| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145556 | A. Building<br>B. Wing | 06/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Winning Wheels | 701 East 3rd Street<br>Prophetstown, IL 61277 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491<br><br>Based on observation, interview, and record review, the facility failed to provide personal care for a resident in a manner to promote dignity for 1 of 1 resident (R49) in the sample of 20.<br><br>The findings include:<br><br>R49's Admission Record, printed by the facility on 6/12/24, showed he had diagnoses including quadriplegia, C5-C7 incomplete, neuromuscular dysfunction of bladder, neurogenic bowel, polyneuropathy (damage to multiple peripheral nerves resulting in problems with sensation, coordination and other body functions) neuralgia (pain caused by damaged or irritated nerve), neuritis (inflammation of one or more nerves that can lead to impaired transmission of neural signals), and edema. R49's facility assessment dated [DATE], showed he was cognitively intact, had an indwelling catheter and was always incontinent of bowel. R49's functional performance care plan, initiated on 4/20/2020, showed he required extensive assist of two staff members for dressing and bed mobility, and total assist of two staff members for toileting, total assist of staff for bilateral lower extremity bathing, and maximal assist of staff for bilateral upper extremity bathing. R49's care plan initiated on 4/20/2020 showed he had impaired physical mobility due to a spinal cord injury. R49's care plan, initiated on 4/20/2020, showed he had an indwelling suprapubic catheter due to neurogenic bladder.<br><br>On 6/11/24 at 1:32 PM, V16, V17, and V18 (all CNAs-Certified Nursing Assistants) were in R49's room bathing R49. V17 and V18 were washing R49's hair and V16 was washing R49's suprapubic catheter, penis and groin areas. V16 left the room to get an incontinent brief and to let V3 (Wound Nurse) know that R49 needed the dressings on his sacral area changed. R49's entire body was left exposed while V17 and V18 finished washing R49's hair and removed his heel protectors to pull his pants over his feet. V18 emptied R49's urinary drainage bag and placed the drainage bag through one of R49's pant legs. The pants were only pulled up to R49's shin areas. No sheet or blanket was draped over R49. R49 was turned on his right side. At 1:47 PM, V3 entered the room to do the dressing change for R49. V3 left the room twice to get supplies needed for the wound care. R49 was left exposed until 2:08 PM (36 minutes in total) when staff finished providing care and wound care.<br><br>On 6/12/24 at 11:19 AM, V11 (Registered Nurse-RN) said leaving a resident's private areas exposed during care is not acceptable for the resident's privacy and dignity. V11 said anyone can walk into the room.<br><br>(continued on next page) |

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.

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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/12/24 at 2:49 PM, V3 said R49 should have been covered when not providing care to that area of the body. He should not have been left uncovered for half an hour for the resident's dignity.<br><br>On 6/13/24 at 1:15 PM, V2 (Director of Nursing-DON) said when the CNAs are not providing care to that area, the resident should be covered to maintain the resident's privacy, and to maintain his dignity.<br><br>The facility's policy and procedure titled Promoting Resident's Dignity, with a revision date of March 2017, showed This facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in recognition of their individuality. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175<br><br>Based on interview and record review the facility failed to ensure a resident's right to be free from abuse for 2 of 3 residents (R38, R44) reviewed for abuse in the sample of 20 and 1 resident (R25) outside the sample.<br><br>The findings include:<br><br>1. On 6/11/24 at 10:11 AM, R38 was in her room in a wheelchair. She was alert and oriented X3. Her speech was clear and she had good eye contact.<br><br>On 06/11/24 at 10:11 AM, R38 said on the Saturday of Memorial Day weekend (5/25/24), she and her old roommate (R42) were in their room. R38 said R42 kept interrupting her and she asked her not to. R38 said R42 became defensive and lifted a fist toward her. R38 said R42 then pulled the room separating curtain and hit her with an open hand and hit her in the back of her head. I started yelling and she (R42) left the room. If she was not in here in the facility, she'd be in jail. She assaulted me. I went down the hall and told V11 Registered Nurse (RN) what happened. She (R42) is very aggressive. She blackened another resident's eye after throwing a shoe at her and hit another resident too. I'm concerned residents more vulnerable than me are at risk. I don't have a traumatic brain injury. I know what's going on and can remember. They're saying I provoked her which is gaslighting. I'm the one who got hit.<br><br>On 06/11/24 at 11:08 AM, V11 RN said on 5/25/24, R38 came down the hall in her wheelchair yelling. R42 was ahead of R38 walking down the same hall. R38 told her R42 open handedly smacked her in the back of the head. V11 said R42 was short tempered and R38 wants to control the behavior of other residents. V11 said she called V1 Administrator and notified her of the incident after she was told about it.<br><br>06/11/24 02:32 PM, V1 said R38's resident to resident incident on 5/25/24 was not abuse because there was no willful intent.<br><br>On 06/12/24 at 09:44 AM, R38 said, when R42 assaulted her she was surprised, scared, and outraged. It was abuse. She hit me.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/12/24 at 01:59 PM, V1 said she was the abuse coordinator. The report says resident to resident altercations and that's how they are investigated and sent in. Abuse investigations and altercations are sent in the same way. None of the reportable incidents were deemed resident to resident abuse. I go back and watch video footage, most areas of the building have cameras. I have determined through video footage that it is not willful intent and a lot of times it is just residents passing by each other swinging their arm out. There haven't been injuries or intent to cause harm. Sometimes there is a red mark, but it disappears. A lot of our residents have cognitive disabilities, so I don't think they are trying to inflict harm on someone. If they are really intending to hurt someone, or harm someone, then that would be considered abuse. This is a difficult population to handle, sometimes we have therapy evaluate them in their electric wheelchairs because that can be an issue with residents getting tangled and getting angry with each other. I think a lot of it is just frustration. We try to give them outlets to discuss things, but it doesn't always work.