits, respiratory failure, obesity, ventilator status, and muscle weakness. The approach listed to assist with bathing as needed, assist with bed mobility as needed, and assist with toileting and/or incontinent care as needed.<br><br>An observation conducted of Resident F, on 5/28/24 at 11:23 a.m., of a bed bath being provided by Certified Nursing Aide (CNA) 6. CNA 6 obtained a basin containing soapy water. She started utilizing a washcloth to Resident F's arms, abdomen, and frontal perineal area. CNA 6 obtained a basin of more water to continue to provide a bed bath to Resident F while using the same gloves. CNA 6 positioned Resident F to the right side and proceeded to utilize the washcloth to wipe the anal area twice. CNA 6 was holding Resident F to their side with her right arm and used her left arm to take the same washcloth used to clean the anal area and proceed to wipe Resident F's posterior thighs.<br><br>A skills competency document titled "Bed Bath", review date of 03/2023, indicated to change gloves and complete hand hygiene after changing bath water as well as provide perineal care according to procedure. 2a. A medication administration observation was conducted on 5/28/24 at 1:01 p.m. with Licensed Practical Nurse (LPN) 20. LPN 20 was preparing Resident 22 medications for | | **6, 21, 41 are receiving medications per protocol. Resident 56 is receiving appropriate infection control procedures related to donning and doffing PPE. LPN 20 has been inserviced on appropriate medication pass per protocol. CAN 9 has been inserviced on donning PPE for residents in isolation.**<br><br>how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:<br><br>**All residents in the facility are at risk.**<br><br>**All staff will be in serviced by the ED/DNS/IP on infection control practices r/t isolation**<br>**All licenses nursing staff/QMAs were inserviced related to appropriate mediation administration.**<br>**All CNAs were inserviced on protocol for bed baths**<br><br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.<br><br>**All staff will be in-serviced by ED/DNS/IP on infection control and prevention** | |

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| | administration when he went to grab a medication cup, he placed his index finger inside the medication cup and thumb on the rim to separate the cups. He then popped the medication into the cup. As he picked up the medication cup to take to the resident, he placed his index finger inside the cup and pinched it between his index finger and thumb to carry it to Resident 22.<br><br>2b. A medication administration observation was conducted on 5/28/24 at 1:09 p.m. with LPN 20. LPN 20 was preparing Resident 6's medications for administration. Resident 6 required his medications be crushed prior to administration so LPN a grabbed plastic sleeve, which is used with the pill crusher, placed his index finger into the pill sleeve to open the pouch, and then dumped the medication into the pouch from the med cup.<br><br>2c. A medication administration observation was conducted on 5/28/24 at 1:12 p.m. with LPN 20. LPN 20 was preparing Resident 21's medications for administration. Resident 21 required her medications be crushed prior to administration so LPN a grabbed plastic sleeve, which is used with the pill crusher, placed his index finger into the pill sleeve to open the pouch, and then dumped the medication into the pouch from the med cup.<br><br>2d. A medication administration observation was conducted on 5/28/24 at 1:15 p.m. with LPN 20. LPN 20 was preparing Resident 41's medications for administration. Resident 41 required his medications be crushed prior to administration so LPN a grabbed plastic sleeve, which is used with the pill crusher, placed his index finger into the pill sleeve to open the pouch, and then dumped the medication into the pouch from the med cup and crushed two of the medications. Resident 41 also had a medication in a capsule form. LPN 20 after | | **All staff will follow infection control policies and procedures for all residents on isolation precautions.**<br><br>**All licensed nursing staff will follow infection control practices during medication administration.**<br><br>**Licensed nursing staff/QMAs will complete skills competency for med pass by DNS/Designee**<br><br>**DNS/Designee will observe CNAs performing bed baths to ensure infection control processes are followed.**<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.<br><br>**To ensure compliance, the ED/DNS/Designee is responsible for the completion of the Infection Prevention and Control QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the** | |

