STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045277	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Pine Bluff	6301 South Hazel Street Pine Bluff, AR 71603

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 49596 Based on observation, interview, and record review, the facility failed to ensure medications were not self-administered without a physician order and an interdisciplinary team (IDT) assessment that determined it was safe for 1 (Resident #275) of 1 sampled resident. The findings are: Resident #275 had a diagnosis of Chronic obstructive pulmonary disease with acute exacerbation, and a physician's order documented as intended to treat it for Budesonide-Formoterol Fumarate Inhalation Aerosol. This medication was administered via a nebulizer, a device that turns the liquid medicine into a mist which is then inhaled through a mouthpiece or a mask. On 03/26/2024 at 10:55 AM, Resident #275 stated to the Surveyor, I am getting ready for my treatment. I can do it on my own. I call for them to bring my stuff and then I do it. On 03/26/24, at 11:00 AM, Resident #275 was observed self-administering the medication utilizing a nebulizer mask. On 03/27/2024 at 11:10 AM, Licensed Practical Nurse (LPN) #1 stated that Resident #275 self-administered their nebulized medication. LPN #1 stated, I'll put the albuterol solution in, or let [Resident #275] do it, the Resident can put the medication in [him/herself]. Then I will leave and let [Resident #275] do it. [Resident #275] will take it off when it is finished. On 03/27/2024 at 11:18 AM, LPN #1 was observed entering Resident #275's room and starting the nebulizer. LPN #1 was then seen leaving Resident #275's room at 11:19 AM, leaving the resident to administer the nebulizer. Resident #275 sat on the bed, holding the nebulizer mask over their nose, and administering the treatment to themselves. On 03/27/2024 at 11:21 AM, the Surveyor asked Resident #275 who put the solution in the nebulizer. Resident #275 stated, I did it. On 03/27/2024 at 11:29 AM, the Surveyor entered Resident #275's room and noted the nebulizer mask in the Resident's right hand. The machine was activated, and the solution was venting into the air. Resident #275 was talking on the telephone while the medication was discharged into the room. This continued until 11:32 AM, when Resident #275 ended the phone call and placed the nebulizer mask back on their face. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/28/2024 at 09:30 AM, LPN #1 was asked, How do you document the administration of the albuterol you set up for Resident #275 over the past two days? LPN #1 stated, In progress notes. The Surveyor asked, So, if I went to the progress notes, that is where I can find the documentation? LPN #1 stated, No, I haven't done it for either day. The Surveyor asked, Should it be documented on the MAR [Medication Administration Record]? LPN #1 stated, Yes, but I didn't. The Surveyor asked, How can you ensure the resident is getting the physician ordered amount of the medication if a resident is self-administering the medication alone in their room? LPN #1 stated, [Resident #275] should not. I put it in the cup and all the medicine will come out of the little bowl. The Surveyor asked, Has [Resident #275] been assessed for self-administration of the albuterol or nebulizer? LPN #1 stated, No. The Surveyor asked, What is the importance of a resident being assessed for self-administration? LPN #1 stated, Have a BIMS of 15 and to make sure the resident is capable of doing it. On 03/27/2024 at 02:00 PM, the Director of Nursing (DON) was asked, Do you have anyone who can self-administer their medication? The DON said, No, but we do have some residents that are cognitively able to be, per-say, able to do theirs after you get the medication going. But we do not have anyone here that can self-administer. There are some here who have a BIMS score of 15 high enough they can sit there with their updraft going but the nurse has to set it up. We do not have anyone here that does that or that has been assessed to do that. The Surveyor asked, Have your nurses assessed any residents for self-administration? The DON stated, No. The IDT would have to meet on the assessment for self-administration. The Surveyor asked, Why is it important to have a self-administration assessment? The DON stated, They would be deemed competent and safe to have an updraft until it is finished. They take up to 15-20 minutes to complete. The Surveyor asked, How does the nurse know how much medication the resident receives? The DON stated, They would have to go back and check the residual of the medication that would be in the apparatus of the updraft. On 03/27/2024 at 11:18 AM, the DON provided the facility Self-Administration of Medication policy which documented, residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so . As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications are safe and clinically appropriate for the resident . Nursing staff reviews the self-administered medication record for each nursing shift and transfers pertinent information to the medication administration record (MAR) kept at the nursing station, appropriately noting that the doses were self-administered . On 03/27/2024 at 11:18 AM, the DON was unable to provide a self-administration safety screen for Resident #275.