<br><br>R38's face sheet showed a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of myocardial infarction, heart failure, Diabetes, obesity, major depressive disorder, generalized anxiety disorder, and hypertension.<br><br>R38's 4/30/24 facility assessment showed she was cognitively intact and had no behaviors. This assessment showed she required supervision or touch assistance to toilet, transfer from bed to a chair, and walk 10 feet. R38 used a walker and required partial/moderate assistance to pick up an object from the floor.<br><br>R38's 5/25/24 at 1:32 PM nurse note authored by V11 showed R38 was in her room. Peer was speaking with patient and interrupted her sentence. R38 asked peer not to interrupt. Peer did not like that, verbal altercation arose, and peer closed curtain to separate herself. R38 stated Slam the curtain, that will show me. Peer reapproached pt and open hand struck other resident on right side back side of head. Peer then left room and R38 came out to hall to report to staff.<br><br>R38's 5/25/2024 at 10:53 PM nurse note showed resident is still upset about the peer to peer.<br><br>R38's 5/25/24 care plan showed she was hit in the back of her head by her roommate.<br><br>R38's 5/25/24 incident report showed R38 was hit in the back of the head by her roommate.<br><br>The facility's 5/26/24 first and final report to the State agency showed R42 hit R38 on the back side of her head after a verbal altercation and becoming upset.<br><br>A 2/25/24 State agency report showed R42 allegedly threw a shoe at another resident and that resident was holding her left eye.<br><br>The facility's 3/17 Abuse Program Policy showed abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. This presumes that instances of abuse of residents even those in a coma, cause physical harm, pain, or mental anguish. Physical abuse includes hitting, slapping, pinching, and kicking. Resident to resident abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain or mental anguish by one resident toward another.<br><br>41639<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2) R25's electronic face sheet printed on 6/13/24 showed R25 has diagnoses including but not limited to intracranial injury, epilepsy, hemiplegia, and major depressive disorder.<br><br>R25's facility assessment dated [DATE] showed R25 has mild cognitive impairment.<br><br>R25's care plan dated 5/1/24 showed, Another peer (R66) was driving down the hallway and said trains coming through out loud causing (R25) to get upset and block (R66) from driving down the hallway. (R66) then smacked (R25) in the face and grabbed his shirt.<br><br>R66's electronic face sheet printed on 6/13/24 showed R66 has diagnoses including but not limited to traumatic brain injury, dementia with agitation, and anxiety disorder.<br><br>R66's behavior monitoring for the past 30 days showed R66 has had behaviors 20 out of the last 30 days ranging from verbal aggression to physical aggression.<br><br>3) R44's electronic face sheet printed on 6/13/24 showed R44 has diagnosis including but not limited to arthrogryposis multiplex, fusion of spine, mood disorder, and developmental disorder.<br><br>R44's facility assessment dated [DATE] showed R44 has no cognitive impairment.<br><br>R44's care plan dated 5/3/24 showed, Another resident (R66) was driving down the hall cursing out loud causing (R44) to be upset and drove up to (R66) telling him to stop. This caused (R66) to become agitated and kick (R44).<br><br>On 6/12/24 at 12:15PM, V22 (Licensed Practical Nurse) stated, We don't know why (R44) went down the hallway to yell at (R66). (R44) was swearing at (R66) because (R66) was having a fit and swearing. We separated them immediately after (R66) kicked (R44). I don't work with (R66) very much so I don't know what his cognitive status is but he is aware of his needs so I would say yes it was intentional and it would be resident to resident abuse. It's hard with this popoulation though because they do have behaviors of hitting other people but I don't know that I would always consider it abuse. I guess I need more clarification on what resident to resident abuse actually is. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>35175<br><br>Based on interview and record review, the facility failed to investigate an allegation of abuse for 2 of 3 residents (R38, R44) reviewed for abuse in the sample of 20 and 1 resident (R25) outside the sample.<br><br>The findings include:<br><br>1. On 6/11/24 at 10:11 AM, R38 was in her room in a wheelchair. She was alert and oriented X3. Her speech was clear and she had good eye contact.<br><br>On 06/11/24 at 10:11 AM, R38 said the Saturday of Memorial weekend (5/25/24) her roommate (R42) hit her in the back of the head. R38 said she reported it to V11 Registered Nurse (RN) right afterward and nobody talked to her about it until the following Tuesday (5/28/24). No one from management came in that whole weekend. R38 said on 5/28/24 around 11:00 AM, V1 Administrator asked how her weekend was. I told her it was fine before the incident. R38 said V1 did not seek her out for any additional questioning but she sought her out later and eventually talked with her about the incident. I told her what happened and that R42 keeps coming and touching me.<br><br>R38's 4/30/24 facility assessment showed she was cognitively intact and had no behaviors. This assessment showed she required supervision or touch assistance to toilet, transfer from bed to a chair, and walk 10 feet. R38 used a walker and required partial/moderate assistance to pick up an object from the floor.<br><br>R38's 5/25/24 at 1:32 PM nurse note authored by V11 showed R38 was in her room. Peer was speaking with patient and interrupted her sentence. R38 asked peer not to interrupt. Peer did not like that, verbal altercation arose, and peer closed curtain to separate herself. R38 stated Slam the curtain, that will show me. Peer reapproached pt and open hand struck R38 on the right back side of head. Peer then left room and R38 came out to hall to report to staff.<br><br>R38's 5/25/2024 at 10:53 PM nurse note showed resident is still upset about the peer to peer.<br><br>R38's 5/25/24 care plan showed she was hit in the back of her head by her roommate.<br><br>R38's 5/25/24 incident report showed R38 was hit in the back of the head by her roommate.<br><br>The facility's incident investigation was requested, and a one-page timeline was received. The facility provided timeline of events showed on 5/25/24, V1 was notified of an incident where R42 struck R38 with an open hand on the right back side of her head.<br><br>The facility's 5/26/24 first and final report to the State agency showed R42 hit R38 on the back side of her head after a verbal altercation and becoming upset. This report showed it was a resident-to-resident altercation not suspected abuse.<br><br>The facility provided timeline of events showed V1 did not speak to R38 or R42 until 5/28/24 (3 days after the event occured).