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| | crushing the other medications, donned (to put on) a pair of gloves, opened the capsule with his gloved hands and poured its contents in with the other medications, then doffed his gloves (to take off), and administered the medications to Resident 41. LPN 20 did not perform hand hygiene prior to donning his gloves nor after doffing his gloves.<br><br>An interview with Nurse Consultant (NC) conducted on 5/28/24 at 4:02 p.m. indicated, she was unable to find a facility policy regarding the not placing of fingers inside medication cups or pill crusher sleeve pouches.<br><br>A Nursing Skills Competency for Gloves received on 5/28/24 at 4:07 p.m. from Director of Nursing (DON) indicated, "Procedure Steps: 1. Perform hand hygiene. 2. Don gloves..." and after using gloves "8. Dispose of gloves in waste basket...9. Perform hand hygiene."<br><br>An Infection Prevention and Control Program Policy received on 5/28/24 at 4:07 p.m. from Director of Nursing (DON) indicated, "The facility shall establish and maintain infection prevention and control program...designed to provide a safe, sanitary...environment and help prevent the development and transmission of communicable diseases and infections...Goals...3. Implementation of acceptable standard of practice to correct problems related to infection control and prevention practices..."3. The clinical record for Resident 56 was reviewed on 5/31/24 at 3:15 p.m. The diagnosis included, but was not limited to, klebsiella pneumonia.<br><br>A physician order dated 5/28/24 indicated Resident 56 was to be in contact isolation for infections CRE (Carbapeneum-resistent enterobateriaceae) in sputum. | | **threshold of 95% is not achieved an action plan will be developed to ensure compliance.** | |

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A nursing progress note dated 5/31/24 indicated "...Resident with orders for vancomycin and ceriminipine on isolation for klebsiella pneumoniae Stenotrophomonas corynebacteria..."

An observation of Resident 56's room on 5/31/24 at 11:00 a.m. The resident's room had a sign indicating the resident's room was in transmission based precautions. The sign indicated the room was in droplet and contact isolation. "...Everyone must: perform hand hygiene: when entering and exiting room and wear all PPE listed below: gown, N95 respirator, eye protection and gloves." There was no observation of available PPE to don prior to entry of the room. A cart that contained PPE was observed inside of the resident's room by the foot of the resident's bed.

An interview was conducted with Respiratory Therapist (RT) 8 on 5/31/23 at 11:05 a.m. She indicated Resident 56 was in isolation, and she had donned the PPE that was in the resident's room by his bed.

An observation was made of Resident 56's room with the Infection Preventionist on 5/31/24 at 11:10 a.m. She indicated Resident 56 was on droplet/contact isolation. The cart that contained PPE should be outside of the room not in the resident's room. The staff should be donning the PPE prior to entering the resident's room.

An interview was conducted with Certified Nursing Aide (CNA) 9 on 5/31/24 at 11:15 a.m. CNA 9 indicated she had utilize the PPE inside of Resident 56's room. She had not been donning PPE prior to entering the resident's room.

An interview was conducted with the Nurse

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| | Consultant on 5/31/24 at 2:22 p.m. She indicated Resident 56 was in contact isolation not droplet. The PPE should be located outside of the resident's room, so staff can don prior to entering the resident's room. At that time, she had provided the Contact Precautions signage. It indicated: "Everyone must: Clean their hands (hand sanitizer or hand washing) before entering and when leaving the room. Put on gloves before room entry. Discard gloves before room exit. Put on a gown before room entry. Discard gown before room exit..."<br><br>A transmission-based precautions policy was provided by the Director of Nursing on 6/3/24 at 9:16 a.m. It indicated "...Policy: The facility shall utilize the appropriate transmission-based precaution based on the means of transmission and the infectious agent or organism involved. The isolation precautions should be the least restrictive possible for the resident under the circumstances...Contact Precautions: refers to measures intended to prevent transmission of infectious agents by direct or indirect contact either with the resident or with the resident's environment. Use for resident(s) with known or suspected infection(s) or evidence with the spread of infection(s). These precautions are in addition to Standard Precautions...Use of Personal Protective Equipment - gown and gloves. Applies to anyone entering the room who may touch the resident or objects in the room should wear PPE. Perform Hand Hygiene prior to entering the room and before leaving room. Personal Protective Equipment (PPE) should be placed in a 3-drawer container or an over-the-door personal protection organizer isolation caddy. The 3-drawer container should be placed outside the room or just upon entrance to the room. The over-the-door isolation caddy should be placed on the outside of the | | | |

