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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and complaint investigations KS00186498, K00186500, and KS 001186597. This 2567 was electronically sent to the facility on 04/23/24.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 64 residents that included 16 residents sampled. Based on observation, record review and interview, the facility failed to maintain Resident (R)20's dignity when staff talked to the resident in a demeaning manner, for R25, when staff failed to close a window when providing incontinence cares, and for R50, that failed to cover the resident's urinary catheter collection bag when in public view.

Findings included:

- The undated "Physician Orders," for Resident (R)20 documented diagnoses which included cognitive communication deficit, cerebral vascular accident (stroke is a sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), traumatic brain injury, repeated falls, fractures (broken bones) and other multiple traumas.

The "Annual Minimum Data Set" (MDS) dated 03/29/24, documented the resident with a "Brief Mental Status Interview," (BIMS) score of 13, indicating cognitively intact. The resident did not

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exhibit behaviors. Choices about her routine and preferences were very important. The resident was always continent of bowel and bladder. She received medications which included diuretics and antidepressants during the look back period.

The "Care Plan," (CP) dated 11/21/23, instructed staff the resident participated in daily activities of interest in the facility. She was outgoing and liked to be involved in community events and activities. The resident did not like conflict.

On 04/09/24 at 12:12 PM, R20 sat in her room in a chair beside her bed. R20 reported that there was a nurse that would speak to her in a demeaning manner, telling her "That's not my job" Resident (R)20 stated she asked the nurse what was wrong, to which the nurse responded, "The resident was lying in their waste." She stated she asked the nurse who was going to take care of the resident to which the nurse stated nursing will. Additionally, she stated she was concerned there are residents in the facility that are confined to their room and cannot help it they cannot control their bowels. "If the nurses do not feel like it is their job to clean someone lying in their own waste, then what will happen to them?" R20 reported what happened in a meeting and some of the staff came to my room and told me they would take care of the situation. "No one has gotten back to me about my report." The girls that took my report said they had other concerns from another resident's regarding the same nurse.

On 04/09/24 at 02:07 PM, Administrative Staff A and Administrative Nurse B confirmed R 20 reported a grievance in the Resident Council Meeting on 03/27/24. The resident reported the

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grievance to the Activity Director (AD) S, who was also a certified nurse aide (CNA). Administrative Staff A stated she instructed CNA/AD S to interview the resident and obtain additional information to clarify what the resident meant by the nurse stating, "that's not my job." Administrative Staff A and Administrative Nurse B confirmed the "Grievance Log," lacked inclusion of R 20's grievance/complaint filed on 03/27/24 in Resident Council. Additionally, the facility lacked follow-up with the resident regarding an action plan to address the concern with the resident.

On 04/10/24 at 11:04 AM, Certified Medication Aide (CMA) I reported there was a nurse that was "grumpy" to other staff members.

The facility's undated "Dignity" policy documented that all residents were to be treated with dignity and respect at all times and included to promote, maintain and protect resident privacy during assistance with personal care.

The facility failed to protect the dignity of R20 when staff talked to the resident in a demeaning manner.

- The "Physician Orders" dated 03/22/24 revealed Resident (R)50 had a diagnosis of retention of urine unspecified (Lack of ability to urinate and empty the bladder) and urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

The "Admission Minimum Data Set" (MDS) dated 08/17/23, revealed a "Brief Interview for Mental Status" (BIMS) score of , indicating severely

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impaired cognition. The "Activities of Daily Living" (ADL's) indicated R50 required extensive assistance with two or more persons for bed mobility, transfers, and toilet use.

The "Quarterly" MDS dated 03/08/24, indicated a (BIMS) score of 12, indicating moderately impaired cognition. R50 required an indwelling catheter.

The "Care Plan" dated 08/11/23, revealed F50 required the need of an indwelling urinary catheter for terminal illness and urinary retention. Staff were to ensure the catheter bag was below the level of the bladder and provide catheter care per the facility policy.

The "Enhanced Barrier Precautions" dated 04/10/24 sign placed on R50's room door, revealed due to R50's wound and catheter, staff were to utilize gloves and gowns for all dressing, changing briefs, transfer, toileting, peri-care, catheter care/ bathing/showering, hygiene changing lines and wound care.

On 04/10/24 at 10:32 AM, observed R50 in bed and the urinary catheter bag hung off his wheelchair. The urinary collection bag did not have a privacy bag attached to the wheelchair or R50's bed.

On 04/10/24 at 02:51 PM, observed R50 in the wheelchair and propelled towards the nurses' station, without a privacy bag attached to the wheelchair.. Observed Certified Nurse Aide (CNA) D attach a privacy bag to the wheelchair.

On 04/10/24 at 02:51 PM, Interview with CNA D revealed she observed R50 without a privacy bag

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for the catheter bag and knew R50 required a collection bag, so she obtained one and placed it on the wheelchair.

On 04/11/24 at 01:40 PM, Interview with Licensed Nurse (LN) F revealed that all residents with catheter bags should have a privacy bag.

On 04/11/24 at 02:40 PM, Interview with Administrative Nurse B revealed the expectation for any resident with an indwelling urinayr catheter should have a privacy bag to protect the resident's dignity.

The facility's policy "Dignity" dated 2001 revealed demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to promote dignity and assist residents, for example: A. helping the resident to keep urinary catheter bags covered.

The facility failed to provide a privacy bag for R50's indwelling foley catheter to promote dignity.
- The Electronic Health Records (EHR) for Resident (R)25 included diagnoses of generalized muscle weakness, reduced mobility, incomplete paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk) and muscle wasting with atrophy (wasting or decrease in size of a part of the body).

R25's "Significant Change Minimum Data Set" (MDS) dated 11/30/23, documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R25 was dependent on staff for all cares except eating and oral care which required supervision. R25 had a urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag)

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and was always incontinent of bowel.

The 11/30/23 "Activities of daily living (ADL's such as walking, grooming, toileting, dressing and eating) Functional / Rehabilitation Potential Care Area Assessment (CAA)", documented R25 required ADL assistance due to functional impairment in activity from generalized weakness and incomplete paraplegia.

The 03/01/24 "Quarterly MDS" documented a BIMS of 15 and R25 was dependent on staff for all cares except eating and oral care which required supervision. R25 had a urinary catheter and was always incontinent of bowel.

The 04/09/24 "Care Plan" lacked documentation of instructions for staff to protect R25's dignity during cares.

On 04/10/24 at 10:55 AM, Licensed Nurse (LN) M and Certified Nurse Aide (CNA) D performed incontinence care and catheter care and failed to lower the window blind that was open to a courtyard that was approximately 50 feet by 50 feet and was adjacent to and visible from the main entrance of the building approximately 100 feet away. During the procedure, the resident's lower abdomen and genitals were fully exposed.

On 04/10/24 at 01:42 PM, R25 recalled the incontinence and catheter care that the window blind was open and stated that this bothered her and had a negative psychosocial effect on her feeling of dignity.

On 04/10/24 at 01:50 PM, CNA D confirmed that the window was open during the procedure and stated that window blinds should be closed during

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F 550	Continued From page 7 procedures in which resident's bodies are exposed. On 04/10/24 at 02:16 PM, LN M confirmed that the window was open during the procedure and stated that window blinds should be down whenever the resident's body is exposed. On 04/10/24 at 02:35 PM, Administrative Nurse B stated that the expectation of staff is to close window blinds whenever resident's body is exposed for any reason to protect the resident's privacy and dignity. The facility's undated "Dignity" policy documented that all residents were to be treated with dignity and respect at all times and included to promote, maintain and protect resident privacy during assistance with personal care. The facility failed to protect the privacy and dignity of R25. This deficient practice led to R25's body being potentially exposed to the public.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: The facility had a census of 64 residents, which included 16 residents sampled, including one resident reviewed for accommodation of needs related to assistive devices. Based on	F 558		

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observation, record review, and interview, the facility failed to ensure Resident (R)11's call light remained within his reach.

Findings included:

- The Electronic Health Records (EHR) for Resident (R)11 included diagnoses of diabetes mellitus type 2 (DM2 - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), generalized weakness, aphasia (condition with disordered or absent language function) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and rheumatoid arthritis (RA - a chronic inflammatory disease that affected joints and other organ systems).

The 12/23/23 "Admission Minimum Data Set (MDS)" documented a Brief Interview for Mental Status (BIMS) score of 15, which indicates intact cognition. R11 required substantial assistance from staff for all cares except eating, which required setup and supervision.

The 12/23/23 " Activities of daily living (ADL's such as walking, grooming, toileting, dressing and eating) Functional / Rehabilitation Potential Care Area Assessment (CAA)", documented R11 had an ADL self-care deficit related to impaired balance during transfers, functional impairment during activity, generalized weakness, and decreased safety awareness.

The 12/23/23 "Falls CAA" documented R11 was at increased risk for falls due to impaired gait (manner or style of walking), impaired mobility,

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weakness, and physical performance limitations.

The 03/05/24 "Quarterly MDS" documented a BIMS score of 15, which indicated intact cognition and R11 required substantial/maximum assistance for all cares except eating which required supervision and setup.

The 04/10/24 "Care Plan", documented an intervention dated 12/28/23 for staff to place R11's call light within his reach.

On 04/11/24 at 07:52 AM, R11 observed in his bed watching TV waiting for staff to assist him up for the morning. R11 observed to be unable to easily reach call light that was tied to the left upper grab bar on the bed with approximately 8 inches of the call light button's cord hanging. R11 had to reposition himself in the bed with his head pressed against the right grab bar with his neck bent at an unnatural angle and right shoulder hung off the bed so that his left hand could grasp the call light. R11 attempted to grasp at the call light chord three times before being able to successfully hold onto the device and press the button for staff assistance.

On 04/11/24 at 07:55 AM, R11 stated that due to the deformity of his fingers due to RA, he had trouble grasping the call light and/or pressing the button. R11 further stated that due to mobility problems with his left shoulder and arm, he was unable to easily grasp things that were placed above his shoulders. R11 stated that he had advised staff that he wanted an easier way to alert staff for assistance, but none had been provided.

On 04/11/24 at 09:08 AM, Certified Nurse Aide

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(CNA) D revealed that call lights should be placed near the hands of residents, especially if they have mobility problems. If a resident was unable to press the call light button easily, CNAs could initiate a change to a pressure-pad call light without having to get an order from the nurse on duty, and that the nurse would be notified of the change after it had been completed.

On 04/11/24 at 09:30 AM, CNA N revealed that call lights should be placed near the resident's hands especially if they have mobility problems. If a CNA discovered that a resident had problems with being able to press the call light, the nurse should be notified so that they could assess the resident to see what could be done to help the resident's ability to utilize a call system for staff assistance..

On 04/11/24 at 09:32 AM, Licensed Nurse (LN) P confirmed CNA staff should place call lights where residents could easily reach them, especially if the resident had mobility problems. CNA staff should notify the LN on duty if they discover that a resident had difficulty pressing the call light so that it could be addressed and immediately corrected.

On 04/11/24 at 09:39 AM, Administrative Nurse B confirmed that CNA staff should place the call lights where residents could reach them, especially if the resident had mobility problems. The expectation was if a staff member identified a problem with call light placement or functionality, staff should report it to the LN on duty and/or administrative staff, so that the problem could be corrected, and a care plan intervention created.