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 37925 Based on observation, interview, and record review, the facility failed to ensure fingernails were cleaned to promote good personal hygiene and grooming for 1 (Resident #28) of 1 sampled resident who required assistance with nail care. The findings are: Resident #28 had a diagnosis of Type 2 diabetes mellitus without complications. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/20/2024 documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 (13-15 indicates cognitively intact) and needed partial assistance from another person to complete self-care activities and substantial to maximal assistance with personal hygiene. a. A care plan, last revised 01/10/2024 documented, .[Resident #28] has an ADL [activities of daily living] self-care performance deficit r/t [related to] Amputation (bilateral amputation of lower extremities) . Nail Care: Check nail length and trim and clean as necessary . b. An ADL Task: Nail Care 21 day look back form had a checkmark in the box for 'No' to the question, Task Completed? on 03/17/2024 and 03/24/2024. c. On 03/25/2024 at 09:11 AM, Resident #28's left hand had a dark brown substance underneath them. The resident's right hand was positioned away so this surveyor was unable to see the fingernails. d. On 03/26/2024 at 02:58 PM, Resident #28's left hand was resting on the bed and the fingernails had a dark brown substance underneath. The right hand was positioned away and unable to be seen. e. On 03/27/2024 at 09:58 AM, Resident #28's left hand had a dark brown substance underneath the fingernails. This Surveyor asked Licensed Practical Nurse (LPN) #2 to look at Resident #28's fingernails and describe what was seen. LPN #2 stated, Yes, they need to be cleaned out as she was holding [Resident #28]'s left hand. Resident #28 held out their right hand and the Surveyor observed both hands. There was a dark brown substance underneath the fingernails on both hands. f. On 03/28/2024 at 11:59 AM, Certified Nursing Assistant (CNA) #8 was asked, Who is responsible for nail care to the residents? She stated, All staff members. Only a nurse can do diabetic resident nails. She was asked, When should it [nail care] be performed? CNA #8 stated As often as needed. She was asked, What do you do if a resident refuses nail care? She stated, Report to the charge nurse. g. A policy titled Fingernails/Toenails, Care of provided by the Director of Nursing (DON) on 03/28/2024, documented, .The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections .General Guideline 1. Nail care included daily cleaning and regular trimming 2. Proper nail care can aid in the prevention of skin problems around the nail bed .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 37925 Based on observation, interview, and record review, the facility failed to ensure a urinary catheter tube was not directly touching the floor to decrease the potential for contamination or trauma for 1 (Resident #172) of 1 sampled resident who had a urinary catheter in place. The findings are: Resident #172 had diagnoses of poor brain development that affected muscle control (Cerebral Palsy) and inability to urinate (Neuromuscular Dysfunctional of Bladder). a. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/03/2024 documented a Brief Interview of Mental Status (BIMS) score of 15 (13-15 indicates cognitively intact) and that the Resident had an indwelling catheter for bladder and bowel appliances. b. A Care plan dated 03/12/2024 documented, .[Resident #172] has a Suprapubic cath [catheter] . monitor/document for s/sx [signs/symptoms] of UTI [Urinary Tract Infection] . c. On 03/25/2024 at 11:34 AM, Resident #172 was sitting up in a wheelchair in the dining area with other residents, with the catheter's urine collection bag underneath it and visible from the doorway, not in a privacy bag, and the tubing was resting directly on the floor (Picture taken at 11:36 AM). d. On 03/28/2024 at 11:59 AM, Certified Nursing Assistant (CNA) #8 when asked where a catheter bag should be placed. CNA #8 stated if [the resident] was in bed, the tubing should be looped and clamped to something, and if in a wheelchair, underneath it. She verbalized the tubing should not be on the floor due to cross contamination and infection control concerns. When asked what could happen to the resident if the tubing is on the floor, she stated it could be pulled out, dragged, or stepped on. e. A Catheter Care, Urinary policy provided by the DON documented, .The purpose of this procedure is to prevent catheter-associated urinary tract infections .Infection Control .Be sure the catheter tubing and drainage bag are kept off the floor .