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| | door facing the hallway..."<br><br>3.1-18(b)(2)<br>3.1-18(l) | | | |
| F 0914<br>SS=D<br>Bldg. 00 | 483.90(e)(1)(iv)(v)<br>Bedrooms Assure Full Visual Privacy<br>§483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident;<br><br>§483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.<br><br>Based on observation, interview, and record review, the facility failed to ensure privacy curtains were present rooms shared by two resident for 4 of 15 residents reviewed for environment (Resident 14, 36, 43, and 53).<br><br>Findings include:<br><br>1a. The clinical record for Resident 14 was reviewed on 5/31/24 at 11:30 a.m. The Resident's diagnosis included, but was not limited to, hypertension.<br><br>A Quarterly MDS (Minimum Data Set) Assessment, completed 3/4/24, indicated he was cognitively intact.<br><br>1b. The clinical record for Resident 36 was reviewed on 5/28/24 at 10:21 a.m.<br><br>On 6/3/24 at 11:20 a.m., Resident 14 and Resident 36's room was observed with the ED (Executive Director). There was no privacy curtain present | F 0914 | **F 914**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>All missing privacy curtains identified during the tour were installed for rooms 14, 36, 43, 53.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents residing in rooms have the potential to be affected by this deficient practice.<br>All staff will be educated on ensuring that privacy curtains are present in all rooms.<br>An audit of all resident rooms will be completed to ensure that privacy curtains are present. | 07/05/2024 |

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| | between the residents' beds.<br><br>During an interview on 6/3/24 at 11:20 a.m., Resident 14 indicated the privacy curtain had been missing for "quite a while".<br><br>2a. The clinical record for Resident 43 was reviewed on 5/29/24 at 11:32 a.m. The Resident's diagnosis included, but was not limited to, anoxic brain injury.<br><br>2b. The clinical record for Resident 53 was reviewed on 5/29/24 at 10:04 a.m. The Resident's diagnosis included, but was not limited to, diabetes.<br><br>A Significant Change MDS Assessment, completed 4/1/24, indicated he had moderately impaired cognition.<br><br>On 6/3/24 at 11:30 a.m., Resident 43 and Resident 53's room was observed with the ED. There was no privacy curtain present on the doorway side of Resident 53's bed.<br><br>During an interview on 6/3/24 at 11:30 a.m., Resident 53 indicated a privacy curtain had not been present since he had been in the room.<br><br>During an interview on 6/03/24 at 1:25 p.m., the ED indicated that resident rooms should have privacy curtains present.<br><br>3.1-19(l)(7) | | **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>All staff will be educated on ensuring that privacy curtains are present in all rooms.<br>Rooms will be audited daily ~~x 30 days~~ to ensure privacy curtains are in place.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>To ensure compliance the ED/Designee will complete a privacy curtain QAPI audit tool for six months with audits being completed daily for one month, and then monthly for 5 months by a nurse manager or designee. The QAPI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee | |
| F 0921 SS=E | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ | | | |

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| Bldg. 00 | §483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>Based on observation, interview, and record review, the facility failed to ensure a clean, comfortable, homelike environment related to splintered chair rails behind beds; scrapped walls with exposed drywall; phone jacks with exposed wires; not ensuring wheel chairs were clean; not assuring feeding pump poles were clean; bed linens, towels, and washcloths with stains; bedroom furniture on the vent unit with missing and scratched veneer; and floors with loose and missing tiles for 10 of 15 residents reviewed for environment (Resident D, 21, 24, 27, 28, 30, 36, 44, 53 and 55).<br><br>Findings include:<br><br>1. On 5/28/24 at 10:28 a.m., Resident 44's room was observed. The chair rail behind his bed was splintered and broken.<br><br>2. On 5/28/24 at 10:21 a.m., Resident 36's room was observed. The wall by the sink was chipped and drywall was exposed. The chair rail behind his bed was broken and splintered. The telephone jack was pulled from the wall with wires exposed.<br><br>3. On 5/28/24 at 10:36 a.m., Resident 27's room was observed. The telephone jack was pulled from the wall with wires exposed.<br><br>4. On 5/28/24 at 11:10 a.m., Resident 28's room was observed. The chair rail behind the bed was broken and the paint on the wall at the back of the bed was scraped. | F 0921 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>All chair rails, scratched veneers, missing floor tiles, scrapped walls, phone jacks identified on the tour have been scheduled for repair by an outside contractor<br>Resident 44 chair rail has been repaired, Resident 36 wall was repaired, phone jack was repaired, wall by sink was repaired, resident 27 telephone jack was repaired, resident 28 chair rail was repaired, resident 21 wheelchair was cleaned, resident 53 pillow case was replaced, IV pole was cleaned, Resident D floor was repaired, bedside table was replaced, Resident 30 and 42 sheets were replaced, flooring was repaired, Resident 55 foot board was attached appropriately, Resident 24 flooring was repaired, bedside storage unit was repaired. The linen on the vent unit was replaced.<br>New linen, washcloths and towels were ordered and now in place.<br>All feeding pump poles have been cleaned.<br>Wheelchairs identified on tour | 07/05/2024 |

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| | 5. On 5/28/24 at 10:32 a.m., Resident 21 was observed sitting in her wheelchair at an activity in the common area. Her wheelchair had a dried orange substance splattered all over the wheels of the wheelchair.<br><br>6. On 5/29/24 at 10:04 a.m., Resident 53 was observed laying in his bed in his room. There was a brown stain present on his pillow case. There was an IV pole with a gastric feeding pump attached to it at his bedside. The base of the pole had brown stains and dried gastric tube feeding formula present on it. There were brown spots on the floor by the pole.<br><br>7. On 5/29/24 at 9:56 a.m., Resident D's room was observed. The floor of the room was missing pieces of flooring. The bedside table was worn, scratched, and missing pieces of the black veneer.<br><br>8. On 5/28/24 at 12:15 p.m., Resident 30 and Resident 42's room was observed. There were stains present on Resident 30's sheets. The floor had pieces of laminate flooring that did not match the rest of the floor. Resident 30 indicated that housekeeping rarely swept or mopped, and the clean sheets and towels were often stained. The flooring had come up and it was replaced with flooring that did not match.<br><br>9. On 5/28/24 at 11:56 a.m., Resident 55's room was observed. The foot board of the bed was crooked and not attached on one side.<br><br>10. On 5/28/24 at 11:53 a.m., Resident 24's room was observed. The flooring at the foot of the bed was loose and pulling up from the floor. The built in bedside storage table was worn, with scratches and missing pieces of black veneer. | | have been cleaned.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents residing in the facility have the potential to be affected by this deficient practice<br>An audit will be conducted to identify any other rooms with missing floor tiles, scratched veneers, damaged phone jacks, and damaged chair rails. Upon identification, those items will be addressed<br>An audit of linen, wheelchairs, and feeding poles will be conducted. Any items identified as a concern will be addressed.<br>Any Inservice will be conducted with all staff on reporting any maintenance or housekeeping concerns timely.<br>All housekeeping staff will be in -serviced on linen stains, deep cleans, and floor care.<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>Any Inservice will be conducted with all staff on reporting any maintenance of housekeeping concerns timely.<br>Nursing staff to be educated on wheelchair cleanliness<br>All housekeeping staff will be | |