The facility failed to provide a policy related to

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F 558	Continued From page 11 reasonable accommodations of individual needs as requested on 04/15/24. The facility failed to provide R11 with appropriate call light equipment, which failed to accommodate this resident's individual needs.	F 558		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through	F 585		

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postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

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F 585	Continued From page 13 (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: The facility reported a census of 64 residents which included 16 residents sampled for review. Based on observation, interview and record review, the facility failed to track grievances through to their conclusions and provide prompt efforts to resolve a grievance filed by a resident (R)20 regarding the behavior of staff, offer or provide written grievance decisions to the resident regarding his or her grievance, and to offer or provide a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance.	F 585		

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Findings included:

- The undated "Physician Orders," for Resident (R)20 documented diagnoses which included cognitive communication deficit, cerebral vascular accident (stroke is a sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), traumatic brain injury, repeated falls, fractures (broken bones) and other multiple traumas.

The "Annual Minimum Data Set" (MDS) dated 03/29/24, documented the resident with a "Brief Mental Status Interview," (BIMS) score of 13, indicating cognitively intact. The resident did not exhibit behaviors. Choices about her routine and preferences were very important. The resident was always continent of bowel and bladder. She received medications which included diuretics and antidepressants during the look back period.

The "Care Plan," (CP) dated 11/21/23, instructed staff the resident participated in daily activities of interest in the facility. She was outgoing and liked to be involved in community events and activities. The resident did not like conflict.

On 04/09/24 at 12:12 PM, the resident sat in her room in the chair beside her bed. She was alert orient and her responses to questions regarding her concern were appropriate. Upon inquiry, she responded, "A nurse told a lie." She reported she frequently walked up and down the hallway to and from the nurse's station. Last month when she went down the hall, a nurse came out of the room and said "That is not my job." Resident (R)20 stated she asked the nurse what was

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wrong, to which the nurse responded, "The resident was lying in their waste." She stated she asked the nurse who was going to take care of the resident to which the nurse stated nursing will. Additionally, she stated she was concerned there are residents in the facility that are confined to their room and cannot help it they cannot control their bowels. "If the nurses do not feel like it is their job to clean someone lying in their own waste, then what will happen to them?" R20 reported what happened in a meeting and some of the staff came to my room and told me they would take care of the situation. "No one has gotten back to me about my report." The girls that took my report said they had other concerns from another resident's regarding the same nurse.

On 04/09/24 at 01:30 PM, Social Service Worker U stated she was responsible for tracking grievances and complaints filed by the residents. She maintained a log which included grievance/complaints from resident council meetings. She stated the Resident Council meetings were conducted by the Activities Director who forwarded concerns from the meeting to her to follow-up with the appropriate department. The interdisciplinary team discusses resident complaints and grievances at the morning meeting. Review of the "Grievance Logs," dated 03/01/24 through 04/09/24 lacked documentation of the concern/Grievance that had been described by R 20. Social Service Worker U stated she was not aware of a grievance or concern that the resident reported last month.

On 04/09/24 at 02:07 PM, Administrative Staff A and Administrative Nurse B confirmed R 20 reported a grievance in the Resident Council Meeting on 03/27/24. The resident reported the

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grievance to the Activity Director (AD) S, who was also a certified nurse aide (CNA). Administrative Staff A stated she instructed CNA/AD S to interview the resident and obtain additional information to clarify what the resident meant by the nurse stating, "that's not my job." Administrative Staff A and Administrative Nurse B confirmed the "Grievance Log," lacked inclusion of R 20's grievance/complaint filed on 03/27/24 in Resident Council. Additionally, the facility lacked follow-up with the resident regarding an action plan to address the concern with the resident.

The facility policy titled "Grievances," dated 04/01/2020, documentation included, "Grievances" is a written complaint or verbal complaint that cannot be resolved promptly by staff. Any complaint that is reduced to writing is considered a grievance. The goal is to provide prompt investigation and resolution to all complaints. The Director of Social Services is the designated Grievance officer which provides oversight of the grievance process including receiving, tracking grievances through their conclusion, and coordinating the issuance of written response, at the direction of the administrator to the person who initiated the grievance. A final response is provided to the complaining party along with a summary of the resolution. A grievance is considered resolved when the resident or grievant is satisfied with the action taken on his/her behalf.

The facility failed to track grievances through to their conclusions and provide prompt efforts to resolve a grievance filed by a resident regarding the behavior of staff, offer or provide written grievance decisions to the resident regarding his or her grievance, and to offer or provide a

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F 585	Continued From page 17 summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance.	F 585		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		

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(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 64 residents which included 16 residents sampled, which included two residents reviewed for comprehensive care plan development. Based on interview, observation, and record review, the facility failed to develop a comprehensive, individualized person-centered care plan for Resident (R) 25 related to the use of grab bar use for bed mobility and for R27 to include the use of oxygen and oxygen related equipment. This deficient practice placed the residents at risk for uncommunicated care needs.

Findings include:

- The Electronic Health Records (EHR) for Resident (R)25 included diagnoses of generalized muscle weakness, reduced mobility, incomplete paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk) and muscle wasting with atrophy (wasting or decrease in size of a part of the body).

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R25's "Significant Change Minimum Data Set" (MDS), dated 11/30/23, documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R25 was dependent on staff for all cares except eating and oral care which required supervision. R25 had a urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) and was always incontinent of bowel. The MDS lacked documentation related to grab bar use.

The 11/30/23 "Activities of daily living (ADL's such as walking, grooming, toileting, dressing and eating) Functional / Rehabilitation Potential Care Area Assessment (CAA)", documented R25 required ADL assistance due to functional impairment in activity from generalized weakness and incomplete paraplegia. The CAA lacked documentation related to grab bar use.

The 11/30/23 "Pressure Ulcer/Injury CAA" documented that R25 had an increased risk of pressure ulcers/injury due to functional impairment and mobility impairment but lacked documentation related to grab bar use for bed mobility.

The "Quarterly MDS" dated 03/01/24 documented a BIMS of 15 and R25 was dependent on staff for all cares except eating and oral care which required supervision. R25 had a urinary catheter and was always incontinent of bowel. The MDS lacked documentation related to grab bar use.

The 04/09/24 "Care Plan" lacked documentation related to the use of grab bars while R25 was in bed.

The physician's orders lacked directions specific

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for grab bar use.

The EHR "Assessments" lacked documentation of grab bar safety assessment.

On 04/09/24 at 02:22 PM, R25 revealed that she uses grab bars on bed to help with bed mobility and repositioning with and without staff assistance.

On 04/10/24 at 01:50 PM, Certified Nurse Aide (CNA) D stated that interventions performed by staff should be on the care plan.

On 04/10/24 at 02:06 PM, Licensed Nurse (LN) M stated that interventions performed by staff should be on the care plan and the care plans are accessible in the EHR.

On 04/15/24 at 03:33 PM, Administrative Nurse B confirmed R25's care plan lacked guidance related to a grab bar.

The facility's undated "Care Plans, Comprehensive Person-Centered" policy documented that the care plan was based on a thorough assessment and described services to be furnished and included any specialized service to be provided.

The facility failed to develop a comprehensive individualized person-centered care plan for R25 related to the use of grab bar use for bed mobility and for R27 to include use of oxygen and oxygen related equipment. This deficient practice placed the residents at risk for uncommunicated care needs.

- Review of Resident (R)27's undated

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"Physician Orders," (POS) revealed diagnoses which included heart failure and chronic respiratory failure.

The "Admission Minimum Data Set," (MDS), dated 07/18/23, included the "Brief Interview for Mental Status" (BIMS) score of BIMS 10, indicating moderate cognitive impairment. She received Oxygen (O2) as a special care and treatment.

The "Quarterly MDS", dated 03/25/24, documented the resident with BIMS score of 11, indicating continued moderate cognitive impairment. She received oxygen, as special care and treatment .

The "Care Plan," (CP) dated 02/07/24, lacked address of special care and treatment related to oxygen which was initially ordered on 07/12/23. Additionally, the CP lacked guidance to the nursing staff related to the expectations to maintain the oxygen equipment to prevent infection.

The POS documentation included an order to apply oxygen to keep oxygen saturation rate (percentage of oxygen content in the blood) greater than or equal to 90 percent (%) as needed, ordered on 07/12/2023.

On 04/09/24 at 11:06 AM, the resident sat on the side of the bed with oxygen administered at two liters per minute by way of nasal cannula. The tubing, cannula, and humidifier bottle did not have a date indicating placement. An undated 2/3rd full gallon container of distilled water sat directly on the resident's bed side commode. The resident stated the staff used the distilled water to

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fill the humidifier bottle to keep her nasal passages from drying out.

On 04/09/24 11:45 AM, Certified Medication Aide (CMA) I verified the above findings. She stated the CP and/or policy should provide guidance to the nursing staff regarding the care and treatment of the resident's oxygen and equipment. To prevent infection and cross contamination, the oxygen tubing, cannula, humidifier bottle and distilled water should be labeled to indicate the date it was placed into service to ensure routine changes to prevent the spread of infection. Additionally, CMA I reported the distilled water should be stored in the resident's room in a location other than the bedside commode to prevent cross contamination.

On 04/11/24 at 09:46 AM, Licensed Nurse (LN) P stated the resident's CP should provide guidance to the staff regarding the care and treatment of the resident related to the maintenance of oxygen equipment including tubing cannula and humidifier bottles should be marked when changed. The protocol for changing the set up includes night shift on Sundays, and as needed to prevent cross contamination. Changes in treatment and care should be addressed in the care plan when they occur.

On 04/15/24 02:48 PM , Administrative Nurse B stated the nursing staff were responsible for maintain the oxygen equipment in a manner to prevent cross contamination and the spread of infection. The CP provided guidance to the staff for the care and treatment of the resident's oxygen tubing, cannula, humidifier bottle, and distilled water should be labeled when initiated or

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F 656	Continued From page 23 changed. The oxygen supplies should be stored in a manner to prevent cross contamination and the spread of infection. The facility policy "Care Plans, Comprehensive Person-Centered," dated 03/2022, documentation included the comprehensive person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being including any specialized services to be provided The facility failed to develop and implement a plan of care for respiratory care related to oxygen use for the resident.	F 656		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 64 residents and identified 11 residents as confused and self-mobile. Based on observation, record review, and interview, the facility failed to ensure the environment was free of accident hazards for these 11 residents, including failure to keep hazardous chemicals out of reach. Furthermore, the facility failed to maintain a safe environment when staff utilized a gait belt to secure Resident	F 689		

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(R)1's door to remain in the open position.

Findings included:

- On 04/09/24 at 11:44 AM, observation revealed R1's room contained an unidentified, unlabeled spray bottle that hung from the foot of the bed. R1 identified the contents as a cleaning agent for staff use when staff emptied her catheter bag and if any urine spilled onto the floor.

On 04/09/24 a 11:46 AM, observation of R1's bathroom revealed a bottle of "Fabuloso" cleaning agent with the manufacturer label documented "Keep out of reach of children". The cleanser sat on the counter next to mouthwash and personal hygiene products.

On 04/10/24 at 10:13 AM, observation of R1's bathroom revealed a bottle of "Fabuloso" cleaning agent with the manufacturer label of "Keep out of reach of children". The cleanser was next to mouthwash and other personal hygiene products.

On 04/10/24 at 01:23 PM, Licensed Nurse (LN) AA entered R1's room to perform cares and removed a gait belt (a thick belt made from semi-rigid plastic or thick semi-rigid fabric used to help transfer a person from one place to another) that was looped around the door knob of the door and a wall-mounted wire glove box holder that restricted door movement and held the door in the open position.

On 04/11/24 at 02:00 PM, observation of R1's room revealed a bottle of air-freshener on the bed in reach of R1 with manufacturer label that with manufacturer labels documented "keep out of

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reach of children".