<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility's 3/17 Abuse Program Policy showed its purpose was to ensure ongoing safety of residents, to ensure that a thorough investigation is completed in alleged incidents An investigation into the alleged incident-during the shift it occurred, is initiated as follows: interview the resident or other resident witnesses (i. e., roommate if appropriate). This interview is to be dated, documented and signed by the supervisor. Use the Resident Interview Form. Interview staff on that unit. Interview staff witnesses or other available witnesses. Witnesses are to document their knowledge of the incident in a written narrative, signed and dated. Use the Employee/Witness Investigation Statement. Obtain narrative statements from employees, residents and other witnesses and include the date, time, identification of employee, implicated, and the account of the incident as witnessed by the individual being interviewed. Narrative statements should be taken after the incident is reported. Staff on the unit at the time of the incident occurred must be interviewed-written statements are to be obtained. The resident involved is interviewed at least three times (by the supervisor on duty at the time the initial report is made, by the Director of Nursing and by the Social Worker or Administrator). Each is to complete the Resident Investigation Report. The purpose of three separate interviews is to determine if the story is consistent. Do not automatically discount a resident with dementia or other cognitive impairment. The Social Worker is to interview other potential victims within 24-48 hours of the alleged incident. Having statements taken- do not allow employees to leave the facility until their statements are obtained. Take statements from everyone that was working on that unit even if they say they do not have information.<br><br>41639<br><br>2) The facility's document titled, Illinois Department Of Public Health Facility Report dated 5/3/24 showed, (R25) was sitting in hallway where wing meets hallway, a resident from another hallway started to come down the wing. (R25) grabbed his arm to try to redirect him the other way and let go, the other resident (R66) continued past him and made open contact with (R25's) cheek. (R25) grabbed (R66's) shirt sleeve. Residents were immediately separated and redirected first and final report.<br><br>No investigation was performed for a possible resident to resident abuse altercation.<br><br>3) The facility's document titled, Illinois Department of Public Health Facility Report dated 5/4/24 showed, (R66) was driving power wheelchair down the hallway and repeatedly saying profanity, this was not directed towards anyone. (R44) went up to resident in regards to the words he was saying out loud. (R66) kicked the other resident in the left leg .First and final report.<br><br>No investigation was performed for a possible resident to resident abuse altercation. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>41639<br><br>Based on interview and record review, the facility failed to obtain a Level 2 PASRR (Pre-Admission Screening and Resident Review) for 2 of 5 residents (R61,R67) reviewed for PASRR screening in the sample of 20.<br><br>The findings include:<br><br>1) R61's electronic face sheet printed on 6/13/24 showed R61 has diagnoses including but not limited to schizophrenia and depression.<br><br>R61's document titled, Notice of PASRR Level 1 Screen Outcome dated 9/26/22 showed R61 does not require a Level II PASRR and has no mental health diagnosis.<br><br>2) R67's electronic face sheet printed on 6/13/24 showed R67 has diagnoses including but not limited to schizophrenia and bipolar disorder.<br><br>R67's document titled, Notice of PASRR Level 1 Screen Outcome dated 1/25/24 showed R67 does not require a Level II PASRR and has no mental health diagnosis.<br><br>On 6/13/24 at 12:04PM, V1 (Administrator) stated, PASRR's are done prior to admission, if there are changes while they are here then we would do a new one. R61 and R67 have not had a Level 2 done. The system says they don't need one. I know it's our responsibility to get them if there is a mental health diagnosis but I'm not sure why we didn't have one done. They should be done to ensure the residents get the appropriate services for their mental health diagnosis.<br><br>The facility was unable to provide a policy regarding PASRR's. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639<br><br>Based on interview and record review, the facility failed to provide feeding assistance to 1 of 1 residents (R37) reviewed for activities of daily living (ADL's) in the sample of 20.<br><br>The findings include:<br><br>R37's electronic face sheet printed on 6/13/24 showed R37 has diagnoses including but not limited to cerebral palsy, dysphagia, major depressive disorder, diaphragmatic hernia, and gastroesophageal reflux disease.<br><br>R37's facility assessment dated [DATE] showed R37 has no cognitive impairment, dependent on staff for eating, and has a mechanically altered diet.<br><br>On 6/12/24 at 10:45AM, during the resident council meeting R37 stated, There was a night last week where I didn't get fed dinner. I need assistance with all of my meals because I can't move my arms to reach my mouth. I eat dinner in bed because I have a lot of pain so I only eat breakfast and lunch in the dining room most of the time. The staff brought a tray to my room and then left it there and never came back to help me eat.<br><br>The facility's form titled, Facility Grievance Form-Written Decision Form dated 6/5/24 showed, (R37) reported to (counselor) that he did not get a dinner tray last night. He states this is not the only time this has happened .steps taken to investigate: Spoke with (R37) regarding tray pass and he stated staff brought the tray in then passed remainder of trays without returning to room-reminded resident to use the call light.<br><br>R37's care plan dated 5/18/23 showed, Resident receives a pureed diet. At risk for aspiration in weight loss. Resident prefers to eat some meals in his bed due to pain. Assist resident with all intake, provide pureed diet.<br><br>R37's care plan dated 6/26/23 showed, Resident receives a pureed diet, due to poor dental status. At risk for weight loss and pressure injury. Assist resident with meal intake.<br><br>R37's meal intake record for 6/4/24 showed no meal intake for R37 at the evening meal.<br><br>On 6/12/24 at 11:22AM, V16 (Certified Nursing Assistant) stated, We should be ensuring that we are documenting meal intakes at all meals for all residents except the tube feeders. If someone refuses a meal we offer an alternative and if they still refuse we would let the nurse know. (R37) doesn't refuse meals. When we deliver trays we should ensure we are circling back to feed the residents after delivering trays so nobody gets missed.<br><br>On 6/13/24 at 12:37PM, V2 (Director of Nursing) stated, There is no reason why any resident would not get assistance with a meal. When staff are delivering trays they should be performing meal set up and assistance right when the tray is served. There is never any excuse as to why a resident would miss a meal due to staff not feeding them.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility's policy titled, Feeding and Tray Delivery Procedures: dated 3/17 showed, The following feeding and tray procedures must be followed to ensure prompt and palatable meal service: Tray Procedure For All Meals: B. If a resident refuses to get up or go to the dining room for a meal, please ask Why? Try to encourage them to participate in meal time in the dining room. If they refuse, offer them the first choice on the menu .Once their tray has arrived on the wing, serve it promptly and provided assistance if needed . |