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48630 Based on observation, interview, and record review, the facility failed to ensure that medications were stored in the med cart with identifiers on the medication cup to identify the resident or to identify the medication. Findings include: During an observation on 03/28/2024 at 12:27 PM, of the medication carts for Halls 400, 500, and 600 revealed two plastic medication cups in the bottom right drawer of the medication cart with multiple different pills with no identifiers on the cups. Plastic medication cup #1 had 10 pills and plastic medication cup #2 had 3 pills in it. During an interview on 03/28/2024 at 12:27 PM, the Licensed Practical Nurse (LPN) #1confirmed that there were 10 pills in cup #1 and 3 pills in cup #2. Also, confirmed there were no identifiers on the cups and that the facility procedure is to waste the pills if the resident is unavailable to take the prescribed pills. The Surveyor asked how the nurse is able to identify the pills in the cup or know who they belong to. LPN #1 responded, I know because I have done this for forever. During an interview on 03/28/2024 at 12:59 PM, the Director of Nurses (DON) confirmed there are multiple pills in the cups without any identifiers. The DON also confirmed that the pills should be wasted if unavailable to identify the pills and that pills should be administered immediately after being prepared in a medication cup. A review of the facility's undated policy titled Storage of Medications, indicated, .Drugs and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received .Drug containers that have missing, incomplete, improper, or incorrect labels . are returned to the dispensing pharmacy or destroyed .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 03508 Based on observation, interview, and record review, the facility failed to ensure meals were served in a method that maintained the appearance of cold products and at temperatures that were acceptable to the residents to improve palatability and encourage good nutritional intake during 2 of 2 meal observed. This failed practice had the potential to affect 16 residents who receive meal trays in their rooms on the 100 Hall, 8 residents who receive meal trays on the 200 hall, 16 residents who receive meal trays in their room on the 300 hall, 11 residents who receive meal trays in their room on 400 Hall, 8 residents who receive meal trays in their room on 500 Hall. The findings are: 1. Resident #35 had a diagnosis of Type 2 diabetes mellitus with hyperglycemia. An Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/26/2024 documented a Brief Interview for Mental Status (BIMS) score of 14 (13-15 indicates cognitively intact). a. A Physician's order dated 02/14/2022 documented Resident #35 had a diet order of NCS (No Concentrated Sweets), regular texture, thin consistency, add large portions. b. On 03/25/2024 at 09:32 AM, the Surveyor asked resident #35 about the temperature of the food and he/she stated, It always be cold. 2. On 03/25/2024 at 01:02 PM, an unheated food cart that contained 11 trays for lunch was delivered to 400 Hall by the Certified Nursing Assistant (CNA) #1. At 01:14 PM, immediately after the last resident was served in their room on 400 hall, temperature of the food items on the tray used as a test tray were taken and read by the Dietary Supervisor with the following results: a. Baked chicken - 106 degrees Fahrenheit. b. Noodles - 109 degrees Fahrenheit. 3. On 03/25/2024 at 01:09 PM, an unheated food cart that contained 8 trays for lunch was delivered to the 200 Hall by CNA #2. At 01:20 PM, immediately after the last resident was served in their room on 200 Hall, the temperature of the food items on the tray used as a test tray were taken and read by the Dietary Supervisor with the following results: a. Noodles - 110 degrees Fahrenheit. 4. On 03/25/2024 at 01:24 PM, an unheated food cart that contained trays for lunch was delivered to the 500 Hall (Unit) by CNA #3. At 01:30 PM, immediately after the last resident was served in the dining room on the 500 Hall, the temperature of the food items on the tray used as a test tray were taken and read by the Dietary Supervisor with the following results: a. Noodles - 109 degrees Fahrenheit. b. Pureed carrots - 111 degrees Fahrenheit. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 03/25/2024 at 01:26 PM, an unheated food cart that contained trays for lunch was delivered to the 300 Hall by the CNA #4. At 01:37 PM, immediately after the last resident was served in their room on the 300 Hall, the temperature of the food items on the tray used as a test tray were taken and read by the Dietary Supervisor with the following results: a. Ground baked chicken 92 degrees Fahrenheit. b. Noodles 105 degrees Fahrenheit. 6. On 03/26/2024 at 01:26 PM, an unheated food cart that contained trays for lunch was delivered to the 300 Hall (Unit) by CNA #4. At 01:37 PM, immediately after the last resident was served in their room on the 300 Hall, temperature of the food items on the tray used as a test tray were taken and read by the Dietary Supervisor with the following results: a. Ground baked chicken - 92 degrees Fahrenheit. b. Noodles - 105 degrees Fahrenheit. 7. On 03/26/2024 at 07:43 PM, an unheated food cart that contained trays for breakfast was delivered to 300 Hall (Unit) by CNA #6. At 07:53 PM, immediately after the last resident was served in their room on the 300 Hall, the temperature of the food items on the tray used as a test tray were taken and read by the Dietary Supervisor with the following results: a. Sausage - 91degrees Fahrenheit. b. Scrambled eggs - 88 degrees Fahrenheit. 8. On 03/26/2024 at 07:49 AM, an unheated food cart that contained trays for breakfast was delivered to the 100 Hall by CNA #7. At 08:11 AM, immediately after the last resident was served in their room on the 100 Hall, the temperature of the food items on the tray used as a test tray were taken and read by the Dietary Supervisor with the following results: a. Pureed sausage - 98 degrees Fahrenheit. b. Pureed scrambled eggs - 106 degrees Fahrenheit. c. Oatmeal - 107 degrees Fahrenheit. d. Regular sausage - 103 degrees Fahrenheit.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 03508 Based on observation and interview, the facility failed to ensure pureed food items were blended to a smooth, lump-free consistency to minimize the risk of choking or other complications for residents who required pureed diets for 2 of 2 meals observed. This failed practice had the potential to affect 6 residents who received pureed diets. The findings are: 1. On 03/25/2024 at 12:16 PM, Dietary Employee (DE) #3 placed 8 servings of baked chicken into a blender, added chicken broth and pureed. At 12:25 PM, DE #3 poured the pureed chicken into a pan and placed it on the steam. The consistency of the pureed chicken was gritty and not smooth. 2. On 03/25/2024 at 12:32 PM, DE #4 used a 4 ounce spoon to place 8 servings of noodle into a blender, added chicken broth and pureed. At 12:36 PM, DE #4 poured the pureed noodles into a pan and placed it on the steam table. The consistency of the pureed noodles was runny. At 01:30 PM, the surveyor asked the Dietary Supervisor to describe the consistency of the pureed food items served to the residents on pureed diets. She stated, Pureed chicken was gritty. Pureed noodles were soupy and ground chicken was dried and needed gravy over it. 3. On 03/26/2024 at 07:30 AM, a pan of pureed sausage to be served to the residents on pureed diets was on the steam table. The consistency of the pureed sausage was gritty and not smooth. At 07:54 AM, the Surveyor asked the Dietary Supervisor to describe the consistency of the pureed sausage served to the residents for breakfast. She stated, It was gritty. They will buy us a new blade.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observation and interview, the facility failed to ensure dietary staff washed their hands before handling clean equipment or food items to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen; ceiling tiles door frames and floor tiles were free of chips, stains and rust and were maintained in clean sanitary conditions, foods stored in the dry storage area refrigerator and freezer were covered and sealed to minimize the potential for food borne illness for residents who received meals from 1 of 1 kitchen; expired food items were promptly removed from stock to prevent potential food borne illness for residents who received meal trays from 1 of 1 kitchen; foods were dated when opened to assure first in, first out usage to prevent potential for food bone illness; 1of 1 ice machine was maintained in clean and sanitary condition to prevent contamination of airborne particles and. These failed practices had the potential to affect 72 residents who received meals from the kitchen, (total census: 74). The findings are: 1. On [DATE] at 08:01 AM, the following observations were made in the kitchen. a. An opened zip lock bag that contained loose coffee filters was on a shelf below the food preparation counter by the steam table. The bag was not sealed. The cover of the light fixture above the 2-door refrigerator in the kitchen