On 04/15/24 at 07:45 AM, observation of R1's bathroom revealed a bottle of air-freshener with manufacturer label to "Keep out of reach of children" and was on the counter next to the mouthwash and other personal hygiene products.

On 04/15/24 at 07:55 AM, an observation of R25's room revealed a can of hair spray and three other items with manufacturer labels documented "Keep out of reach of children" sat on R25's bedside table.

On 04/10/24 at 01:30 PM, LN AA confirmed that door movement should not be restricted with any device (door stop or otherwise) due to accident/fire hazard concerns.

On 04/10/24 at 01:50 PM, Certified Nurse Aide (CNA) D revealed that no chemicals could be stored in resident's rooms and if discovered, the chemicals would be removed and taken to the LN.

On 04/10/24 at 02:05 PM, Certified Nurse Aide (CNA) N revealed that chemicals were not allowed to be stored in resident's rooms and if discovered, the chemicals should be moved out of the resident's reach and to notify the Licensed Nurse (LN).

On 04/10/24 at 02:10 PM, LN E revealed that chemicals were prohibited in resident rooms and if discovered, they would be removed from the resident's room and turned over to Housekeeping Supervisor J for proper storage.

On 04/15/24 at 08:55 AM, Administrative Nurse B

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F 689	Continued From page 26 confirmed that chemicals should not be stored in resident's rooms under any circumstances but should be kept somewhere secured with a lock that requires a key. Door movement or operation could not be restricted with any mechanical device due to fire/safety hazard concerns. The facility failed to provide a policy related to prevention of accident hazards as requested on 04/15/24. The facility failed to keep hazardous chemicals out of reach for the 11 confused, mobile residents of the facility. Furthermore, the facility failed to maintain a safe environment when staff utilized a gait belt to secure R1's door to remain in the open position.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §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. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (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; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		

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is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§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.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 64 residents with 16 residents included in the sample. Based on observation, interview, and record review, the facility failed to provide necessary services to decrease the risk of a urinary tract infection when staff failed to use proper hand hygiene and Enhanced Barrier precautions (EBP) when providing urinary catheter care for resident (R)1 and R25.

Findings included:

- R1's Electronic Medical Record (EMR) revealed diagnoses that included acute kidney failure (a sudden decline in kidney function that occurs within a few hours or days), neuromuscular dysfunction of bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), and urinary tract infection ([UTI] infection of any part of the urinary system, including kidneys, ureters,

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bladder, and urethra).

R1's Annual Minimum Data Set (MDS) dated 06/22/23, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required extensive to total assistance for all cares. R1 had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 06/22/23, documented risk factors included recurrent UTI's and injury from use of the catheter.

The "Bladder/Bowel" care plan, dated 01/27/23, revealed R1 required a urinary catheter, and guided staff to provide catheter care policy.

Observation on 04/09/24 at 11:19 AM revealed R1's catheter bag stored top of a dignity bag that was stored directly on the floor.

Observation on 04/10/24 at 10:13 AM, revealed R1's catheter bag hung from the edge of her bed, with dark amber colored urine in the drainage bag, and clear yellow urine with sediment in the tubing.

Observation of 04/10/24 at 01:23 PM, revealed Licensed Nurse (LN) AA donned a gown and pushed the gown sleeves above her wrists. She then washed her hands with soap and water, removed a gait belt from the back of door handle, then donned her gloves and pulled the gown sleeves back down to her wrists. LN AA wiped the catheter tubing with a no-rinse foam soap-soaked gauze, and removed and reapplied a new pair of

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gloves without performing hand hygiene, removed the spigot from the catheter collection system, emptied the urine from the collection bag into a urinal, then washed the spigot with a no-rinse foam soap-soaked gauze, then saline soaked gauze, then alcohol wipes. She removed her gloves, emptied the urinal into the commode and rinsed the urinal with tap water from the resident's sink. She pulled her sleeves up on her arms, washed her hands with soap and water and removed her gown.

On 04/09/24 at 02:09 PM, R1 reported that she required a urinary catheter because she was unable to urinate.

On 04/10/24 at 01:32 PM, LN AA confirmed no hand hygiene was done when changing her gloves and carrying the urinal to the bathroom and improper infection control techniques.

Interview on 04/10/24 at 02:35 PM, Administrative Nurse B reported wipes should be used for one wipe per swipe for either peri or catheter care. Hand hygiene should be performed with either alcohol-based hand rub (ABHR) or soap/water before the procedure and with every glove change, and with soap/water only at the end of a procedure.

The facility's policy for Catheter care, dated 08/22, revealed the purpose of this procedure is to prevent urinary catheter -associated complications including urinary tract infections. Use aseptic technique when handling or manipulating the drainage system.

The facility's policy for Enhanced Barrier Precautions, dated 08/22 revealed EBPs are

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used in conjunction with standard precautions and expand the use of Personal Protective Equipment to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of Multi Drug Resistant Organisms (MDRO) to staff hands or clothing.

The facility failed to provide necessary services to decrease the risk of a urinary tract infection when the staff failed to use proper hand hygiene and Enhanced Barrier Precautions when providing catheter care for resident (R)1.

- Resident (R) 25's diagnoses included neuromuscular dysfunction of bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), and urinary tract infection (Infection of any part of the urinary system, including kidneys, ureters, bladder, and urethra).

The "Significant Change" Minimum Data Set (MDS) dated 11/03/23, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident was dependent for all cares and had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

The 11/03/23 "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 11/03/23, revealed the resident required a urinary catheter.

The care plan, dated 10/13/23, revealed the resident required a urinary catheter.
Revision of the care plan revealed on 04/10/2024, the resident required Enhanced Based

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Precautions (EBP) related to wound and catheter. Staff were to wear gloves and gowns for all dressing, changing brief, catheter care, emptying catheter, transfers, toileting, peri care, bathing/showering, hygiene, changing linens, and wound care.

The Physician Orders included to check and verify catheter securement was in place and the tubing was free of kinks, two times a day, ordered 04/12/2024.

Observation on 04/10/24 at 10:55 AM revealed Licensed Nurse (LN) M provided urinary catheter care with the assistance of Certified Nursing Aide (CNA) D. CNA D performed hand hygiene upon entry to the room and donned gloves, LN M failed to perform hand hygiene and donned gloves when entering the room. CNA D left the resident's room to retrieve the full body mechanical lift outside the room with neither staff member engaged in enhanced barrier precautions. Staff transferred the resident with the mechanical lift to her bed. CNA D went to the bathroom to retrieve warm/soapy wash cloth while LN M removed the resident's brief at the front and assisted the resident to hold her legs apart. The resident was incontinent of bowels. CNA D wiped the front of the resident, then discarded the soiled washcloth and changed gloves without performing hand hygiene. CNA D retrieved incontinence wipes from the bedside table drawer and initiated peri-care. Staff assisted the resident and the resident positioned to her left side. LN M started cleaning up feces with multiple swipes with the same wipe, LN M changed her gloves without hand hygiene. CNA D removed her gloves and left the resident room for additional supplies and failed to perform hand hygiene. When CNA D

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returned to the resident's room, CNA D donned new gloves and took the washcloth to the bathroom to make a warm/soapy wash cloth, then walked to bedside and cleaned resident's genitals, then cleaned around the resident's catheter, then wiped the resident's genitals a second time, then cleaned the resident's catheter a second time, folding and /refolding the same washcloth with each pass. CNA D then disposed of the washcloth and changed gloves but failed to perform hand hygiene. LN M removed gloves and left the resident's room to obtain additional supplies and failed to perform hand hygiene. CNA D replaced resident's brief and LN M returned to the room and failed to perform hand hygiene. LN M attempted to place a commercially available adhesive catheter securement device to the resident, but the resident declined this as she had a documented history of adverse reaction to the adhesive. LN M removed her gloves and performed hand hygiene with an alcohol-based hand solution, then left the room. CNA D collected the soiled supplies and removed gloves, then exited the room without performing hand hygiene.
On 04/10/24 at 09:38 AM, R25 stated staff have not put on any full personal protective equipment (PPE) when emptying her catheter bag. She reported she did not have a tubing anchoring/securement device because she was allergic to the anchor, and the facility was to get her a harness type securement device but had not done that yet.

Interview on 04/10/24 at 11:20 AM, CNA D stated she would not have changed anything with the procedure as observed except that staff may have needed extra supplies to prevent having to leave to go get additional supplies. CNA D

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confirmed that no EBP were in place at the time of catheter/peri care.

On 04/10/24 at 11:18 AM, LN M stated she would not have changed anything with the procedure as observed.

Interview on 04/10/24 at 02:06 PM with LN M confirmed that no EBP was in place at the time of catheter/peri care, and reported it was acceptable to wipe/fold/reuse with wash cloth but not with wipes, confirmed that she had reused wipe to remove BM from resident's skin. Stated that CNA D should not have re-wiped a second time of genitals or catheter with wash cloth because it presented as an infection control concern.

Interview on 04/10/24 at 02:35 PM, Administrative Nurse B reported an expectation for staff that wash cloths should not be used for peri care or catheter care, only for bathing. Wipes should be used for one wipe per swipe for either peri or catheter care. Hand hygiene should be performed with either alcohol-based hand rub (ABHR) or soap/water before procedure, and with every glove change and with soap/water only at the end of a procedure. Residents with catheters should have some sort of securement device for the tubing to be secured to the resident's leg. It is never acceptable for resident to have a catheter without it being secured to the leg.

Interview on at 04/10/24 at 04:05 PM, CNA CC reported there were no special orders in progress for a foley securement device. Walk through with CNA CC of the facility's supply room revealed leg securement straps in house stock.

Interview on at 04/10/24 at 04:25 PM with

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F 690	Continued From page 34 Administrative Nurse B, informed of above and was unable to provide an explanation as to why a securement device had not been in place prior to location of the device in the facility's supply room. The facility's policy for Catheter care, dated 08/22, revealed the purpose of this procedure was to prevent urinary catheter -associated complications including urinary tract infections. Use aseptic technique when handling or manipulating the drainage system. The facility's policy for Enhanced Barrier Precautions, dated 08/22, revealed EBPs are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of Multi Drug Resistant Organisms (MDRO) to staff hands or clothing. The facility failed to provide necessary services to decrease the risk of a urinary tract infection when the staff failed to use proper hand hygiene, catheter cleansing, and Enhanced Barrier Precautions when providing catheter care for resident (R)25.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 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, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		

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and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 64 residents with 16 residents sampled, including three residents reviewed for respiratory care. Based on observations, record reviews, and interviews, the facility failed to properly clean and store a nebulizer (a device for administering inhaled medications) for Resident (R)28 and R11 in accordance with the standards of care. In addition, the facility failed to place a date label on the oxygen tubing for R27. This deficient practice placed the residents at risk of respiratory complications that could also have a negative impact on the resident's psychosocial wellbeing.

Findings included:

- R28's "Electronic Health Record" (EHR) documented pertinent diagnoses of atherosclerotic (buildup of plaques in the blood vessels) heart disease, history of pulmonary embolism (a blood clot in the blood vessels of the lungs), asthma (a chronic disorder of narrowed airways that caused wheezing and shortness of breath), generalized weakness, difficulty in walking and respiratory failure (a condition in which respiratory function is inadequate to maintain the body's need for oxygen supply and/or carbon dioxide removal while at rest).

The "Significant Change Minimum Data Set" (MDS), dated 02/07/24, documented a "Brief Interview for Mental Status" (BIMS) score of 14, indicating intact cognition. The resident was dependent on staff for all cares except eating which was performed independently and received oxygen.