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| Winning Wheels | 701 East 3rd Street<br>Prophetstown, IL 61277 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491<br><br>Based on observation, interview and record review, the facility failed to identify a resident's skin concern, assess the area, and start a treatment for 1 of 1 resident (R49) reviewed for skin concerns in the sample of 20.<br><br>The findings include:<br><br>R49's Admission Record, printed by the facility on 6/12/24, showed he had diagnoses including quadriplegia, C5-C7 incomplete, neuromuscular dysfunction of bladder, neurogenic bowel, polyneuropathy (damage to multiple peripheral nerves resulting in problems with sensation, coordination and other body functions) neuralgia (pain caused by damaged or irritated nerves), neuritis (inflammation of one or more nerves that can lead to impaired transmission of neural signals), and edema. R49's facility assessment dated [DATE], showed he was cognitively intact, had an indwelling cather, was always incontinent of bowel and was at risk of developing pressure ulcers/injuries. R49's functional performance care plan, initiated on 4/20/2020, showed he required extensive assist of two staff members for dressing and bed mobility, total assist of two staff members for toileting, total assist of staff for bilateral lower extremity bathing, and maximal assist of staff for bilateral upper extremity bathing. R49's care plan initiated on 4/20/2020 showed he had impaired physical mobility due to a spinal cord injury.<br><br>On 6/11/24 at 1:32 PM, V16-V18 CNAs (Certified Nursing Assistants) were providing personal care for R49. After bathing and washing R49's hair, he was turned onto his right side. This surveyor saw an area on R49's right buttocks that was dark in color and asked V17 what that was. V17 said she did not know what it was and took a wash cloth and wiped over the area several times. At 1:47 PM, V3 (Wound Nurse) entered R49's room. V17 asked V3 about the area on R49's right buttocks. V3 said she did not know about it, it must be a new area. V3 said she would have to measure the area and start a treatment for it. V3 went out of the room to get treatment supplies and a tape to measure the area. After assessing the area, V3 said it was a scab measuring 3.0 cm (centimeters) by 2.5 centimeters.<br><br>The facility's Wounds report, from 6/3/24-6/10/24, showed R49 had venous wounds to his right lower extremity and his left lower extremity. The report did not list any other wounds for R49.<br><br>R49's Wound Evaluation and Management Summary dated 6/10/24 showed venous wounds to his left and right calf. No other wounds were identified in the Wound evaluation.<br><br>R49's Order Summary Report, printed by the facility on 6/12/24, showed an active order dated 5/26/23 for daily skin checks for R49. The order showed a progress note must be completed after each skin check. Must include any new skin issues with measurements and treatment orders if applied. R49's Order Summary Report also showed a new order dated 6/11/24 (the day this surveyor inquired about the area) to cleanse scab to buttock every other day and apply xeroform with dry dressing as needed. Change dressing as needed if soiled.<br><br>On 6/12/24 at 2:49 PM, V3 said she would have at least expected the wound on R49's right buttocks to be identified the day before (6/10/24) because he has daily skin checks.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/13/24 at 9:07 AM, V24 (Nurse Practitioner) said she would expect staff to identify a skin issue prior to it developing into a 3.0 cm by 2.5 cm scab.<br><br>R49's care plan showed: Wound Management Shearing to upper right gluteal measures 3.0 cm x 2.5 cm with no measurable depth due to dry non-viable fibrous tissue (scab) dated 6/11/2024.<br><br>On 6/13/24 at 9:29 AM, V3 said she categorized the scab on R49's right buttocks as shearing. V3 said shearing is not pressure, V3 said shearing occurs when the skin is moving and the pressure of the weight of the body coming down on the skin, as it is moving, causes shearing of the skin tissue. V3 was asked about the 6/10/24 wound physician's notes only listing the venous wounds to R49's bilateral lower extremities. V3 said the wound doctor had been in the previous day (6/10/24) but did not look at R49's buttocks because there was no wounds on his buttocks. V3 said R49 only had a dressing to protect the skin on his sacral area due to previous skin issues.<br><br>R49's daily Skin Assessments from 6/7/24-6/10/24 showed only the bilateral venous wounds on R49's posterior lower extremities.<br><br>On 6/13/24 at 1:22 PM, V2 (Director of Nursing-DON) said she would expect staff to identify an area of skin concern prior to a 3.0 x 2.5 cm scab, especially since most of our residents have decreased sensation.<br><br>R49's COMS-Skin Only Evaluation dated 6/11/24, showed a scab on his buttocks measuring 3.0 x 2.5.<br><br>R49's 6/11/24 Skin-Non-Pressure note entered by V11 (Registered Nurse-RN) 2:26 PM, showed Sheering on buttock causing scab measuring 3 x 2.5 cm. No depth. Xeroform and dry dressing applied. Order to change every other day until healed.<br><br>The facility's policy and procedure titled Pericare, with a revision date of March 2017, showed Report to the nurse on duty significant assessments, such as redness, swelling, or discharge, excoriation, and/or open area.<br><br>The facility's undated Skin Care Protocol showed 1. Nurse aides and Certified nurse aides are to notify the nurse of any changes of the skin while performing daily cares. This includes completing a bath/shower assessment on all residents when bathing and showering them. The nurse is then to notify the Director of Nursing (DON). 2. The nurse will start a newly acquired skin care sheet. The sheet is turned into the DON for assessment and staging of the area. 3. The nurse will then notify the MD and obtain orders for appropriate treatment. The protocol showed 13. Weekly skin checks to be done by a licensed nurse and documented on the appropriate forms. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175<br><br>Based on observation, interview, and record review, the facility failed to prevent a medical device related pressure injury and failed to identify an area of pressure prior to becoming a Stage 3 for 2 of 4 residents (R32, R23) reviewed for pressure in the sample of 20.