was broken. b. The wall below the hand washing sink and the wall above the 3-compartment sink had paint peeling, spillage stains and cement exposed. c. Two poles and regular box attached to the oven had dried brown grease substances on them. d. The cabinet below the deep fryer has 4 pallets which have grease on them. The bottom of the cabinet had a mixture of grease and greasy food crumbs. The Surveyor asked the Dietary Supervisor, How often do you clean the deep fryer and pallets? She stated, It is cleaned every week. e. The wall behind the deep fryer and the floor had grease stains on them. f. The paint on the door frame in the dish washing machine was chipped, exposing the metal frame. g. The floor in the dish washing machine room had a mixture of brown, black and gray stains on it. h. The edges of the vent hood in the dish washing machine had rust stains on it. i. The flat panels on the wall under the counter in the dirty machine area were loose from the wall. j. The ceiling air vent by the steam table and one by the food preparation counter had rust and gray stains. k. There were loose dried food particles on the bottom shelf of the food preparation counter where the cutting board holder and clean pans were located. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On [DATE] at 08:20 AM, Dietary Employee (DE) #1 pushed a cart into the kitchen that contained an ice chest from the dining room, contaminated his hands. Without washing his hands, he picked up glasses to be used in serving beverages to the residents for the lunch meal by their rims and set them on the trays. The Surveyor asked DE #1, What you should have done after touching dirty objects or before handling clean Equipment? He stated, I should have washed my hands. 3. On [DATE] at 08:56 AM, the following observations were made: a. A bag of an opened granulated plain salt, on the shelf in the storage room was not sealed. b. An opened box of powdered sugar was on the shelf, in the storage room. The box was not covered or sealed. There was no date on the box as of when it was opened to assure first in first out. c. An opened bag of potato pearl was on a shelf in the storage room. The bag was not sealed. d. An opened box of thickener was on a shelf in the storage room. The box was not covered or sealed. e. There was no date on the box as of when it was opened to ensure first in first out. f. An opened box of graham crumbs with no opening date was on a shelf in the storage room. An opened box cornstarch was on a shelf in the storage room. The box was not covered or sealed. g. The wall behind the door in the storage had paint peeling, exposing the cement. The floor tiles were missing across the dry food storage rack in the storage room. 3. On [DATE] at 09:09 AM, the following observations were made on a shelf in the 1st two door refrigerator: a. There was a gallon of sweet baby barbeque sauce that was closed but had on open date. b. There was a gallon of Caesar dressing that was closed but had no opening date. c. There was a container of honey mustard that was closed but had no opening date. d. An opened box of sausage. The box was not covered or sealed. 4. On [DATE] at 09:18 AM, the following observations were made on a shelf in the 2nd two door refrigerator. There were (5) 32 ounce boxes of vanilla high calorie-high protein nutritional drinks with an expiration date of [DATE]. The Dietary Supervisor removed them and threw them away. 5.On [DATE] at 09:24 AM, the food items in the freezer located in the storage did not have an open date on them: a. An opened box of carrots. The box was not covered or sealed. No open date on it. b. An opened box of green peas. The box was not covered. No open date on the box. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. An opened box of corn. No open date was on the box. d. An opened of lima beans. No open date was on the box. 6. On [DATE] at 09:28 AM, the food items in the second freezer located in the storage room did not have an open date on them: a. An opened box of cinnamon rolls. b. An opened box of broccoli. c. An opened box of French bread. The box was not covered or sealed. 7. On [DATE] at 09:42 AM, the ice machine in a room facing the dining room and or leading to the 300 Hall had wet black residue on the area where ice the ice shot down to the ice collector. There was a wet accumulation of black residue on the inside body of the ice machine that could fall on the ice. The Dietary Supervisor was asked by the Surveyor, How often they cleaned the ice machine and who used the ice from the machine? She stated, We clean it every Monday. That's the ice the CNAs [Certified Nursing Assistants] use for the water pitchers in the residents' rooms, and we use it to fill beverages served to the residents at mealtimes. The Dietary Supervisor to describe what was observed in the ice machine. She stated, It's dirty. 