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The "Activities of daily living (ADL's such as walking, grooming, toileting, dressing and eating) Functional / Rehabilitation Potential Care Area Assessment (CAA)", dated 02/07/24, documented that R28 had impaired functional abilities due in part to diagnoses of respiratory failure and asthma.

The "Psychosocial Well-Being" CAA, dated 02/07/24 documented that R28 had little interest or pleasure in doing things due in part to diagnoses of respiratory failure and asthma.

The "Quarterly MDS", dated 12/22/23, documented a BIMS score of 15, which indicated intact cognition. The resident was dependent on staff for all cares except eating which was performed independently, and R28 received oxygen.

The 04/10/24 "Care Plan" documented R28 received nebulizer medications and the care plan lacked guidance related to care of the nebulizer equipment.

The EHR "Physician Orders" included an order, dated 03/21/23, for Ipratropium-Albuterol solution (two medications used to relax airway muscles to ease the work of breathing), 0.5 milligrams (mg), and 2.5 mg in three milliliters (mL) to inhale orally via nebulizer once per day for shortness of breath or wheezing. The order lacked orders specific instructions to care or maintenance of the nebulizer or the nebulizer equipment.

On 04/09/24 at 11:52 AM, observation of R28's room revealed a nebulizer intact sitting on top of a nebulizer machine with an unknown clear liquid

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in the nebulizer chamber.

On 04/15/24 at 12:55 PM, Certified Medication Aide (CMA) K revealed that only Licensed Nurses (LN) give nebulized medications and LN staff were responsible for the care and maintenance of nebulizer equipment.

On 04/15/24 at 12:55 PM, LN X revealed that after a nebulized medication was administered, nursing staff should disassemble the nebulizer and rinse it with tap water and then set the components on a paper towel to dry. Then, after the components were dry, staff would reassemble the pieces and the set would be placed in a clear plastic bag and left on top of the nebulizer machine until the next use.

On 04/15/24 at 03:00 PM, Administrative Nurse B revealed that her expectation at the end of a breathing treatment that the LN would disassemble the nebulizer device and rinse with tap water and then set the components to dry on a clean paper towel. Once the components were dry, staff were to reassemble them and place them in a clean plastic bag until the next use.

The facility's undated "Administering Medications through a Small Volume (Handheld) Nebulizer) policy documented after a treatment was completed, staff were to rinse and disinfect the nebulizer equipment per facility protocol or wash with warm soapy water, rinse with hot water, and allow to air dry on a paper towel. When the equipment was completely dry, staff were instructed to store in a plastic bag or other plastic container.

The facility failed to provide respiratory care

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consistent with professional standards of care for R28, regarding the use and cleaning of the nebulizer equipment.

- The Electronic Health Records (EHR) for Resident (R)11 included diagnoses of diabetes mellitus type 2 (DM2 - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), generalized weakness, aphasia (condition with disordered or absent language function) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and rheumatoid arthritis (RA - a chronic inflammatory disease that affected joints and other organ systems).

The 12/23/23 "Admission Minimum Data Set (MDS)" documented a Brief Interview for Mental Status (BIMS) score of 15, which indicates intact cognition. R11 required substantial assistance from staff for all cares except eating, which required setup and supervision.

The 12/23/23 " Activities of daily living (ADL's such as walking, grooming, toileting, dressing and eating) Functional / Rehabilitation Potential Care Area Assessment (CAA)", documented R11 had an ADL self-care deficit related to impaired balance during transfers, functional impairment during activity, generalized weakness, and decreased safety awareness.

The 12/23/23 "Falls CAA" documented R11 was at increased risk for falls due to impaired gait (manner or style of walking), impaired mobility, weakness, and physical performance limitations.

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The 03/05/24 "Quarterly MDS" documented a BIMS score of 15, which indicated intact cognition and R11 required substantial/maximum assistance for all cares except eating which required supervision and setup.

The 04/10/24 "Care Plan" lacked instructions for staff related to care of nebulizer equipment.

The EHR "Physician Orders" included an order, dated 03/26/24, for Ipratropium-Albuterol solution (two medications used to relax airway muscles to ease the work of breathing), 0.5 milligrams (mg) and 2.5 mg in three milliliters (mL) to inhale orally, via nebulizer, every four hours, as needed (PRN) for shortness of breath or wheezing. The orders lacked instructions specific for the care or maintenance of the nebulizer or the nebulizer equipment.

On 04/09/24 at 01:34 PM, observation of R11's room revealed a nebulizer intact sitting on a windowsill.

On 04/15/24 at 12:55 PM, Certified Medication Aide (CMA) K revealed that only Licensed Nurses (LN) give nebulized medications and LN staff were responsible for the care and maintenance of nebulizer equipment.

On 04/15/24 at 12:55 PM, LN X revealed that after a nebulized medication was administered, nursing staff should disassemble the nebulizer and rinse it with tap water and then set the components on a paper towel to dry. Once the components were dry, staff was to reassemble the pieces and place it in a clear plastic bag and left on top of the nebulizer machine until the next

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use.

On 04/15/24 at 03:00 PM, Administrative Nurse B revealed that her expectation at the end of a breathing treatment that the LN would disassemble the nebulizer device and rinse with tap water and then set the components to dry on a clean paper towel. Once the components were dry, staff were to reassemble them and place them in a clean plastic bag until the next use.

The facility's undated "Administering Medications through a Small Volume (Handheld) Nebulizer) policy documented that after a treatment was completed that staff were to rinse and disinfect the nebulizer equipment per facility protocol or wash with warm soapy water, rinse with hot water then allow to air dry on paper towel. When the equipment was completely dry, staff were instructed to store in a plastic bag or other plastic container.

The facility failed to provide respiratory care consistent with professional standards of care for R28, regarding the use and cleaning of the nebulizer equipment.

- Review of Resident (R)27's undated "Physician Orders," (POS) revealed diagnoses which included heart failure and chronic respiratory failure.

The "Admission Minimum Data Set," (MDS), dated 07/18/23, included the "Brief Interview for Mental Status" (BIMS) score of BIMS 10, indicating moderate cognitive impairment. She received Oxygen (O2) as a special care and treatment.

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The "Quarterly MDS", dated 03/25/24, documented the resident with BIMS score of 11, indicating continued moderate cognitive impairment. She received oxygen, as special care and treatment .

The "Care Plan," (CP) dated 02/07/24, lacked address of special care and treatment related to oxygen.

The POS documentation included an order to apply oxygen to keep oxygen saturation rate (percentage of oxygen content in the blood) greater than or equal to 90 percent (%) as needed, ordered on 07/12/2023.

On 04/09/24 at 11:06 AM, the resident sat on the side of the bed with oxygen administered at two liters per minute by way of nasal cannula. The tubing, cannula, and humidifier bottle did not have a date indicating placement. An undated 2/3rd full gallon container of distilled water sat directly on the resident's bed side commode. The resident stated the staff used the distilled water to fill the humidifier bottle to keep her nasal passages from drying out.

On 04/09/24 11:45 AM, Certified Medication Aide (CMA) I verified the above findings. She stated the oxygen tubing, cannula, humidifier bottle and distilled water should be labeled to indicate the date it was placed into service to ensure routine changes to prevent the spread of infection. Additionally, CMA I reported the distilled water should be stored in the resident's room in a location other than the bedside commode to prevent cross contamination.

On 04/10/24 at 11:04 AM, CMA I stated the night

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F 695	Continued From page 42 shift was to change the oxygen tubing and cannulas weekly to prevent infection. The staff should label the tubing with the date at the time the change was made. The distilled water should be dated when opened. On 04/11/24 at 09:46 AM, Licensed Nurse (LN) P stated oxygen equipment including tubing cannula and humidifier bottles should be marked when changed. The protocol for changing the set up includes night shift on Sundays, and as needed to prevent cross contamination. On 04/15/24 02:48 PM , Administrative Nurse B stated the nursing staff were responsible for maintain the oxygen equipment in a manner to prevent cross contamination and the spread of infection. The oxygen tubing, cannula, humidifier bottle, and distilled water should be labeled when initiated or changed. The oxygen supplies should be stored in a manner to prevent cross contamination and the spread of infection. The facility lacked a policy to address of maintain oxygen equipment to prevent the spread of infection. The facility failed to provide appropriate respiratory care related to maintaining respiratory equipment to prevent the spread of infection for the resident.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure	F 700		

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correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.

§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.

§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 64 residents which included 16 residents sampled, which included one resident reviewed for bed rail safety. Based on interview, observation, and record review, the facility failed to assess Resident (R)25 for safety and risk of entrapment from bed rail use and failed to ensure R25 obtained informed documented consent from the resident or resident representative prior to installation of the siderails. This deficient practice placed R25 at a risk for uninformed decisions related to the risks and benefits associated with the use of side rails and placed the resident at risk due to possible injury due to bed rail use.

Findings include:

- The Electronic Health Records (EHR) for Resident (R)25 included diagnoses of

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generalized muscle weakness, reduced mobility, incomplete paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk) and muscle wasting with atrophy (wasting or decrease in size of a part of the body).

R25's "Significant Change Minimum Data Set" (MDS), dated 11/30/23, documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R25 was dependent on staff for all cares except eating and oral care which required supervision. The MDS lacked documentation related to grab bar use.

The 11/30/23 "Activities of daily living (ADL's such as walking, grooming, toileting, dressing and eating) Functional / Rehabilitation Potential Care Area Assessment (CAA)", documented R25 required ADL assistance due to functional impairment in activity from generalized weakness and incomplete paraplegia. The CAA lacked documentation related to grab bar use.

The 11/30/23 "Pressure Ulcer/Injury CAA" documented that R25 had an increased risk of pressure ulcers/injury due to functional impairment and mobility impairment but lacked documentation related to grab bar use for bed mobility.

The "Quarterly MDS" dated 03/01/24 documented a BIMS of 15 and R25 was dependent on staff for all cares except eating and oral care which required supervision. The MDS lacked documentation related to grab bar use.

The 04/09/24 "Care Plan" lacked documentation related to the use of grab bars while R25 was in bed.

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The physician's orders lacked directions specific for grab bar use.

The EHR "Assessments" lacked documentation of grab bar safety assessment.

On 04/09/24 at 02:22 PM, R25 revealed that she used grab bars on the bed to help with bed mobility and repositioning with and without staff assistance.

On 04/10/24 at 02:06 PM, Licensed Nurse (LN) M stated that safety assessments should be accessible in the EHR.

On 04/15/24 at 03:33 PM, Administrative Nurse B confirmed R25's EHR lacked a safety assessment for bed rail use.

On 04/15/24 at 03:40 PM, Administrative Nurse B provided a safety assessment performed by Administrative Nurse BB on 04/15/24 and confirmed that no safety assessment existed previously.

On 04/17/24 at 09:40 AM, Administrative Staff A provided a copy of the informed consent from the resident that was dated 04/15/24 and confirmed that no consent had existed previously.

The facility's undated "Bed Safety and Bed Rails" policy identified "bed rails" to include side rails, safety rails and grab assistance bars and defined as adjustable metal or rigid plastic bars that attach to the bed. The policy documented that the use of bed rails was prohibited unless the criteria had been met which included resident assessment for potential risks to the resident(s)

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F 700	Continued From page 46 associated with the use of bed rails and informed consent about the benefits and potential hazards associated with the use of bed rails. The facility failed to assess R25 for safety and risk of entrapment from bed rail use and failed to obtain informed documented consent from the resident or resident representative prior to installation of the siderails. This deficient practice placed R1 at risk for uninformed decisions related to the risks and benefits associated with the use of a side rail and placed the resident at risk for possible injury due to bed rail use.	F 700		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding	F 726		

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to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 64 residents. The sample included 16 residents with five residents sampled. Based on observation, record review, and interview, the facility failed to ensure certified nursing staff had appropriate competencies and skill set to provide nursing related services to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This placed Resident (R) 3, R11, and R165 at risk of injury during call light response and R25, R50 for proper catheter care which placed all residents at risk for decreased quality of care.

Findings included:

- The "Physician Orders" for Resident (R)50, dated 03/22/24, indicated diagnoses that included retention of urine unspecified (Lack of ability to urinate and empty the bladder) and urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

The "Admission Minimum Data Set" (MDS) dated 08/17/23, revealed a "Brief Interview for Mental Status" (BIMS) score of three, indicating severely impaired cognition. The "Activities of Daily Living" (ADL's) indicated Resident R 50 required extensive assistance with two or more persons

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for bed mobility, transfers, and toilet use.

The "Quarterly" MDS dated 03/08/24, indicated a BIMS score of 12, indicating moderately impaired cognition. R50 required an indwelling urinary catheter.

The "Care Plan" dated 08/11/23 revealed F50 required the need of a indwelling urinary catheter for terminal illness and urinary retention. Staff were to ensure the catheter bag remained below the level of the bladder to minimize the risk of infection. Staff were to provide catheter care per facility policy.
R50 required "Enhanced Barrier Precautions" dated 04/10/24, due to wound and urinary catheter. Staff were to wear gloves and gowns for all dressing, changing brief, transfer, toileting, peri-care, catheter care/ bathing/showering, hygiene, changing lines and wound care.

On 04/10/24 at 10:32 AM, observed R50 in his bed and the urinary catheter bag hung off of his wheelchair. The urinary collection bag lacked a privacy bag.

On 04/10/24 at 10:58 AM, Certified Nurse Aide (CNA) C provided catheter care. CNA C did not wash her hands prior to applying gloves and did not apply a gown before starting the cleaning of R50's catheter. CNA C used wipes to clean R50's penis and catheter. CNA C placed the soiled wipes on top of the package of the clean wipes. CNA C finished the catheter care. CNA C failed to wash her hands between the soiled gloves. CNA C also failed to wash her hands after removing her soiled gloves and before leaving R50's room.

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On 04/10/24 at 11:04 AM, interview with CNA C revealed she was not aware of the guidelines for proper catheter care and was unaware of the guidelines for the Enhanced Barrier protection.

On 04/11/24 at 01:30 PM, Interview with Licensed Nurse F revealed the staff now have to follow the Enhanced Barrier Precautions of wearing a gown and gloves while providing care of residents with a catheter.

The policy "Catheter Care Urinary" dated 2001 revealed the purpose of the procedure is to prevent urinary catheter-associated complication, including urinary tract infections. The Routine Perineal Hygiene guidance is to place the clean equipment on the bedside stand or overbed table. Perform hand hygiene with the non-dominant hand and retract the foreskin of uncircumcised male residents. Maintain the position of this hand throughout the procedure. Cleanse the glans using circular strokes from the meatus outward with a clean washcloth or wipe, rinse using the about technique, and return the foreskin to normal the position. Perform hand hygiene after finishing catheter care.

The facility failed to ensure certified staff had appropriate competencies and skill sets to provide nursing related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This placed the resident at risk for decreased quality of care.

- The "Physicians Orders" for R165, dated 04/04/24, included the diagnosis for after care following surgery for pacemaker (implanted

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device to regulate the beating of the heart).

The "Admission Minimum Data Set" (MDS dated 04/08/24) revealed a "Brief Interview for Mental Status" (BIMS) score of 15, revealing intact cognition, and R165 required assistance with bathing.

The "Care Area Assessment " (CAA) dated 04/10/24 indicated staff were to wear gloves and gowns for all dressing, changing brief, transfers, toileting, pericare, catheter care, bathing/showering, hygiene, changing linens, and wound care.

The "Care Plan" dated 04/04/24, documented R 165 required the assistance of one staff member for bathing, personal hygiene, and dressing.

Review of the call light log for R165 room from 04/02/24 to 04/09/24 indicated the call light remained unanswered for 18 occurrences ranging from 15 minutes to 30 minutes before staff answered the call light.

On 04/10/24 at 11:48 AM, R165 revealed that she sometimes had to wait at least 45 minutes for a staff member to answer the call light.

On 04/11/24 at 08:34 AM, Interview with Certified Nursing Aide (CNA) D revealed R167 will complain about the length of the call light response. Several residents complain about the response time of the call lights. There is enough staff, but it depends on the staff working.

On 04/11/24 at 01:35 PM, Licensed Nurse LN F revealed staff have pagers that notify the nurses how long a call light has been initiated.

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On 04/11/24 at 10:09 AM, Administrative Nurse B revealed staff needs are determined by the acuity of the residents and or the census. When staff do not answer the call lights timely, and if the call light response was longer than 10 minutes, then Administrative Nurse B was to conduct audits, investigate the staff working, interview the resident, and provide 1:1 counseling with the staff .

The facility failed to provide a policy regarding call lights as requested on 04/15/24.

The facility failed to ensure certified staff had appropriate competencies and skill sets to provide nursing related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This placed all residents at risk for decreased quality of care.

- Resident (R) 25's diagnoses included neuromuscular dysfunction of bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), and urinary tract infection (Infection of any part of the urinary system, including kidneys, ureters, bladder, and urethra).

The "Significant Change" Minimum Data Set (MDS) dated 11/03/23, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident was dependent for all cares and had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

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The 11/03/23 "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 11/03/23, revealed the resident required a urinary catheter.

The care plan, dated 10/13/23, revealed the resident required a urinary catheter. Revision of the care plan revealed on 04/10/2024, the resident required Enhanced Based Precautions (EBP) related to wound and catheter. Staff were to wear gloves and gowns for all dressing, changing brief, catheter care, emptying catheter, transfers, toileting, peri care, bathing/showering, hygiene, changing linens, and wound care.

The Physician Orders included to check and verify catheter securement was in place and the tubing was free of kinks, two times a day, ordered 04/12/2024.

Observation on 04/10/24 at 10:55 AM revealed Licensed Nurse (LN) M provided urinary catheter care with the assistance of Certified Nursing Aide (CNA) D. CNA D performed hand hygiene upon entry to the room and donned gloves, LN M failed to perform hand hygiene and donned gloves when entering the room. CNA D left the resident's room to retrieve the full body mechanical lift outside the room with neither staff member engaged in enhanced barrier precautions. Staff transferred the resident with the mechanical lift to her bed. CNA D went to the bathroom to retrieve warm/soapy wash cloth while LN M removed the resident's brief at the front and assisted the resident to hold her legs apart. The resident was incontinent of bowels. CNA D wiped the front of the resident, then discarded the soiled washcloth and changed gloves without performing hand

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hygiene. CNA D retrieved incontinence wipes from the bedside table drawer and initiated peri-care. Staff assisted the resident and the resident positioned to her left side. LN M started cleaning up feces with multiple swipes with the same wipe, LN M changed her gloves without hand hygiene. CNA D removed her gloves and left the resident room for additional supplies and failed to perform hand hygiene. When CNA D returned to the resident's room, CNA D donned new gloves and took the washcloth to the bathroom to make a warm/soapy wash cloth, then walked to bedside and cleaned resident's genitals, then cleaned around the resident's catheter, then wiped the resident's genitals a second time, then cleaned the resident's catheter a second time, folding and /refolding the same washcloth with each pass. CNA D then disposed of the washcloth and changed gloves but failed to perform hand hygiene. LN M removed gloves and left the resident's room to obtain additional supplies and failed to perform hand hygiene. CNA D replaced resident's brief and LN M returned to the room and failed to perform hand hygiene. LN M attempted to place a commercially available adhesive catheter securement device to the resident, but the resident declined this as she had a documented history of adverse reaction to the adhesive. LN M removed her gloves and performed hand hygiene with an alcohol-based hand solution, then left the room. CNA D collected the soiled supplies and removed gloves, then exited the room without performing hand hygiene.

On 04/10/24 at 09:38 AM, R25 stated staff have not put on any full personal protective equipment (PPE) when emptying her catheter bag. She reported she did not have a tubing

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anchoring/securement device because she was allergic to the anchor, and the facility was to get her a harness type securement device but had not done that yet.

Interview on 04/10/24 at 11:20 AM, CNA D stated she would not have changed anything with the procedure as observed except that staff may have needed extra supplies to prevent having to leave to go get additional supplies. CNA D confirmed that no EBP were in place at the time of catheter/peri care.

On 04/10/24 at 11:18 AM, LN M stated she would not have changed anything with the procedure as observed.

Interview on 04/10/24 at 02:06 PM with LN M confirmed that no EBP was in place at the time of catheter/peri care, and reported it was acceptable to wipe/fold/reuse with wash cloth but not with wipes, confirmed that she had reused wipe to remove BM from resident's skin. Stated that CNA D should not have re-wiped a second time of genitals or catheter with wash cloth because it presented as an infection control concern.

Interview on 04/10/24 at 02:35 PM, Administrative Nurse B reported an expectation for staff that wash cloths should not be used for peri care or catheter care, only for bathing. Wipes should be used for one wipe per swipe for either peri or catheter care. Hand hygiene should be performed with either alcohol-based hand rub (ABHR) or soap/water before procedure, and with every glove change and with soap/water only at the end of a procedure. Residents with catheters should have some sort of securement device for the tubing to be secured to the resident's leg. It is

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never acceptable for resident to have a catheter without it being secured to the leg.

Interview on at 04/10/24 at 04:05 PM, CNA CC reported there were no special orders in progress for a foley securement device. Walk through with CNA CC of the facility's supply room revealed leg securement straps in house stock.

Interview on at 04/10/24 at 04:25 PM with Administrative Nurse B, informed of above and was unable to provide an explanation as to why a securement device had not been in place prior to location of the device in the facility's supply room.

The facility's policy for Catheter care, dated 08/22, revealed the purpose of this procedure was to prevent urinary catheter -associated complications including urinary tract infections. Use aseptic technique when handling or manipulating the drainage system.

The facility failed to ensure certified staff had appropriate competencies and skill sets to provide nursing related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This placed the resident at risk for decreased quality of care.

- The Electronic Health Records (EHR) for Resident (R)11 included diagnoses of diabetes mellitus type 2 (DM2 - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), generalized weakness, aphasia (condition with disordered or absent language function) following cerebral infarction (stroke - sudden death of brain cells

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due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and rheumatoid arthritis (RA - a chronic inflammatory disease that affected joints and other organ systems).

The 12/23/23 "Admission Minimum Data Set (MDS)" documented a Brief Interview for Mental Status (BIMS) score of 15, which indicates intact cognition. R11 required substantial assistance from staff for all cares except eating, which required setup and supervision.

The 12/23/23 " Activities of daily living (ADL's such as walking, grooming, toileting, dressing and eating) Functional / Rehabilitation Potential Care Area Assessment (CAA)", documented R11 had an ADL self-care deficit related to impaired balance during transfers, functional impairment during activity, generalized weakness, and decreased safety awareness.

The 12/23/23 "Falls CAA" documented R11 was at increased risk for falls due to impaired gait (manner or style of walking), impaired mobility, weakness, and physical performance limitations.

The 03/05/24 "Quarterly MDS" documented a BIMS score of 15, which indicated intact cognition and R11 required substantial/maximum assistance for all cares except eating which required supervision and setup.

The 04/10/24 "Care Plan", documented an intervention dated 12/28/23 for staff to place R11's call light within his reach.