<br><br>The findings include:<br><br>R32's face sheet showed a [AGE] year-old male with diagnosis of spina bifida, obstructive sleep apnea, chronic kidney disease stage 3, neuromuscular dysfunction of the bladder, klebsiella pneumoniae infection, presence of a cerebrospinal fluid drainage device, dependence on a wheelchair and history of urinary tract infections.<br><br>On 06/11/24 at 09:30 AM, R32 was on his back in bed. R32 had an indwelling urinary catheter. There was a catheter securing device to his right anterior thigh. R32's catheter tubing was not in the device but over his left thigh and attached to a urinary drainage bag. R32's penile shaft was disfigured by a split in the shaft beginning at the distal (entry) end downward. The skin on both sides of the split was healed.<br><br>On 06/12/24 at 12:06 PM, V3 wound nurse said R32 was admitted with one pressure wound to the ischium. R32 now has a pressure injury to his penis from his catheter. The penis wound is a medical device related pressure injury. We use a stat lock now. A stat lock holds the catheter in place so it can't be pulled and keeps pressure off the skin. It's important to use the device to prevent further damage and to promote healing. V3 said the slit is healed now.<br><br>On 6/13/24 at 8:00 AM, V3 said R32's penis is permanently disfigured now. Without surgery, it will always have that slit there.<br><br>R32's 4/26/24 skin evaluation showed an open area to the tip of the penis measuring 3.0 centimeters (cm) X 1.0 cm X 0.5 cm. R32's catheter tends to lay on the area when brief is in place.<br><br>R32's care plan showed he required extensive assist of two person to physically assist for toilet use and bed mobility. R32 was dependent for toileting hygiene and rolling in bed.<br><br>R32's penis wound care plan showed to change stat lock to other direction to prevent further skin complications.<br><br>The facility's 9/2014 Urinary Catheter Care Policy showed to prevent the catheter from being pulled out, secure the catheter tubing to the thigh without tension on the tubing. Nursing assistants must do catheter and perineal care with am and pm care, and after each of the resident's bowel movements. With all catheter care, check the skin around the catheter entry site for signs of irritation, redness, tenderness, swelling or discharge.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility's 6/2014 Pressure Ulcer Prevention Program Policy showed the facility will ensure that a resident that enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable. A pressure ulcer is defined as a localized injury to skin and/or underlying tissue, usually over a bony prominence, as a result of pressure in combination with shear.<br><br>31615<br><br>2. R23's admission record shows he was admitted to the facility on [DATE] with multiple diagnoses including diffuse traumatic brain injury with loss of consciousness of unspecified duration, and hemiplegia. The facility's annual assessment of 4/18/24 documents R23 to have moderate cognitive impairment. The same assessment shows he is dependant on staff for bathing, showers, and transfers. He is unable to roll left and right or sit to stand. The bladder and bowel assessment shows he is always incontinent of his bowels.<br><br>R23's skin evaluation of 4/11/24 shows V3 identified a pressure ulcer wound on the sacrum. The note shows R23 had a 1.5 cm x 2.0 cm x 0.2 cm stage 3 pressure injury to scar tissue on an old wound site. The 4/15/24 wound physician noted the stage 3 wound to be 2.5 cm x 2.5 cm x 0.2 cm.<br><br>On 6/13/24 at 8:05 AM, V3 said R23's sacral wound was identified by staff, and evaluated on 4/11/24. It was unstageable because it had necrotic tissue, and could not see the wound bed. Staff found it on the weekend and let me know, then did the evaluation, but do not know the cause of the injury. His skin checks are nightly because he is up most of the day, V3 said she would have hoped the wound happened that day, and they found it that day.<br><br>On 6/12/24, at 2:00 PM, V3 positioned R23 on his right side. When the sheet was pulled back, he was found to have stool on his buttocks. Without cleaning up the bowel movement, V3 removed the dressing from the sacral area, and cleaned the wound, and applied a new dressing. V3 called for an aide to clean R23's buttocks. When the CNA arrives, he wipes the stool from R23's buttocks area, around the clean dressing V3 just applied. After the buttocks were cleaned, V3 then removed the remaining dressings and cleaned the wounds and applied clean dressings.<br><br>On 6/13/24 at 8:05 AM, V3 said the stool was not near the wound, but she still should have cleaned the bowel movement before applying clean dressings to the sacral wound. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident's splint was applied to prevent further limited range of motion for 2 of 4 residents (R19, R30) reviewed for limited range of motion in the sample of 20.<br><br>The findings include:<br><br>1) R19's electronic face sheet printed on 6/13/24 showed R19 has diagnoses including but not limited to hemiplegia affecting left non-dominant side, traumatic brain injury, edema, mild cognitive impairment, and localized swelling of left limb.<br><br>R19's facility assessment dated [DATE] showed R19 has severe cognitive impairment, no rejection of cares, upper and lower extremity impairment, and requires splint or brace assistance 7 days a week.<br><br>R19's care plan dated 4/14/20 showed, Decrease in functional range of motion in my BLE (bilateral lower extremity) and LUE (left upper extremity). Apply L (left) WHO (wrist, hand, finger orthosis) for 8 hours daily for contraction management.<br><br>R19's physician's orders dated 9/21/23 showed, left WHO on for up to 4 hours as tolerated.<br><br>On 6/11/24 at 1:32PM, R19 was laying in his bed with no splint to his left hand. On 6/13/24 at 9:45AM, R19 was up in his wheelchair with no splint to his left hand. V16 (Certified Nursing Assistant) was in the room and stated R19 does wear a splint to his left hand but she is unable to find it.<br><br>2) R30's electronic face sheet printed on 6/13/24 showed R30 has diagnoses including but not limited to aneurysm, morbid obesity, flaccid hemiplegia, edema, major depressive disorder, and anxiety disorder.<br><br>R30's facility assessment dated [DATE] showed R30 has no cognitive impairment, has no rejection of care behaviors, and requires splint or brace assistance 7 days a week.<br><br>R30's care plan dated 4/8/20 showed, I have risks of contractures due to hemiplegia and cerebrovascular accident. Will be able to wear left WHO when up in wheelchair and off at bedtime .<br><br>R30's physician's orders showed, 2/25/22 left WHO on in morning-6 hours wear time. 9/21/23 left WHO on for up to 4 hours.<br><br>On 6/11/24 at 9:32AM, R30 was up in his wheelchair with no splint applied to his left hand. R30 stated staff put his splint on sometimes, but not all the time. R30 stated he would wear the splint if it was applied. On 6/13/24 at 10:33AM, R30 was up in his wheelchair with not splint to his left hand and stated staff had not applied his splint today nor had they offered to apply it.