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| | On 5/31/24 at 11:30 a.m., the clean linen cart on the vent unit was observed with RN (Registered Nurse) 2. There were wash cloths and towels on the clean linen care that had brown stains present on them. RN 2 indicated there had been a lot of complaints from the residents and families about the stained linen. RN 2 had noticed that the sheets, towels, washcloths and blankets were often stained and had made the laundry aware of the issue.<br><br>On 5/31/24 at 2:00 p.m., RN 2 indicated that housekeeping on the vent unit had been a problem. The housekeepers seem to only sweep and go over the floors with a "swifter" looking device. The items in the rooms are not getting wiped down. The unit appeared dirty. She had brought up the lack of housekeeping and had been told there were staffing issues with housekeeping.<br><br>On 6/3/24 at 11:13 a.m., an environmental tour was completed with the ED (Executive Director). Resident 44's room was observed and the chair rail behind the bed was broken and splintered. The ED indicated it should be fixed and that it was an ongoing problem in many of the rooms. Resident 36's room was observed and the chair rail behind the bed continued to be broken and splintered. The wall by the sink had chipped and exposed drywall. and the phone jack continued to have exposed wires. The ED indicated the area on the wall had been an ongoing problem and that the phone jack could be fixed. Resident 27's room was observed, and the phone jack had exposed wires. Resident 53's room was observed and the IV pole by the bed had brown spots and an old piece of plastic wrapped around the bottom of the pole. The ED indicated that the pole should be cleaned. Resident D's room was observed to be missing a | | in-serviced on linen stains, deep cleans, and floor care.<br>ED/Designee to round with maintenance, nursing and housekeeping daily to ensure a homelike environment<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>To ensure compliance the ED/Designee will complete a sanitary/comfortable environment CQI audit tool for six months with audits being completed once daily for one month, and then monthly for 5 months by a nurse manager or designee. The CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. | |

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| | 2-inch x 4-inch piece of flooring by the head of the bed. The furniture in the room was worn, scratched, and missing black veneer. The ED was unsure of when the furniture on the vent unit had last been replaced. Resident 30's room was observed to have mismatched flooring. The ED indicated that some of the flooring had become loose and had been replaced with the flooring that was available. Resident 55's room was observed, and the foot board was crooked on the end of the bed and the low air loss mattress pump was laying on the floor under the foot of the bed. The ED indicated he would have someone look at the bed and fix the foot board. Resident 24's room was observed to have flooring boards that were loose and pulling up from the floor. The built-in bedside table was worn, with scratches and missing pieces of black veneer. The ED indicated that the flooring should have been repaired. Deep cleaning of rooms was scheduled monthly. Resident 21 was observed in the common area of the dementia care unit sitting in her wheelchair. The wheelchair was observed to have dried, caked on food and an orange substance splattered on the wheels of her wheel chair. The ED indicated the wheelchair needed to be cleaned.<br><br>During an interview on 6/3/24 at 3:03 p.m., Family Member 24 indicated that the bed linens were not always clean and had stains. The furniture on the vent unit was old and worn looking and could be replaced.<br><br>On 6/3/24 at 1:25 p.m., the ED provide the schedule for deep cleaning of the resident rooms for March, April, and May 2024. The ED indicated that there were no logs available to track when deep cleaning of the resident rooms had been completed. | | | |

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| | On 6/3/24 at 1:25 p.m., the ED provided the Deep Cleaning Practices policy, last revised December 2021, which read "Deep cleaning calendars should list rooms and area for each housekeeping assignment area. New calendars should be made out each month, and past months retained for at least 1 year. Each housekeeper when completing a deep clean shall fill out a quality control deep cleaning checklist signed and dated and provide it to the housekeeping supervisor upon completion of the deep clean. The deep cleaning checklist should be used for supervisor to utilize as an inspection tool to ensure the room has been cleaned within standards..."<br><br>3.1-19(f)(5)<br>3.1-19(g)(4) | | | |