Review of the call light log from 03/01/24 to 03/14/24 revealed 345 call light entries with 47

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entries greater than 15 minutes, which included entries of 45.23 minutes, 32.5 minutes, 34.3 minutes, 33.3 minutes, 32.8 minutes, 37.8 minutes, 35.8 minutes, 36 minutes, 43 minutes, and 39 minutes.

On 04/11/24 at 08:34 AM, Interview with Certified Nursing Aide (CNA) D revealed R167 will complain about the length of the call light response. Several residents complain about the response time of the call lights. There is enough staff, but it depends on the staff working.

On 04/11/24 at 01:35 PM, Licensed Nurse LN F revealed staff have pagers that notify the nurses how long a call light has been initiated.

On 04/11/24 at 10:09 AM, Administrative Nurse B revealed staff needs are determined by the acuity of the residents and or the census. When staff do not answer the call lights timely, and if the call light response was longer than 10 minutes, then Administrative Nurse B was to conduct audits, investigate the staff working, interview the resident, and provide 1:1 counseling with the staff .

The facility failed to provide a policy regarding call lights as requested on 04/15/24.

The facility failed to ensure certified staff had appropriate competencies and skill sets to provide nursing related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This placed all residents at risk for decreased quality of care.

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- The Electronic Health Records (EHR) for Resident (R)3 revealed diagnoses that included muscle weakness, history of falls, reduced mobility.

The Annual Minimum Data Set (MDS), dated 03/22/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.

The "Activities of Daily Living (ADL)/Functional/Rehabilitation Potential Care area Assessment" (CAA), dated 03/22/24, documented R3 had reduced mobility.

Review of the call light log from 03/01/24 to 03/14/24, revealed 149 call light entries with 24 entries greater than 15 minutes which included one entry each for 37.7 minutes, 35.55 minutes, 34.3 minutes, 47 minutes, 63.6 minutes and 33.2 minutes.

On 04/09/24 at 02:59 PM, R3 reported staff do not answer her call lights quick enough and she has to wait sometimes over 45 minutes for someone to answer her call light. Because of the delay of call light response, she will at times become incontinent. She reported she also had to be hospitalized because of a urinary tract infection, and felt it was because she would try to hold her urine while waiting for staff to assist her.

On 04/11/24 at 08:34 AM, Interview with Certified Nursing Aide (CNA) D revealed R167 will complain about the length of the call light response. Several residents complain about the response time of the call lights. There is enough staff, but it depends on the staff working.

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F 726	Continued From page 59 On 04/11/24 at 01:35 PM, Licensed Nurse LN F revealed staff have pagers that notify the nurses how long a call light has been initiated. On 04/11/24 at 10:09 AM, Administrative Nurse B revealed staff needs are determined by the acuity of the residents and or the census. When staff do not answer the call lights timely, and if the call light response was longer than 10 minutes, then Administrative Nurse B was to conduct audits, investigate the staff working, interview the resident, and provide 1:1 counseling with the staff . The facility failed to provide a policy regarding call lights as requested on 04/15/24. The facility failed to ensure certified staff had appropriate competencies and skill sets to provide nursing related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This placed all residents at risk for decreased quality of care.	F 726		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		

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Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 64 residents and identified 11 residents as confused and self-mobile. Based on observations, interviews, and record review, the facility failed provide a safe environment for 11 residents by the failure to ensure that Resident (R)25 and R1's rooms remained free of unsecured medications, when the facility failed to secure medications in both residents' rooms. This deficient practice had the potential to create an accidental ingestion of medications to these confused, mobile residents.

Findings included:

- The Electronic Health Records (EHR) for Resident (R)25 included diagnoses of generalized muscle weakness, reduced mobility, incomplete paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk) and muscle wasting with atrophy (wasting or decrease in size of a part of the body).

R25's "Significant Change Minimum Data Set"

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(MDS), dated 11/30/23, documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R25 was dependent on staff for all cares except eating and oral care which required supervision.

The "Activities of daily living (ADL's such as walking, grooming, toileting, dressing and eating) Functional / Rehabilitation Potential Care Area Assessment (CAA)", dated 11/30/23, documented that R25 required ADL assistance due to functional impairment in activity from generalized weakness and incomplete paraplegia.

The 04/10/24 "Care Plan" lacked information related to self-administration of medications.

The EHR "Evaluations" tab lacked a self-administration assessment.

The EHR "Physician's Orders" lacked a self-administration order for any medications.

On 04/15/24 at 07:55 AM, an observation of R25's room revealed bottle of generic antacid tablets on the bathroom counter next to personal hygiene items.

On 04/10/24 at 02:05 PM, Certified Nurse Aide (CNA) N revealed that medications were not allowed to be stored in resident's rooms and if discovered, the medications should be moved out of the resident's reach and to notify the Licensed Nurse (LN).

On 04/10/24 at 02:10 PM, LN E revealed that medications were prohibited in resident rooms unless the resident had been assessed for self-administration safety and had a physician's

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order specific to the self-administration of each medication.

On 04/15/24 at 08:55 AM, Administrative Nurse B confirmed that medications should not be stored in resident's rooms unless the resident had a self-administration safety assessment and a physician's order for self-administration for each medication. Administrative Nurse B then confirmed the lack of self-administration safety assessment and physician's order for self-administration.

The facility's undated "Storage of Medications" policy documented that medications were stored in safe, secure and orderly manner and lacked instructions related to self-administration of medications.

The facility failed provide a safe environment for 13 residents by the failure to ensure that R25's room remained free of unsecured medications. This deficient practice had the potential to create an accidental ingestion of medications to these confused, mobile residents.

- The Electronic Health Records (EHR) for Resident (R)1 included diagnoses of generalized anxiety disorder (a disorder characterized by chronic free-floating anxiety and such symptoms as tension or sweating or trembling or lightheadedness or irritability etc. that has lasted for more than six months), major depressive disorder (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks) and generalized muscle weakness.

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R1's "Annual Minimum Data Set (MDS)", dated 06/22/23, documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. R1 required extensive or total assistance for all cares except eating which was performed independently and R1 had a urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

R1's "Activities of daily living (ADL's such as walking, grooming, toileting, dressing and eating) Functional / Rehabilitation Potential Care Area Assessment (CAA)", dated 06/22/23, documented that R1 had impaired functional impairment in activity due to decreased safety awareness.

R1's "Quarterly MDS", dated 03/09/24, documented a BIMS score of 15 which indicated intact cognition. R1 required extensive or total assistance for all cares except eating which was performed independently.

The 04/10/24 "Care Plan" lacked information related to medication self-administration.

The EHR "Evaluations" tab lacked a self-administration assessment.

The EHR "Physician's Orders" lacked a self-administration order for any medications.

On 04/09/24 at 11:44 AM, an observation of R1's room revealed a bottle of refresh eyedrops (an over the counter [OTC - available without a prescription] medication used to lubricate the eyes and harmful to humans if swallowed) on the over-the-bed-table sitting on top of an insulated

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cup with a lid, Ciclopirox (a prescription antifungal medication used to treat fungal infections of fingernails and toenails and harmful to humans if swallowed) drops and Restasis (a prescription medication used to lubricate and reduce inflammation on the surface of the eye and harmful to humans if swallowed) drops on over-the-bed table.

On 04/10/24 at 10:13 AM, observation of R1's room revealed a bottle of refresh eye drops on the insulated cup with lid, Ciclopirox drops and Restasis drops on the resident's over-the-bed table.

On 04/11/24 at 09:15 AM, observation of R1's room revealed R1 resting in bed watching TV with a breakfast tray present on over-the-bed table with ciclopirox drops, Restasis and refresh drops also present on over-the-bed table.

On 04/11/24 at 02:00 PM, observation of R1's room revealed ciclopirox drops, Restasis and refresh drops present on over-the-bed table.

On 04/15/24 at 07:45 AM, observation of R1's room revealed ciclopirox drops, Restasis and refresh drops remained on over-the-bed table.

On 04/10/24 at 02:05 PM, Certified Nurse Aide (CNA) N revealed that medications were not allowed to be stored in resident's rooms and if discovered, the medications should be moved out of the resident's reach and to notify the Licensed Nurse (LN).

On 04/10/24 at 02:10 PM, LN E revealed that medications were prohibited in resident rooms unless the resident had been assessed for

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F 761	Continued From page 65 self-administration safety and had a physician's order specific to the self-administration of each medication. On 04/15/24 at 08:55 AM, Administrative Nurse B confirmed that medications should not be stored in resident's rooms unless the resident had a self-administration safety assessment and a physician's order for self-administration for each medication. Administrative Nurse B then confirmed the lack of self-administration safety assessment and physician's order for self-administration. On 04/17/24 at 11:15 AM, according to the Poison Control Center (1-800-222-1222 https://www.poison.org) reported ciclopirox, Restasis and refresh medications were harmful and would cause gastrointestinal distress that included nausea, vomiting and diarrhea. The facility's undated "Storage of Medications" policy documented that medications were stored in safe, secure, and orderly manner and lacked instructions related to self-administration of medications. The facility failed provide a safe environment for 13 residents by the failure to ensure that R1's room remained free of unsecured medications. This deficient practice had the potential to create an accidental ingestion of medications to these confused, mobile residents.	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides-	F 804		

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§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 64 residents. The facility identified one central kitchen with two satellite kitchens and two dining areas. Based on observation, interview, and record review, the facility failed to provide food that was palatable, attractive and at a safe and appetizing temperature.

Findings included:

- On 04/11/24 at 09:00 AM, test trays were requested from Dietary Staff H for the noon meal service, one from each of the satellite kitchens.

On 04/11/24 at 12:24 PM Dietary Staff H provided surveyors with a meal tray from the west kitchen with all foods measured by Dietary Staff H above appropriate temperature of 135 degrees Fahrenheit (°F) for food service. All foods were sampled for palatability, and all were acceptable except for the tater-tots which tasted stale and freezer burnt.

On 04/11/24 at 12:48 PM Dietary Staff Z provided surveyors with a meal tray from the east kitchen with all foods measured by Dietary Staff Z. The tater-tots measured at 130.9 °F and popcorn shrimp measured at 132 °F. Dietary Staff Z stated that all foods were to be served at 135°F or higher. All foods were sampled for palatability,

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F 804	Continued From page 67 and all were acceptable except for the tater-tots which were cool and tasted stale and freezer burnt and the shrimp which was cool and unpalatable. On 04/11/24 at 01:10 PM, Dietary Staff H confirmed that all hot foods should be served at a minimum of 135 °F. The facility failed to provide a policy related to food palatability and food service temperatures as requested on 04/11/24. The facility failed to provide food that was palatable, attractive and at a safe and appetizing temperature. This deficient practice had the potential to lead to resident's not eating appropriate portion sizes and causing foodborne illnesses due to improper serving temperature.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		

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§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 64 residents. The facility identified one central kitchen with two satellite kitchens and two dining areas. Based on observation, interview, and record review, the facility failed to provide sanitary food preparation and storage of food to prevent the spread of food borne illness to the residents of the facility.

Findings included:

- Initial tour of the kitchen on 04/09/24 at 09:05 AM with Dietary Staff H, revealed the following areas of concerns:

1. In the west kitchen, Dietary Staff Y performed tasks in the kitchen and had long hair exposed below the level of her buttocks with hair restraint device covering only the top of her head.

2. In the west kitchen, in the refrigerator, a bottle of orange juice with a factory expiration date of 09/29/23.

3. In the west kitchen, in the freezer, a package of hotdog buns unsealed and opened to air.

4. In the west kitchen freezer, a package of miscellaneous bread products unsealed and opened to air.

5. In the main kitchen food preparation area, four cutting boards with non-cleanable surfaces.

6. In the main kitchen, in the stand-alone freezer,

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four bags of various types of potatoes (chunked, whole, tater-tots, etc.) unsealed and undated.

7. In the main kitchen, in the stand-alone freezer, one bag of sliced onions undated.

8. In the main kitchen, in the stand-alone refrigerator, one large container of mayonnaise undated.

9. In the main kitchen, in the walk-in refrigerator, one large bag of raw chicken, open and undated.

10. In the main kitchen, in the walk-in freezer, one package of an unknown and unidentifiable food product unlabeled and undated.

11. In the main kitchen, in the walk-in freezer, one large bag of assorted vegetables, opened and undated.

12. In the main kitchen, in the walk-in freezer, one large box of frozen corn, opened and undated.

13. In the main kitchen, in the walk-in freezer, one bag of corn dogs, opened and undated.

14. In the main kitchen, in the walk-in freezer, one large box of hot links, opened and undated with ice crystals on the food.

On 04/09/24 at 09:53 AM, Dietary Staff H stated that all items in the refrigerators and freezers should be sealed and dated with an expiration date. All staff should have hair restraint devices on when in the kitchen areas.

The facility's undated "Food Storage" policy documented that all foods in the kitchen would be

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F 812	Continued From page 70 labeled and include the name of the food and expiration date. Additionally, documented that raw poultry should not be left uncovered or unsealed. The facility failed to provide a policy for hair-restraint use in the kitchen areas as requested on 04/09/24, The facility failed to provide sanitary food preparation and storage of food. This deficient practice had the potential to cause the spread of food borne illness to the residents of the facility.	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: The facility reported a census of 64 residents. Based on observation, interview, and record review, the facility failed to maintain and/or dispose of garbage and refuse properly in a sanitary condition to prevent the harborage and feeding of pests. Findings included: - Initial tour of the kitchen facilities on 04/09/24 at 09:50 AM with Dietary Staff H, revealed that the outside dumpster area was littered with medical waste that included soiled bandages and disposed gloves and that the dumpster lid was in the open position. On 04/09/24 at 09:53 AM, Dietary Staff H stated that she was unaware of the requirement that	F 814		

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F 814	Continued From page 71 kitchen staff were responsible for the cleanliness of the area around the dumpster or that the dumpster lid was to always remain closed. On 04/09/24 at 09:58 AM, Administrative Nurse B stated that her expectation was for all staff that takes trash to the dumpster to ensure that the area around the dumpster is kept free of any debris and that the lid of the dumpster should be closed at all times. The presence of medical waste on the ground outside the dumpster was an unacceptable practice as it had the potential to attract pest animals and could be a potential infection control concern. On 04/09/24 at 10:25 AM, Housekeeping Supervisor J stated that she was unaware of the requirement that the dumpster area be free of debris and that the lid of the dumpster remain closed when not in use. The facility failed to provide a policy related to garbage and refuse handling and disposal as requested on 04/09/24. The facility failed to provide sanitary garbage and refuse containers that were maintained in a sanitary condition free of debris with lids or otherwise contained and covered. This deficient practice had the potential to lead to harborage and feeding of pest animals.	F 814		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		

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comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§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;

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

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circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 64 residents which included 16 residents sampled. Based on observation, interview and record review, the facility failed to provide a sanitary and safe environment to prevent cross contamination and infection related to provision appropriate use of personal protective equipment (PPE) for 13 residents (R)1, R 4, R 11, R 19, R 25, R 26, R 37, R 38, R 40, R 48, R 50, R 55, and R 57, which required enhanced barrier precautions to be in place and available for nine residents with catheters (R 1, R 26, R 11, R 55, R19, R 37, R 50, R 04, R 25), five residents with wounds (R 38, R 40, R 19, R 50, and R 25), two residents with percutaneous enteral gastrostomy tube (PEG- artificial opening through the abdominal

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wall where a catheter is placed to supply nutrition), (R 37 and R 48), four residents (R 55, R 38, R 48, and R 57 of the 13 identified residents that required enhanced barrier precautions during care received therapy.

Additionally, the facility failed to provide safe and sanitary handling of glucometer (a device used to measure glucose/sugar content of the blood) between residents hand hygiene with don (application) and doffing (removal) of gloves, to prevent cross contamination and infections for residents (R)34, R 56, and R 113 related to glucometer use.

Furthermore, the facility failed to provide appropriate catheter care and hand hygiene for R1 and R 25 to prevent infection and prevent cross contamination.

Findings included:

- On 04/11/24 at 09:46 AM, Licensed Nurse (LN) P reported he had three blood sugars order for two hours after meals. He stated that each resident had their own glucometer to test their blood sugar, which was maintained in a closed container and stored in their rooms. LN P stated the facility kept a community glucometer contained in a closed plastic container stored in the treatment cart to use in the event of a new admission and/or inability to locate the resident's personal glucometer. He removed the community glucometer from the treatment cart and examined the content of the box which contained the glucometer, lancets (device to stick finger to obtain a blood sample), container of test strips, cotton balls, and alcohol swab. LN P stated

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when the staff used the community glucometer, they were required to sanitize the glucometer after each use and between each resident to prevent cross contamination and prevention of blood borne pathogens. He explained further the wipes for sanitizing the glucometer were in the drawer of the medication cart. LN P verified the order for Resident (R) 34 on the electronic health record (EHR). The order directed staff to check the resident's blood sugar fasting, two hours after meals, call the physician if the resident's blood glucose/sugar reading was below 60 and/or above 350. LN P proceeded to the resident's room and determined the resident did not have his individual glucometer present in the room. He returned to the cart and removed the Community glucometer container, stating he could not locate the resident's glucometer in his room. LN P reentered the room, retrieved gloves from the box by the door and applied the gloves without performing hand hygiene. Upon inquiry, he stated he should have washed his hands prior to applying the gloves. He placed the glucometer container on the resident's dresser, then removed the gloves and disposed of them in the resident's trash can. He provided hand hygiene and applied gloves. He then picked up the glucometer container from the dresser with his gloved hand. He reached into his scrub uniform pocket with his gloved hand and pulled out his cell phone and explained he needed to shut his phone off. He swiped his gloved hand across the cell phone screen and replaced the cell phone in his pocket. LN P then picked up the glucometer with his gloved hand, approached the resident and explained that he was going to check the resident's blood sugar. The resident agreed and LN P cleansed the third finger of the resident's left hand with an alcohol swab, while continuing to

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wear the same gloves. He then used the lancet to obtain a blood sample which he then applied to the test strip, applied a cotton ball to the resident's sampled finger while continuing to wear the same gloves. The nurse removed his gloves, performed hand hygiene, disposed of the paper towels in the resident's trash can, placed the glucometer in the container which sat directly on the resident's dresser, and took it to the treatment cart, opened the drawer and placed it in the cart without sanitizing the glucometer or the container. He proceeded to set the container with the glucometer directly on top of the medication cart, opened the drawer of the cart and insert the glucometer container in the drawer with other stored medications. LN P did not sanitize the surface of the medication cart nor the glucometer or its container. He then proceeded to roll the medication cart down the hall and checked on R 56 . LN P reported he would come back to check her blood sugar because her floor was wet. He rolled the medication cart across the hall to R 113. He reported he could not locate the resident's glucometer in her room. He then removed the community glucometer from the medication cart and proceeded to R 11's doorway. Upon inquiry he agreed the glucometer and container , and med cart had not been sanitized after its use with R56 as it should. He returned to the cart, opened the bottom drawer and reported the cart lacked Sani-wipes to sanitize the glucometer, the container and contents, and the medication cart to prevent cross contamination. At that point Certified Medication Aide(CMA) I walked by, and LPN P asked her to get the Sani-wipes. CMA I provided sanitizing wipes with a two-minute dwell time. LPN P removed a wipe and swiped the glucometer a coupe of times and replaced the

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glucometer back in the unsanitized container. He stated he should have sanitized the glucometer, medication cart top, the resident's dresser, washed his hands prior to applying gloves and upon removal of gloves to prevent cross contamination and prevent the spread of infections.

On 04/11/24 at 02:45 PM, Administrative Nurse B verified that each resident should have a plastic container to store their individual glucometer and supplies to obtain their blood sugar. The facility maintained a container with a glucometer and supplies for use with new admits. The staff should sanitize their hands before applying gloves and after removing gloves. There should be a barrier between a surface where the glucometer rests and while the glucometer is wrapped in the sanitizing wipes to remain wet for the dwell time to prevent infection and cross contamination.

The facility policy titled "Obtaining a Fingerstick Glucose," dated 10/2011, documentation included always ensure that glucose meters intended for reuse are cleaned and disinfected between resident uses. Clean and disinfect reusable equipment between uses according to current infection control standard. Remove gloves and discard into designated container and perform hand hygiene.

The facility failed to provide a sanitary and safe environment to prevent cross contamination and infection related to the provision appropriate use of personal protective equipment (PPE) and the safe and sanitary handling of glucometer (a device used to measure glucose/sugar content of the blood) between residents hand hygiene with don (application) and doffing (removal) of gloves,

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to prevent cross contamination and infections for residents (of the facility.

- On 04/09/24 at 09:30 AM, during resident screening the following residents were noted to lack Enhanced Barrier precautions (EBP) or the readily available Personal Protective Equipment (PPE) nor signage during the resident screening process of the following as required:

1. Nine residents with catheters (R 1, R 26, R 11, R 55, R19, R 37, R 50, R 04, R 25),

2. Five residents with wounds (R 38, R 40, R 19, R 50, and R 25)

3. Two residents with percutaneous enteral gastrostomy tube (PEG- artificial opening through the abdominal wall where a catheter is placed to supply nutrition), (R 37 and R 48)

4. Four residents (R 55, R 38, R 48, and R 57 of the 13 identified residents that required enhanced barrier precautions during care received therapy.

On 04/10/24 at 02:35 PM, Administrative Nurse B reported the facility had not implemented Enhanced Barrier precautions for the resident on 04/01/24 to date for the residents with catheters, wounds, percutaneous enteral feeding tubes, and residents that received therapy that should have PPE enhanced precautions as required by Centers for Medicare and Medicaid Services (CMS). She reported she did not think the facility had to fully implement Enhanced Barrier Precautions for 30 days after the 04/01/24 directive.

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On 04/11/24 at 09:46 AM, Licensed Nurse P reported that he was not aware of the need for the use of EBP for residents with feeding tubes, catheters, and wounds until "yesterday" (04/10/24). He stated the gowns were not accessible in the rooms and the signage was not up until then as well.

On 04/11/24 10:21 AM, therapy staff V reported she had direct contact with residents during therapy. She reported she had one resident she provided direct care for that had a feeding tube. Therapy staff V stated she did not know the resident had to utilize EBP including PPE until the day before. She stated she always wore gloves and a mask, but did not wear a gown until yesterday when the signs were put on the door, and full PPE was not available.

On 04/15/24 at 3:30 PM, Administrative Nurse B reported 13 residents (R)1, R 4, R 11, R 19, R 25, R 26, R 37, R 38, R 40, R 48, R 50, R 55, and R 57, which required enhanced barrier precautions to include available PPE supplies to include gowns, and signage as specified in the 04/01/24 CMS memo was not in place until 04/10/24.

The facility policy titled "Enhanced Barrier Precautions," dated 08/2022 documentation included EBPs are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multiple drug resistant organisms (MDRO)'s to staff hands and clothing. Examples of high contact resident care activities requiring the use of gowns and gloves for EBPs include device care such as urinary catheters,

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feeding tubes, wound care, during providing hygiene, transfers during assistance with bathing and when working with residents in the therapy gym. Specifically, while assisting with transfers and mobility. Signs are posted on the door or wall outside the resident's room indicating the type of precautions and PPE required.

The facility failed to provide a sanitary and safe environment to prevent cross contamination and infection related to provision EBP related to the availability and appropriate use of personal protective equipment (PPE) for the residents of the facility.

- The "Physician Order" dated 03/22/24 indicated Resident (R)50 had the following diagnoses of retention of urine unspecified (Lack of ability to urinate and empty the bladder) urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

The "Admission Minimum Data Set" (MDS) dated 08/17/23 revealed a "Brief Interview for Mental Status" (BIMS) score of three, indicating severely impaired cognition. The "Activities of Daily Living" (ADL's) indicated R 50 required extensive assistance with two or more person for bed mobility, transfers, and toilet use.

The "Quarterly" (MDS) dated 03/08/24, indicated a BIMS score of 12, indicating moderate impaired cognition. R50 required an indwelling urinary catheter.

The "Care Plan" dated 08/11/23, revealed F50 required the need of a indwelling foley catheter for terminal illness and urinary retention. Staff were to ensure the catheter bag was below the

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level of the bladder to minimize the risk of infection. Staff were to provide catheter care per facility policy.

The "Enhanced Barrier Precautions" dated 04/10/24, revealed R50 required the Enhanced Barrier Precautions due to wound and catheter. Staff were to wear gloves and gowns for all dressing, changing brief, transfer, toileting, peri-care, catheter care/ bathing/showering, hygiene changing lines and wound care.

On 04/10/24 at 10:58 AM, observed Certified Nurse Aide (CNA) C provided catheter care. CNA C did not wash her hands prior to applying gloves and did not apply a gown before starting the cleaning of R50's catheter. CNA C used disposable wipes to cleanse the penis and catheter. CNA C placed the soiled wipes on top of the package of the clean wipes. CNA C finished the catheter care, then failed to wash her hands after removing her soiled gloves and before leaving R50's room.

On 04/10/24 at 11:04 AM, interview with CNA C revealed she was not aware of the guidelines for catheter care and proper hand hygiene.

On 04/11/24 at 01:30 PM, Interview with Licensed Nurse (LN) F revealed the staff now must follow the Enhanced Barrier Precautions, that indicated staff must wear a gown and gloves while providing care of catheters.

On 04/11/24 at 02:35 PM, Interview with Administrative Nurse C revealed the nursing staff should perform hand hygiene with either alcohol-based hand sanitizer or soap/water before the procedure and with every glove

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change, then at the end of the procedure.

The facility's policy for "Catheter Care Urinary" dated 2001, revealed the purpose of this procedure is to prevent urinary catheter-associated complication, including urinary tract infections. The Routine Perineal Hygiene (guidance is to) place the clean equipment on the bedside stand or overbed table. Perform hand hygiene with non-dominant hand and retract the foreskin of uncircumcised male residents. Maintain the position of this hand throughout the procedure. Cleanse the glans using circular strokes from the meatus outward with a clean washcloth or wipe, rinse using the about technique, return foreskin to normal position. Perform hand hygiene after finishing catheter care.

The facility failed to provide this resident, who required a urinary catheter, infection control techniques to prevent possible urinary system infections.

- R1's Electronic Medical Record (EMR) revealed diagnoses that included acute kidney failure (a sudden decline in kidney function that occurs within a few hours or days), neuromuscular dysfunction of bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), and urinary tract infection ([UTI] infection of any part of the urinary system, including kidneys, ureters, bladder, and urethra).

R1's Annual Minimum Data Set (MDS) dated 06/22/23, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact

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cognition. The resident required extensive to total assistance for all cares. R1 had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 06/22/23, documented risk factors included recurrent UTIs and injury from use of the catheter.

The "Bladder/Bowel" care plan, dated 01/27/23, revealed R1 required a urinary catheter, and guided staff to provide catheter care policy.

Observation on 04/09/24 at 11:19 AM revealed R1's catheter bag stored top of a dignity bag that was stored directly on the floor.

Observation on 04/10/24 at 10:13 AM, revealed R1's catheter bag hung from the edge of her bed, with dark amber colored urine in the drainage bag, and clear yellow urine with sediment in the tubing.

Observation of 04/10/24 at 01:23 PM, revealed Licensed Nurse (LN) AA donned a gown and pushed the gown sleeves above her wrists. She then washed her hands with soap and water, removed a gait belt from the back of door handle, then donned her gloves and pulled the gown sleeves back down to her wrists. LN AA wiped the catheter tubing with a no-rinse foam soap-soaked gauze, and removed and reapplied a new pair of gloves without performing hand hygiene, removed the spigot from the catheter collection system, emptied the urine from the collection bag into a urinal, then washed the spigot with a no-rinse foam soap-soaked gauze, then saline

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soaked gauze, then alcohol wipes. She removed her gloves, emptied the urinal into the commode and rinsed the urinal with tap water from the resident's sink. She pulled her sleeves up on her arms, washed her hands with soap and water and removed her gown.

On 04/09/24 at 02:09 PM, R1 reported that she required a urinary catheter because she was unable to urinate.

On 04/10/24 at 01:32 PM, LN AA confirmed no hand hygiene was done when changing her gloves and carrying the urinal to the bathroom and improper infection control techniques.

Interview on 04/10/24 at 02:35 PM, Administrative Nurse B reported wipes should be used for one wipe per swipe for either peri or catheter care. Hand hygiene should be performed with either alcohol-based hand rub (ABHR) or soap/water before the procedure and with every glove change, and with soap/water only at the end of a procedure.

The facility's policy for Catheter care, dated 08/22, revealed the purpose of this procedure is to prevent urinary catheter -associated complications including urinary tract infections. Use aseptic technique when handling or manipulating the drainage system.

The facility's policy for Enhanced Barrier Precautions, dated 08/22 revealed EBPs are used in conjunction with standard precautions and expand the use of Personal Protective Equipment to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of Multi Drug Resistant

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Organisms (MDRO) to staff hands or clothing.

The facility failed to provide necessary services to decrease the risk of a urinary tract infection when the staff failed to use proper hand hygiene and Enhanced Barrier Precautions when providing catheter care for resident (R)1.

- Resident (R) 25's diagnoses included neuromuscular dysfunction of bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), and urinary tract infection (Infection of any part of the urinary system, including kidneys, ureters, bladder, and urethra).

The "Significant Change" Minimum Data Set (MDS) dated 11/03/23, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident was dependent for all cares and had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

The 11/03/23 "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 11/03/23, revealed the resident required a urinary catheter.

The care plan, dated 10/13/23, revealed the resident required a urinary catheter.
Revision of the care plan revealed on 04/10/2024, the resident required Enhanced Based Precautions (EBP) related to wound and catheter. Staff were to wear gloves and gowns for all dressing, changing brief, catheter care, emptying catheter, transfers, toileting, peri care, bathing/showering, hygiene, changing linens, and

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wound care.

The Physician Orders included to check and verify catheter securement was in place and the tubing was free of kinks, two times a day, ordered 04/12/2024.

Observation on 04/10/24 at 10:55 AM revealed Licensed Nurse (LN) M provided urinary catheter care with the assistance of Certified Nursing Aide (CNA) D. CNA D performed hand hygiene upon entry to the room and donned gloves, LN M failed to perform hand hygiene and donned gloves when entering the room. CNA D left the resident's room to retrieve the full body mechanical lift outside the room with neither staff member engaged in enhanced barrier precautions. Staff transferred the resident with the mechanical lift to her bed. CNA D went to the bathroom to retrieve warm/soapy wash cloth while LN M removed the resident's brief at the front and assisted the resident to hold her legs apart. The resident was incontinent of bowels. CNA D wiped the front of the resident, then discarded the soiled washcloth and changed gloves without performing hand hygiene. CNA D retrieved incontinence wipes from the bedside table drawer and initiated peri-care. Staff assisted the resident and the resident positioned to her left side. LN M started cleaning up feces with multiple swipes with the same wipe, LN M changed her gloves without hand hygiene. CNA D removed her gloves and left the resident room for additional supplies and failed to perform hand hygiene. When CNA D returned to the resident's room, CNA D donned new gloves and took the washcloth to the bathroom to make a warm/soapy wash cloth, then walked to bedside and cleaned resident's genitals, then cleaned around the resident's

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catheter, then wiped the resident's genitals a second time, then cleaned the resident's catheter a second time, folding and /refolding the same washcloth with each pass. CNA D then disposed of the washcloth and changed gloves but failed to perform hand hygiene. LN M removed gloves and left the resident's room to obtain additional supplies and failed to perform hand hygiene. CNA D replaced resident's brief and LN M returned to the room and failed to perform hand hygiene. LN M attempted to place a commercially available adhesive catheter securement device to the resident, but the resident declined this as she had a documented history of adverse reaction to the adhesive. LN M removed her gloves and performed hand hygiene with an alcohol-based hand solution, then left the room. CNA D collected the soiled supplies and removed gloves, then exited the room without performing hand hygiene.
On 04/10/24 at 09:38 AM, R25 stated staff have not put on any full personal protective equipment (PPE) when emptying her catheter bag. She reported she did not have a tubing anchoring/securement device because she was allergic to the anchor, and the facility was to get her a harness type securement device but had not done that yet.

Interview on 04/10/24 at 11:20 AM, CNA D stated she would not have changed anything with the procedure as observed except that staff may have needed extra supplies to prevent having to leave to go get additional supplies. CNA D confirmed that no EBP were in place at the time of catheter/peri care.

On 04/10/24 at 11:18 AM, LN M stated she would not have changed anything with the procedure as

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observed.

Interview on 04/10/24 at 02:06 PM with LN M confirmed that no EBP was in place at the time of catheter/peri care, and reported it was acceptable to wipe/fold/reuse with wash cloth but not with wipes, confirmed that she had reused wipe to remove BM from resident's skin. Stated that CNA D should not have re-wiped a second time of genitals or catheter with wash cloth because it presented as an infection control concern.

Interview on 04/10/24 at 02:35 PM, Administrative Nurse B reported an expectation for staff that wash cloths should not be used for peri care or catheter care, only for bathing. Wipes should be used for one wipe per swipe for either peri or catheter care. Hand hygiene should be performed with either alcohol-based hand rub (ABHR) or soap/water before procedure, and with every glove change and with soap/water only at the end of a procedure. Residents with catheters should have some sort of securement device for the tubing to be secured to the resident's leg. It is never acceptable for resident to have a catheter without it being secured to the leg.

Interview on at 04/10/24 at 04:05 PM, CNA CC reported there were no special orders in progress for a foley securement device. Walk through with CNA CC of the facility's supply room revealed leg securement straps in house stock.

Interview on at 04/10/24 at 04:25 PM with Administrative Nurse B, informed of above and was unable to provide an explanation as to why a securement device had not been in place prior to location of the device in the facility's supply room.

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F 880	Continued From page 89 The facility's policy for Catheter care, dated 08/22, revealed the purpose of this procedure was to prevent urinary catheter -associated complications including urinary tract infections. Use aseptic technique when handling or manipulating the drainage system. The facility's policy for Enhanced Barrier Precautions, dated 08/22, revealed EBPs are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of Multi Drug Resistant Organisms (MDRO) to staff hands or clothing. The facility failed to provide necessary services to decrease the risk of a urinary tract infection when the staff failed to use proper hand hygiene, catheter cleansing, and Enhanced Barrier Precautions when providing catheter care for resident (R)25.	F 880		