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/13/24 at 9:45AM, V23 (Restorative Director) stated, (R30's) hand brace is applied by restorative staff, foot braces are done by floor staff due to residents needing them applied prior to transfers. His hand brace is supposed to be put on daily for 4 hours. I'm not sure why it wasn't put on Tuesday. Two of my staff members got pulled to the floor earlier today but one of them is back so that's probably why it's not on. (R19) has a hand brace and that is supposed to be on during the day as well. He plays with his brace a lot so sometimes we have to find it. Tuesday it was put on and then he took it off. The aides should be checking to make sure it is on and they are able to reapply braces and splints as needed if we are not there to do it. Today (R19's) brace hasn't been put on because of staffing. It's important that both of these residents wear their braces and splints to prevent further debilitation of their joints.<br><br>The facility's policy titled, Restorative Nursing Program/Services dated 8/08 showed, It is the policy of this facility to provide restorative nursing which promotes the residents ability to adapt and adjust to living as independently and safely as possible. Restorative nursing focuses on achieving and maintaining optimal physical, mental and psychological functioning of the resident. 1. Restorative nursing services are provided by restorative nursing assistants, certified nursing assistants, or other trained in restorative techniques .6. Specific components of the restorative nursing program include .prosthetic care, splint of brace assistance . |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491<br><br>Based on observation, interview and record review, the facility failed to safely transfer a hospice resident using a gait belt for 1 of 1 resident (R76) reviewed for transfers in the sample of 20.<br><br>The findings include:<br><br>R76's Admission Record, printed by the facility on 6/12/24, showed she had diagnoses including cerebral infarction (stroke), chronic obstructive pulmonary disease, polyneuropathy (damage to multiple peripheral nerves resulting in problems with sensation, coordination and other body functions), hypertension, osteoarthritis of bilateral knees, dyspnea (shortness of breath), restlessness and agitation, pain and edema. R76's facility assessment dated [DATE] showed she had short-term memory problems and modified independence in cognitive skills for daily decision making. The assessment showed R76 required substantial/maximal assistance with transfers from chair-to-bed, and bed-to-chair.<br><br>On 6/11/24 at 12:42 PM, V19 CNA (Certified Nursing Assistant) entered R76's room to transfer her into bed after the lunch meal. V19 wrapped her arms around R76, under her arms and told R76 to put her arms around V19's neck. V19 picked R76 up out of her wheelchair, pivoted her around and sat her on the bed. Other than putting her arms around V19's neck, R76 was not assisting with the transfer and her feet were not flat on the floor. No gait belt was used during R76's transfer from her wheelchair to her bed.<br><br>On 6/12/24 at 11:16 AM, V11 (Registered Nurse-RN) was asked what R76's transfer needs were. V11 said she would check the CNAs group list. V11 walked over to V25 (CNA) and asked where the list was showing resident transfer needs. V25 showed V11 the list and both V11 and V25 said R76 is a stand-pivot-transfer using two staff members. V11 and V25 said there should be a gait belt used for the transfer. V11 said it is important to have two staff for the transfer and to use a gait belt, to prevent a change of plane. V11 said that is what the facility uses to describe falls.<br><br>R76's care plan initiated on 12/28/23 showed she is at risk for falls due to decreased mobility, pain, decreased strength, and a new diagnosis of CVA (stroke) with some confusion. R76's ADL (activities of daily living) care plan, initiated on 12/28/23 showed she had an ADL self-care performance deficit related to activity intolerance, confusion, fatigue, impaired balance, limited mobility and pain. The care plan showed resident is on hospice services post CVA. The ADL care plan showed R76 requires max assist of 1 staff for a stand-pivot transfer to move between surfaces.<br><br>On 6/13/24 at 1:19 PM, V2 (Director of Nursing-DON) said she does not know if R76's transfer needs were changed, however, a gait belt should be used with all assisted resident transfers.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility's policy and procedure titled Safe Patient Lifting Policy, with a revision date of March 2017, showed The Safe Patient Lifting Policy exists to ensure a safe working environment for resident handlers . Initial screening will be performed on residents to assess transfer and ambulating status. Resident transfer status will be reviewed via care-plan time frame and on an as needed basis .Gait Belt usage is mandatory for resident handling with the exception of bed mobility and medical contraindications. the gait belt will be considered a part of the certified nursing assistant's uniform. An ambulating belt may be used as an appropriate substitute |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175<br><br>Based on observation, interview and record review, the facility failed to keep a urinary drainage bag below the level of the bladder and failed to prevent a urinary drainage bag from contact with the floor for 1 of 2 residents (R28) reviewed for catheters in the sample of 20.<br><br>The findings include:<br><br>R28s face sheet showed a [AGE] year-old male with diagnosis of intracranial injury, protein-calorie malnutrition, retention of urine, chronic peripheral venous insufficiency, neuromuscular dysfunction of the bladder, convulsions, dementia, history of urinary tract infections, acquired absence of a kidney, and carrier or suspected carrier or methicillin resistant staphylococcus aureus.<br><br>On 06/11/24 at 02:18 PM, R28 was in his bed. R28's catheter drainage bag and tubing were in contact with the floor and not in a dignity bag.<br><br>On 06/12/24 at 08:33 AM, V7 Certified Nursing Assistant (CNA) assisted R28 to reposition to his left side while in bed. R28 was supine. V7 removed R28's urinary drainage bag from the bed frame, lifted it over his body and laid it on the bed. The urine in the drainage tubing was cloudy yellow with white sediment.<br><br>On 6/12/24 at 12:06 PM, V3 wound nurse/Infection Preventionist was asked if a urinary drainage bag should be on the floor. V3 said I would think not, bugs do crawl. They should be inside a dignity bag. It could cause infection to go up drainage tubing and cause a urinary tract infection (UTI). A urinary drainage bag should never be above the level of the bladder. If it was, it can backflow (of urine) into the bladder, cause pain and infection. R28 gets frequent UTI's and has other issues that put him at a higher risk for infection.<br><br>The facility's 9/2014 Urinary Catheter Care Policy showed to keep the bag below the level of the resident's bladder at all times.<br><br>R28's catheter care plan showed to ensure the catheter bag is always lower than the bladder.<br><br>R28's 3/25/24 nurse's note showed he was unresponsive and sweaty. R28 was sent to a local emergency room . R28 returned to the facility with a diagnosis of a urinary tract infection.<br><br>R28's 3/25/24 urine culture showed a urinary tract infection with greater than 100,000 colonies per milliliter of methicillin resistant staphylococcus aureus. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>34491<br><br>Based on observation, interview and record review, the facility failed to prepare and serve food in a clean, sanitary manner. This failure has the potential to affect all of the residents in the facility.<br><br>The findings include:<br><br>The CMS 671 form dated 6/11/24 showed 82 residents resided in the facility. The Diet Type Report, printed by the facility on 6/12/24 showed 5 of the 82 residents (R31, R35, R40, R60, and R184) did not take food by mouth.<br><br>On 6/11/24 at 9:10 AM, the oil in the deep fryer was black. Dark food crumbs were visible around the edges of the fryer, at the top of the oil level.<br><br>On 6/11/24 at 11:00 AM, V14 (Dietary Cook) was getting ready to serve the lunch meal. V14 was asked to take the temperature of the foods prior to serving. V14 picked up the digital thermometer from the prep table behind her and inserted the thermometer into the orange chicken, and then into the turkey without sanitizing the digital thermometer. At 11:14 AM, V15 ((another Dietary Cook) uncovered two pans that the temperature had not been checked yet. V15 said the items were the pureed and mechanical soft egg rolls. V15 was asked to check the temperatures of these two items. V15 reached back and picked up the digital thermometer and ran the fingers section of her gloved hand down the thermometer gauge two times, then put the thermometer into the mechanical soft, and then the pureed egg rolls. V15 had been handling meal tickets, lid handles and kitchen utensils with the gloves prior to wiping the thermometer gauge with her gloved hand. V15 did not sanitize the digital thermometer before putting it into the mechanical and pureed egg rolls.<br><br>On 6/11/24 between 9:10 AM-9:20 AM, the kitchen floor appeared dirty. The floor was sticky and there was food debris in multiple areas (under the prep tables and serving tables, on the floor by the grill and over by where the food carts were stored) in the kitchen. Several raised areas of debris were observed under the left 3-compartment sink area.<br><br>On 6/12/24 at 11:29 AM, V15 (Cook) said country fried steak was what was served for the lunch meal that day (6/12/24). V15 said it was cooked in the deep fryer. The oil in the deep fryer was still black and more crumbs could be seen at the top of the oil level. The debris/substance that was observed under the 3-compartment sink area was still there and there were mopheads under the ice machine. Food debris was also seen on the floor, by the food cart storage area.<br><br>(continued on next page) |

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|---|---|---|---|
| | 145556 | A. Building<br>B. Wing | 06/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Winning Wheels | 701 East 3rd Street<br>Prophetstown, IL 61277 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 6/12/24 at 11:55 AM, V4 (Dietary Manager-DM) said it is important to alcohol the digital thermometer off before and after use to prevent cross-contamination. At 11:58 AM, V4 said the deep fryer is cleaned as needed depending on how often it is used. V4 said the deep fryer was used today for the country fried steak, yesterday for the egg roll, Monday for the french fries, Sunday for the tater tots, Friday for tater tots and fish poor boy sandwiches, the previous Wednesday for fish, The previous Tuesday for chicken strips and country fried steak. V4 said the oil should be changed when it needs it, adding, Obviously it needs it. V4 said the oil and the deep fryer area does not look appetizing. At 12:02 PM, V4 was asked where the facility stores the unopened oil for the deep fryer. V4 showed this surveyor the unused container. The color of the oil resembled a light-colored apple juice. At 12:14 PM, V4 (DM) provided the facility's policy for cleaning the fryers. the policy showed fryers will be cleaned on a regular basis. V4 was asked how often that would be. V4 said she would say weekly. V4 was shown the weekly cleaning schedule. V4 said the deep fryer cleaning was not marked off as done since May 21, 2024. V4 said it is not being done weekly. V4 said the dietary staff have been using the deep fryer every day for almost a week.<br><br>On 6/13/24 at 11:40 AM, the kitchen floor was still tacky/sticky, with debris/substance still under the 3-compartment sink area. food debris was on the floor by the food cart storage area. Mop heads were on the floor, under the ice machine. V20 (Cook, diet aide and CNA-Certified Nursing Assistant) said the dietary aides should be cleaning and mopping the floor every shift. V20 said It only gets done once a week if I complain enough. V20 agreed the floors were tacky and looked dirty. V20 said the kitchen does not look clean and sanitary. V20 said she thinks she is the only one that cleans the deep fryer. V20 said she works in the kitchen on Mondays, Thursdays, and every other weekend. At 11:47 AM, V4 (Dietary Manager) entered the kitchen. This surveyor pointed to the debris along the wall and the substances under the 3-compartment sink area. V4 said the dietary aides mop the floor every shift. V4 said the substances under the 3-compartment sink area were from the drain not draining fast enough, and debris builds up there. V4 provided a copy of the kitchen staff's daily cleaning schedule. Multiple days did not have information/initials entered to show the cleaning was done as scheduled. V4 agreed that the floor did not look clean. V4 said, obviously the aides are not cleaning well enough or it would not look like that.<br><br>The facility's undated policy and procedure titled Cleaning Instructions: Fryers showed Fryers will be cleaned on a regular basis and cared for in such a way to maintain optimum production.<br><br>The facility's 2017 policy and procedure titled General Sanitation of Kitchen showed Food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule .1. Cleaning and sanitation tasks for the kitchen will be outlined in a written cleaning schedule. 2. Tasks will be assigned to be the responsibility of specific positions. 3. Frequency of cleaning for each task will be defined .6. On the cleaning schedule employees will initial and date tasks when completed. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175<br><br>Based on observation, interview, and record review, the facility failed to ensure staff wore the correct personal protective equipment when providing care to a resident on enhanced barrier precautions and failed to identify residents on enhanced barrier precautions for 4 of 4 residents (R32, R23, R31, R67) reviewed for infection control in the sample of 20.<br><br>The findings include:<br><br>1. R32's face sheet showed a [AGE] year-old male with diagnosis of spina bifida, obstructive sleep apnea, chronic kidney disease stage 3, neuromuscular dysfunction of the bladder, klebsiella pneumoniae infection, presence of a cerebrospinal fluid drainage device, dependence on a wheelchair and history of urinary tract infections.<br><br>On 6/11/24 at 3:20 PM, V9 Certified Nursing Assistant (CNA) and V10 CNA were in R32's room changing his incontinent brief and linens. R32 was involuntary of stool. Neither V9 nor V10 had isolation gowns or masks on. V9 emptied R32's urinary drainage bag into a urinal. V9 then transported the urine from the bedside to the bathroom with only gloves on. R32's room door had an enhanced barrier precaution (EBP) sign posted which directed staff to wear gloves and a gown when changing linens, providing hygiene, changing briefs and care of a urinary catheter. There was personal protective equipment (PPE) available immediately outside R32's room.<br><br>On 06/12/24 at 12:06 PM, V3 wound nurse/Infection Preventionist (IP) said R32 is on Enhanced Barrier Precautions (EBP) because he has a multi drug resistant organism (MDRO) in the urine. He has had it and been on isolation for a few years. Staff should wear gowns and gloves when providing care to him. If appropriate personal protective equipment (PPE) is not worn, the infection can be spread. PPE needs to be worn to stop the spread and not give him anything else. Staff should have worn gowns when providing care, emptying his catheter and transporting the urine.<br><br>R32's care plan showed he had a urinary tract infection, bacteremia, extended-spectrum beta-lactamase (ESBL) in the blood and urine history. This care plan showed to utilize enhanced barrier precautions due to a history of multiple multi drug resistant organisms (MDRO)s in the blood and urine. Ensure proper personal protective equipment (PPE) is worn when entering room.<br><br>R32's physician orders showed a 6/11/24 or for enhanced barrier precautions (EBP) due to MDRO in urine with indwelling device.<br><br>R32's 3/13/24 hospital history and physical (H&P) showed admission for severe sepsis/septic shock, presumed ESBL/gram positive cocci urinary tract infection (UTI) and methicillin resistant staphylococcus aureus (MRSA) positive nasal swab and a temperature of 104.4. This H&P showed admission to the intensive care unit (ICU).<br><br>The enhanced barrier precautions signage showed staff must wear gloves and a gown for the following activities: dressing, bathing, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: urinary catheter, feeding tube, tracheostomy; wound care: any skin opening requiring a dressing.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The facility's 2023 Enhanced Barrier Precautions Policy showed it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug resistant organisms (MDRO). Enhanced barrier precautions refer to the use of gown and gloves for use during high contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high contact resident care activities that require the use of gown and gloves. An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds and/ or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. Initiate enhanced barrier precautions for infection or colonization with any resistant organisms targeted by the CDC and epidemiologically important MDRO when contact precautions do not apply. Make gowns and gloves available immediately outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. High contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes and wound care: any skin opening requiring a dressing. Enhanced barrier precautions should be followed outside the resident's room when performing transfers and assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility, or any high contact activity. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device is removed.<br><br>31615<br><br>2. R23's order summary sheet for June 2024 shows an order for enhanced barrier precautions related to history of MDRO (Multiple Drug Resistant Organism) with indwelling devices every day and night shift for infection control management. The order was not started until 6/12/24.<br><br>On 6/12/24 at 2:00 PM, V3 entered R23's room to complete his dressing change. He had no sign on the door to indicate enhanced barrier precautions, and V3 did not don a gown before performing the dressing change. R23 was observed to have open wounds on his buttocks, an indwelling catheter, and a feeding tube.<br><br>On 6/13/24 at 8:05 AM, V3 said R23 should be on enhanced barrier precautions due to having a MDRO in his blood and multiple indwelling devices such as his tracheotomy, feeding tube and catheter. He should have signage up on his door and PPE available for staff. She stated when performing his dressing change, she should have been wearing a gown.<br><br>3. R31's order summary sheet for June 2024 documents an order for EBP (Enhanced Barrier Precautions) for history of MDRO with indwelling devices every day and night for infection control management. The orders show R31 to have a feeding tube, and a suprapubic indwelling catheter.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R31's door was observed on throughout the survey from 6/11/24 to 6/13/24, and at no time was a sign posted on his door to indicate to staff the needed PPE to enter and provide care.<br><br>On 6/13/24 at 11:10 AM, V2 said R31 has a history of MDRO and he should be on EBP status. He should have a sign on his door for staff to wear PPE.<br><br>41639<br><br>4. R67's electronic face sheet printed on 6/13/24 showed R67 has diagnoses including but not limited to cerebral infarction, hemiplegia and hemiparesis, schizophrenia, depression, aphasia, and hypertension.<br><br>R67's physician's orders dated 6/12/24 showed, Enhanced barrier precautions due to history of multi-drug resistant organism with indwelling devices.<br><br>R67's facility assessment dated [DATE] showed R67 has mild cognitive impairment and has an indwelling catheter.<br><br>On 6/11/24 at 9:25AM, R67's door showed a sign stating Enhanced barrier precautions V17 (Certified Nursing Assistant) emptied R67's urinary catheter bag with only gloves on. V17 stated that R67 is on enhance barrier precautions and when staff are providing catheter care, emptying catheter drainage bag, and providing wound care they should be wearing a gown and gloves at all times.<br><br>On 6/13/24 at 12:37PM, V2 (Director of Nursing) stated, I'm not sure why there wasn't an order in (R67's) chart for her enhanced barrier precaution isolation. She has been on that since at least March 2024. Staff should be wearing a gown and gloves in her room whenever they are providing care due to her resistant organisms in her urine and wound. |