8. On [DATE] at 11:22 AM, DE #2 picked up the water hose with bare hand, used it to spray leftover food from inside of the blender bowl, contaminating her hands. She placed it in the dirty rack and pushed the rack into the dish washing machine to wash. After the dishes stopped washing, she moved to the clean side of the dishwasher area and picked up a clean blade from the rack and attached it to the base of the blender to be used for pureeing food items to be served to the residents on pureed diets. The Surveyor asked DE #2, What should you have done after touching dirty objects or before handling clean equipment? She stated, I should have washed my hands. 9. A facility policy titled, Quick Resource Tool: QRT Hand Washing, documented, .When to wash hands, wash your hands as often as possible. It is important to wash your hands: Before starting to work with food, utensils, or equipment. Before putting on gloves and as often as needed during food preparation and when changing tasks .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045277	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Pine Bluff	6301 South Hazel Street Pine Bluff, AR 71603

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37925 Based on observation, interview, and record review, the facility failed to ensure Personal Protective Equipment (PPE) was used before entering a room labeled as contact precautions to decrease the potential for cross contamination for 1 (Resident #172) of 1 sampled resident who had contact isolation precautions in place. The findings are: Resident #172 had a diagnosis of not being able to urinate (Neuromuscular dysfunction of bladder) per the order summary. a. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/03/2024 documented a Brief Interview of Mental Status (BIMS) score of 15 (13-15 indicates cognitively intact) and had an indwelling catheter for bladder and bowel appliances. b. An Order Summary documented, .Contact isolation every shift for MRSA . with an order date of 03/19/2024. c. Resident #172's Hospital Summary, with an admitted [DATE], on page 3 and 4 documented on 03/12/2024 at 10:34 AM, a urine culture was abnormal and contained Methicillin Resistant Staphylococcus Aureus. d. On 03/25/2024 at 08:23 AM, this Surveyor was making rounds on the 600 Hall and observed a white cabinet with three drawers outside Resident #172's room. N95 masks, face shields and yellow disposable stethoscopes were in the top drawer. There was one disposable blue gown in the middle drawer and red biohazard bags and clear melt away bags in bottom drawer. There were no gloves in either drawer, on the wall outside the room or on top of the cabinet. The sign on the door documented, Contact Precautions Everyone Must . Put on gloves before room entry . Put on gown before room entry . The door was partially open, and Resident #172 was in bed with the head of bed up and an oxygen concentrator was in the room. e. On 03/25/2024 at 08:47 AM, Licensed Practical Nurse (LPN) #1 was observed in the room replacing a clear plastic humidifier bottle and tubing with another one and the items were on the resident's bedside table. LPN #2 was not wearing any PPE at this time. This Surveyor stood by the door and at 8:51 AM LPN #1 exited the Resident's room. She was asked, What precautions is [Resident #172] on? She stated, MRSA [Methicillin Resistant Staphylococcus Aureus] (an bacteria that the medication Methicillin will not kill) in urine. When asked if she had put on any isolation equipment before entering the Resident's room, she stated she had already been in [Resident #172]'s room before. She was asked, But the sign says you are to put on those things before going in the room, so did you put on any isolation equipment before entering the room? and she stated she didn't. f. An Infection Control Policy provided by the Director of Nursing on 03/28/2024 documented, .The facility appropriately notifies the physician of possible incidents of communicable disease or infections and administers the most appropriate treatment . implements standard and transmission-based precautions to prevent spread of infection . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045277	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. An Isolation-Categories of Transmission-Based Precautions policy documented, .Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection . or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents . When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door . so that personnel and visitors are aware of the need for and the type of precaution . Contact Precautions . Staff and visitors will wear gloves (clean, non-sterile) when entering the room .Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed .