

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/07/2022
NAME OF PROVIDER OR SUPPLIER KPC PROMISE SKILLED NURSING FACILITY OF OVERLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 6505 W 103RD STREET OVERLAND PARK, KS 66212		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00168002.	F 000			
F 582 SS=D	The 2567 was sent electronically on 02/21/22 Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

02/21/2022

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

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F 582	Continued From page 1 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: The facility identified a census of 23 residents. The sample included 12 residents with three residents sampled for beneficiary notification. Based on record review and interviews, the facility failed to provide notices for Medicare Non-Coverage to resident and/or resident's family/Durable Power of Attorney (DPOA- document that designated a person who made health care decisions for resident if they were no longer able to make their own decisions) for Resident (R) 3, R124, and R125. This deficient practice had the risk for miscommunication between resident/resident family and facility and potential for missed skilled services and unanticipated charges.	F 582			

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F 582	Continued From page 2 Findings included: - Medicare Liability Notice, CMS 101123- Notice of Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) were requested for R3, R124, and R125. Facility was unable to provide the requested documents. In an interview on 02/02/22 at 01:29 PM, Administrative Nurse D stated the business office manager quit working at the facility recently and facility was unable to locate the requested forms. In an interview on 02/07/22 at 03:23 PM, Administrative Nurse D stated the current social worker was in charge of the NOMNC and ABN forms now. In an interview on 02/07/22 at 03:26 PM, SSD X stated she had the family or DPOA come in to the facility to sign the NOMNC and ABN forms three days prior to the resident's last day of coverage. Facility was unable to provide a policy related to NOMNC and ABN notices. The facility failed to provide notices to the resident and/or family/DPOA for Medicare Non-Coverage for R3, R124, and R125. This deficient practice had the risk for miscommunication between resident/resident family and facility and potential for missed skilled services and unanticipated charges.	F 582			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623			

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F 623	Continued From page 3 Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 623			

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F 623	Continued From page 4 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility	F 623			

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F 623	Continued From page 5 must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: The facility identified a census of 23 residents. The sample included 12 residents; one resident reviewed for hospitalization. Based on observations, record reviews, and interviews, the facility to notify the state ombudsman of transfers and failed to provide a written notification of transfers to Resident (R) 13's family/durable power of attorney (DPOA- legal document that named a person to make healthcare decisions when the resident was no longer able to) in a practicable amount of time. This deficient practice had the risk of miscommunication between facility and resident/family and possible missed opportunity for healthcare services. Findings included: - R13 was transferred to the hospital on 12/13/21 and readmitted to the facility on 12/18/21. R13's medical record documented diagnoses of acute respiratory failure (serious condition that develops when the lungs can't get enough oxygen	F 623			

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F 623	Continued From page 6 into the blood), and persistent vegetative state (comatose patient continues to be unable to communicate or respond to stimuli). The "Admission Minimum Data Set (MDS)" dated 03/03/21, documented R13 required total physical assistance with two staff members for bed mobility; and total physical assistance with one staff member for dressing, eating, toileting, and personal hygiene. The "Quarterly MDS" dated 12/4/21, documented R13 required total physical assistance with two staff members for bed mobility; and total physical assistance with one staff member for dressing, eating, toileting, and personal hygiene. The "Pressure Ulcer/Injury (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) Care Area Assessment (CAA)" dated 03/10/21, documented R13 was dependent on staff for all cares. The "Care Plan" dated 03/10/21, documented R13 had a decline in her activities of daily living (ADLs) and mobility related to a motor vehicle accident that left her in a persistent vegetative state and she was dependent on staff for all cares and ADLs. Written notification of transfer to DPOA was requested for hospitalization on 12/13/21. Facility was unable to provide written notification of transfer. State Ombudsman notification for December 2021 was requested. Facility was unable to	F 623			

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F 623	Continued From page 7 provide notification to State Ombudsman documentation. On 02/02/22 at 02:38 PM, R13 laid in bed on her back, eyes closed. She appeared comfortable and without signs of distress or discomfort. On 02/03/22 at 07:23 AM, Administrative Nurse D stated when a resident was transferred to the hospital, the facility documented on the physician order sheet at time of transfer with a check mark that family was notified. She stated the facility did not complete written notification of transfers for residents. On 02/03/22 at 01:29 PM, Administrative Nurse D stated the facility did not notify the State Ombudsman of transfers or discharges. On 02/07/22 at 12:27 PM, Administrative Nurse D stated she called the State Ombudsman and was notified that the Ombudsman had never received any notification of any discharges from the facility. She stated she would start the notification process started. The facility's "Transfer or Discharge Notice" policy, dated 07/27/21, directed the facility provided a resident and/or the resident's representative with a thirty day advance notice of an impending transfer or discharge except if an immediate transfer or discharge is required by the resident's urgent medical needs. The resident and/or representative was provided with the following information: the reason for the transfer or discharge; the effective date of the transfer or discharge; the location to which the resident is being transferred or discharged; the name, address, and telephone number of the state	F 623			

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F 623	Continued From page 8 long-term care ombudsman; the name, address, and telephone number of each individual or agency responsible for the protection and advocacy or mentally ill or developmentally disabled individuals (as applies); and the name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices. The policy does not address ombudsman notification. The facility to notify the state ombudsman of transfers and failed to provide a written notification of transfers to Resident (R) 13's DPOA in a practicable amount of time. This deficient practice had the risk of miscommunication between facility and resident/family and possible missed opportunity for healthcare services.	F 623			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657			

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F 657	Continued From page 9 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility identified a census of 23 residents. The sample included 12 residents; two residents sampled for accidents. Based on observations, record reviews, and interviews, the facility failed to revise the care plan with interventions to prevent further falls for Resident (R) 5. This deficient practice had the risk for further falls, possible injuries from falls, and unwarranted physical complications. Findings included: - R5's medical record documented diagnoses of acute and chronic respiratory failure (serious condition that develops when the lungs can't get enough oxygen into the blood), dependence on respirator status, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The "Admission Minimum Data Set (MDS)" dated 11/18/21, documented R5 had a Brief Interview for Mental Status of 13. R5 required extensive	F 657			

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F 657	Continued From page 10 physical assistance with one staff member for bed mobility and dressing; total physical dependence with one staff member for eating, toileting, and personal hygiene. R5 had not had any falls in the month prior to admission and had not had any falls since admission. The "Falls Care Area Assessment (CAA)" dated 12/1/21, documented R5 had poor short term memory, extreme anxiety, and was a fall risk due to medications. The "Care Plan" dated 12/13/21 documented R5 was at risk for falls and documented interventions for increased staff supervision with intensity based on resident need, other comprehensive medication review by pharmacist, and fall mats in place and frequent monitoring sheet initiated. R5's history of fall investigations received from facility and revealed the following falls: On 12/06/21 at 05:30 AM, R5 was found on floor mat stating he was going home. Nurse reoriented resident to surroundings, fall mats remained in place, bed in lowest position, and frequent behavior monitoring log in place. On 12/30/21 at 01:20 AM, R5 was found on floor mat next to bed with vent hose disconnected. He stated he did not know what he was trying to do. R5 showed signs and symptoms of confusion. Findings and analysis documented R5 was agitated and confused, bed bound, and vent dependent. Steps taken to prevent reoccurrence were medication given, family called to sit at bedside, resident moved to room outside nurses station for close monitoring, and close observation form for 72 hours.	F 657			

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F 657	Continued From page 11 On 01/09/22 at 11:45 PM, R5 was found lying on right side of fall mat on floor. R5 denied pain or discomfort and refused to say what happened and why he was on the floor. R5 was back in bed with hourly checks in place. Findings and analysis on 01/11/22 documented R5 had a history of falls, was ventilator dependent, bedbound, had severe anxiety, and was combative with staff. His bed was kept in low position with fall mat next to R5's bed nearest door. R5 was found on right side of bed by staff and was at baseline cognition. Steps to prevent reoccurrence were R5 was placed on behavior monitoring with hourly checks and additional fall mat was placed along his bed so both sides of R5's bed have a floor mat along them, continued with bed in lowest position for safety. On 01/26/22 at 08:00 AM, R5 had a fall trying to get out of bed. Findings and analysis on 01/27/22 documented R5 had severe anxiety, restlessness, and had history of several falls. His room was across from the nurses station for frequent observation and had experienced an unwitnessed fall while attempting to get out of bed on his own. R5 was found lying on fall mat beside his bed with bed in lowest position and call light within reach, call light was not pressed before fall. Steps to prevent reoccurrence were R5 was assisted back into bed and vital signs were obtained per protocol and was reeducated on importance of using call light to notify nurse of any needs and to not attempt to leave bed alone. R5's bed was in lowest position and call light within reach, floor mats placed alongside his bed, and reeducated staff on importance of frequent resident monitoring.			F 657			

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F 657	Continued From page 12 On 01/31/22 at 03:40 AM, R5 was found on the floor, confused. His bed was low to the ground, resident was not hurt. Findings and analysis documented resident had history of frequent falls and had severe anxiety and restlessness. R5 was found on floor beside his bed on floor mat, he was reported to be confused, bed was in lowest position at time of fall. Steps to prevent reoccurrence were staff reeducated on importance of frequent resident monitoring, nurse educated on proper fall incident procedures per protocol and on clinical findings that needed to be reported to provider. On 02/02/22 at 02:42 PM, R5 laid in bed with eyes closed. He appeared comfortable and without signs of distress. Fall mat was noted on the floor on the left side of the bed, no fall mat on right side of bed. On 02/03/22 at 09:50 AM, R5 laid in bed with eyes closed. He appeared comfortable and without signs of distress. Fall mat on floor on left side of bed, no fall mat on right side of bed on floor. On 02/0/22 at 08:46 AM, R5 laid in bed with eyes open. He appeared comfortable and without signs of discomfort or distress. Fall mat on left side of bed on floor, no fall mat observed on right side of bed. On 02/07/22 at 01:36 PM, Certified Nurse Aide (CNA) M stated when a resident had a fall, they were immediately assessed to see if they were okay and then she got help. She stated a resident was never moved after a fall, especially if it was unwitnessed. The staff discussed what happened, when was the last time staff were in	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/07/2022
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F 657	Continued From page 13 the room, and what interventions they could put in place to keep resident safe. CNA M stated interventions to prevent falls were found in the resident's care plan. R5's interventions were his bed was in lowest position at all times and fall mat on left side of the bed on the floor since he tended to lean towards the left side the most. On 02/07/22 at 02:09 PM, Licensed Nurse (LN) I stated when a resident had a fall the nurse asked the resident what was going on, the nurse completed a mental evaluation, vital signs were taken per protocol, a full investigation was completed, and the fall packet was completed. He was not sure if interventions were placed on the care plan but they were relayed in huddles and in hand off report. R5's current interventions were bed in lowest position, fall mat on left side of bed, and frequent checks. He stated he did not recall there ever being a fall mat on the right side of the bed and R5 was not currently on hourly checks. On 02/07/22 at 02:49 PM, Administrative Nurse D stated when a resident had a fall, the nurse filled out an incident report, and notified the doctor and family member. Some interventions that were put into place after falls were fall mat beside bed, room close to nurses station, hourly close observations, and therapy notification for rescreening. She stated R5 had all of those interventions in place and new interventions were relayed to the MDS Coordinator who updated the care plan. Administrative Nurse D stated interventions and falls were discussed in morning meets, staff could find interventions in care plan, and received interventions in bedside report after falls.	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2022
FORM APPROVED
OMB NO. 0938-0391

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F 657	Continued From page 14 The facility's "Care Plan- Comprehensive" policy, not dated, directed an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychosocial needs was developed for each resident with input from the Interdisciplinary Team (IDT). The "policy" directed was responsible for the review and updating of the care plan when there was a significant change in resident's condition and when the desired outcome was not met. The facility's "Care Plan Use" policy, not dated, directed the care plan was used in developing the resident's daily care routines and was available to staff who have the responsibility for providing care or services to the resident. The "policy" directed completed care plans were in three-ring binders located at the appropriate nurses' station and any changes in the resident's condition was reported to the MDS Coordinator so that a review of the resident's assessment and care plan were done. The facility failed to revise the care plan with interventions to prevent further falls for R5. This deficient practice had the risk for further falls, possible injuries from falls, and unwarranted physical complications.	F 657			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2022
FORM APPROVED
OMB NO. 0938-0391

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F 689	Continued From page 15 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 23 residents. The sample included 12 residents; two residents sampled for accidents. Based on observations, record reviews, and interviews, the facility failed to implement and follow-through with interventions after falls to prevent further falls for Resident (R) 5. This deficient practice had the risk for further falls, possible injuries from falls, and unwarranted physical complications. Findings included: - R5's medical record documented diagnoses of acute and chronic respiratory failure (serious condition that develops when the lungs can't get enough oxygen into the blood), dependence on respirator status, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The "Admission Minimum Data Set (MDS)" dated 11/18/21, documented R5 had a Brief Interview for Mental Status of 13. R5 required extensive physical assistance with one staff member for bed mobility and dressing; total physical dependence with one staff member for eating, toileting, and personal hygiene. R5 had not had any falls in the month prior to admission and had not had any falls since admission. The "Falls Care Area Assessment (CAA)" dated	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2022
FORM APPROVED
OMB NO. 0938-0391

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F 689	Continued From page 16 12/1/21, documented R5 had poor short term memory, extreme anxiety, and was a fall risk due to medications. The "Care Plan" dated 12/13/21 documented R5 was at risk for falls and documented interventions for increased staff supervision with intensity based on resident need, other comprehensive medication review by pharmacist, and fall mats in place and frequent monitoring sheet initiated. R5's history of fall investigations received from facility and revealed the following falls: On 12/06/21 at 05:30 AM, R5 was found on floor mat stating he was going home. Nurse reoriented resident to surroundings, fall mats remained in place, bed in lowest position, and frequent behavior monitoring log in place. On 12/30/21 at 01:20 AM, R5 was found on floor mat next to bed with vent hose disconnected. He stated he did not know what he was trying to do. R5 showed signs and symptoms of confusion. Findings and analysis documented R5 was agitated and confused, bed bound, and vent dependent. Steps taken to prevent reoccurrence were medication given, family called to sit at bedside, resident moved to room outside nurse's station for close monitoring, and close observation form for 72 hours. On 01/09/22 at 11:45 PM, R5 was found lying on right side of fall mat on floor. R5 denied pain or discomfort and refused to say what happened and why he was on the floor. R5 was back in bed with hourly checks in place. Findings and analysis on 01/11/22 documented R5 had a history of falls, was ventilator dependent, bedbound, had severe	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2022
FORM APPROVED
OMB NO. 0938-0391

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F 689	Continued From page 17 anxiety, and was combative with staff. His bed was kept in low position with fall mat next to R5's bed nearest door. R5 was found on right side of bed by staff and was at baseline cognition. Steps to prevent reoccurrence were R5 was placed on behavior monitoring with hourly checks and additional fall mat was placed along his bed so both sides of R5's bed have a floor mat along them, continued with bed in lowest position for safety. On 01/26/22 at 08:00 AM, R5 had a fall trying to get out of bed. Findings and analysis on 01/27/22 documented R5 had severe anxiety, restlessness, and had history of several falls. His room was across from the nurses station for frequent observation and had experienced an unwitnessed fall while attempting to get out of bed on his own. R5 was found lying on fall mat beside his bed with bed in lowest position and call light within reach, call light was not pressed before fall. Steps to prevent reoccurrence were R5 was assisted back into bed and vital signs were obtained per protocol and was reeducated on importance of using call light to notify nurse of any needs and to not attempt to leave bed alone. R5's bed was in lowest position and call light within reach, floor mats placed alongside his bed, and reeducated staff on importance of frequent resident monitoring. On 01/31/22 at 03:40 AM, R5 was found on the floor, confused. His bed was low to the ground, resident was not hurt. Findings and analysis documented resident had history of frequent falls and had severe anxiety and restlessness. R5 was found on floor beside his bed on floor mat, he was reported to be confused, bed was in lowest position at time of fall. Steps to prevent	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 689	Continued From page 18 reoccurrence were staff reeducated on importance of frequent resident monitoring, nurse educated on proper fall incident procedures per protocol and on clinical findings that needed to be reported to provider. On 02/02/22 at 02:42 PM, R5 laid in bed with eyes closed. He appeared comfortable and without signs of distress. Fall mat was noted on the floor on the left side of the bed, no fall mat on right side of bed. On 02/03/22 at 09:50 AM, R5 laid in bed with eyes closed. He appeared comfortable and without signs of distress. Fall mat on floor on left side of bed, no fall mat on right side of bed on floor. On 02/0/22 at 08:46 AM, R5 laid in bed with eyes open. He appeared comfortable and without signs of discomfort or distress. Fall mat on left side of bed on floor, no fall mat observed on right side of bed. On 02/07/22 at 01:36 PM, Certified Nurse Aide (CNA) M stated when a resident had a fall, they were immediately assessed to see if they were okay and then she got help. She stated a resident was never moved after a fall, especially if it was unwitnessed. The staff discussed what happened, when was the last time staff were in the room, and what interventions they could put in place to keep resident safe. CNA M stated interventions to prevent falls were found in the resident's care plan. R5's interventions were his bed was in lowest position at all times and fall mat on left side of the bed on the floor since he tended to lean towards the left side the most.	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 689	Continued From page 19 On 02/07/22 at 02:09 PM, Licensed Nurse (LN) I stated when a resident had a fall the nurse asked the resident what was going on, the nurse completed a mental evaluation, vital signs were taken per protocol, a full investigation was completed, and the fall packet was completed. He was not sure if interventions were placed on the care plan but they were relayed in huddles and in hand off report. R5's current interventions were bed in lowest position, fall mat on left side of bed, and frequent checks. He stated he did not recall there ever being a fall mat on the right side of the bed and R5 was not currently on hourly checks. On 02/07/22 at 02:49 PM, Administrative Nurse D stated when a resident had a fall, the nurse filled out an incident report, and notified the doctor and family member. Some interventions that were put into place after falls were fall mat beside bed, room close to nurses station, hourly close observations, and therapy notification for rescreening. She stated R5 had all of those interventions in place and new interventions were relayed to the MDS Coordinator who updated the care plan. Administrative Nurse D stated interventions and falls were discussed in morning meets, staff could find interventions in care plan, and received interventions in bedside report after falls. The facility's "Fall Prevention Program" policy, dated 07/27/21, directed any time a resident fell, the nurse assessed the resident's physical condition, completed a Fall Risk Assessment, notified the physician and family, initiated the fall prevention protocol, completed rehabilitation screening request, initiated a "Potential of Injury" plan of care, implemented strategies to reduce	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2022
FORM APPROVED
OMB NO. 0938-0391

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F 689	Continued From page 20 further risk for falling, initiated patient/family education plan, and documented the facts specific to the fall in the patient record.	F 689			
F 757 SS=D	The facility failed to implement and follow-through with interventions to prevent further falls for R5. This deficient practice had the risk for further falls, possible injuries from falls, and unwarranted physical complications. Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility reported a census of 23 residents. The sample included 12 residents; five residents	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2022
FORM APPROVED
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F 757	Continued From page 21 sampled for unnecessary medication review. Based on observations, record reviews, and interviews, the facility failed to ensure consistent medication administration for Resident (R) 5, failed to ensure ordered medications had diagnoses for R5, and failed to ensure nursing staff notified the physician when blood glucose levels were outside of ordered parameters for R8. This deficient practice had the risk for unwarranted physical complications and unnecessary medication use. Findings included: - R5's medical record documented diagnoses of acute and chronic respiratory failure (serious condition that develops when the lungs can't get enough oxygen into the blood), dependence on respirator status, Chronic Obstructive Pulmonary Disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The "Admission Minimum Data Set (MDS)" dated 11/18/21, documented R5 had a Brief Interview for Mental Status of 13. R5 required extensive physical assistance with one staff member for bed mobility and dressing; total physical dependence with one staff member for eating, toileting, and personal hygiene. R5 received antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), antianxiety (class of medications	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2022
FORM APPROVED
OMB NO. 0938-0391

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F 757	Continued From page 22 that calm and relax people with excessive anxiety, nervousness, or tension), and opioid (pain medication) medications seven days in the seven-day lookback period. The "Psychotropic (any drug that affects brain activities associated with mental processes and behavior) Medication Use Care Area Assessment (CAA)" dated 12/01/21, documented R5 was admitted with diagnoses of severe COPD and non-weanable vent. R5 took Ativan (antianxiety medication) frequently due to anxiety. The "Care Plan" dated 12/01/21, documented R5 was at risk for side effects and interactions for more than nine medications and psychotropic medications. The "Care Plan" directed staff observed for any changes such as pain, infection, anxiety, or changes in environment such as noise, lighting, temperature, and overcrowding. R5's medical record documented an order with a start date of 11/11/21 for albuterol sulfate (medication used to treat wheezing and shortness of breath caused by breathing problems) 90 micrograms (mcg) two puffs inhalation into the lungs three times daily with directions to wait at least one minute between puffs and an order with a start date of 11/11/21 for hydrocortisone (topical- steroid medication applied to the surface of the skin) 2.5 % cream topically to affected area twice daily. Neither order had a diagnosis for medication usage. Review of R5's "Medication Administration Record (MAR)" for 11/11/21 to 02/07/22 revealed the following missing administrations for albuterol sulfate scheduled three times daily: three out of 58 scheduled administrations for November	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 757	Continued From page 23 2021, 11 out of 93 scheduled administrations in December 2021, eight out of 93 scheduled administrations in January 2022, and six out of 19 scheduled administrations in February 2022. Review of R5's "MAR" for 11/11/21 to 02/07/22 revealed the following missing administrations for hydrocortisone cream scheduled twice daily: 38 out of 38 scheduled administrations in November 2021, six out of 62 scheduled administrations in December 2021, four out of 62 scheduled administrations in January 2022, and one out of 13 scheduled administrations in February 2022. On 02/03/22 at 09:50 AM, R5 laid in bed with eyes closed. He appeared comfortable and without signs of discomfort or distress. On 02/07/22 at 02:05 PM, Consultant HH stated respiratory treatments were documented in the MAR. If it was not given, then it would be documented on the MAR and the appropriate code would be used. She stated if the MAR was not signed off then it was not given, the respiratory therapist signed the MAR after a medication was given. If the order was for three times daily then the MAR was signed off when given as scheduled for three times daily. On 02/07/22 at 02:09 PM, Licensed Nurse (LN) I stated if there were blanks on the MARs then the medication or treatment did not get done, there should not have been any blanks as staff signed off MARs as medication was given. He stated he and Administrative Nurse D reviewed the orders every month to ensure orders had diagnoses. On 02/07/22 at 02:49 PM, Administrative Nurse D stated the staff documented on the MAR after	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2022
FORM APPROVED
OMB NO. 0938-0391

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F 757	Continued From page 24 medications were given and before moving on to the next resident. When medications were due, they should have been given and signed off, if there were blanks then it was not done. She stated she and LN I reviewed the "Physician Order Sheets (POS)" at the end of the month and added diagnoses to any medication that did not have a diagnosis and pharmacy printed them on the POS and MARs for the next month. The facility's "Medication Administration" policy, not dated, directed the administration of medications, including omitted and refused doses, were documented utilizing the medication administration record. Immediately after administering the medications prior to preparing medications for the next resident, the nurse and/or respiratory therapist documented the administration on the MAR. The facility failed to provide consistent medication administration and failed to ensure ordered medications had diagnoses for R5. This deficient practice had the risk for unwarranted physical complications and unnecessary medication use. - R8's medical record documented diagnoses for acute respiratory failure (serious condition that develops when the lungs can't get enough oxygen into the blood), dependence on respirator status, and diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) The "Admission Minimum Data Set (MDS)" dated 08/21/21, documented R8 required total physical dependence with two staff members for bed mobility; total physical dependence with one staff member for dressing, eating, toileting, and	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/07/2022
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F 757	Continued From page 25 personal hygiene. R8 received insulin (medication used to control blood sugar in people who have diabetes mellitus) seven days in the seven-day lookback period. The "Quarterly MDS" dated 11/21/21, documented R8 required total physical dependence with two staff members for bed mobility and toileting; total physical dependence with one staff member for dressing, eating, and personal hygiene. R8 received insulin seven days in the seven-day lookback period. The "Psychotropic (any drug that affects brain activities associated with mental processes and behavior) Medication Use Care Area Assessment (CAA)" dated 08/26/21, documented R8 was unable to be weaned from the vent and received all nutritional and hydration needs through feeding tube (tube for introducing high calorie fluids into the stomach). The "Care Plan" dated 08/26/20, documented R8 was at risk for side effects and interactions for more than nine medications and psychotropic medications. The "care plan" directed staff observed for any changes such as pain, infection, anxiety, or changes in environment such as noise, lighting, temperature, and overcrowding. R8's medical record documented an order with a start date of 08/13/20 for accuchecks (glucometer- instrument used to calculate blood glucose) every six hours with instructions to notify the medical doctor if blood glucose was less than 50 milligram/deciliter (mg/dL) or greater than 300 mg/dL. Review of R8's "Medication Administration	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2022
FORM APPROVED
OMB NO. 0938-0391

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F 757	Continued From page 26 Record (MAR)" for January 2022 to 02/07/22 revealed the following accuchecks that were over 300 mg/dL with no documentation the physician was notified: 01/11/21 Noon, 336 mg/dL; 01/11/21 Evening (PM), 342 mg/dL; 01/12/21 Morning (AM), 313 mg/dL; 01/12/21 PM, 302 mg/dL; 01/12/21 Midnight, 312 mg/dL; 01/13/21 Noon, 331 mg/dL; 01/13/21 PM, 374 mg/dL; 01/14/21 Midnight, 321 mg/dL. On 02/03/22 at 09:53 AM, R8 laid in bed with eyes open, head of bed elevated. He appeared comfortable and without signs of distress, discomfort, or agitation. On 02/07/22 at 02:09 PM, Licensed Nurse (LN) I stated the physician was notified if there was a blood pressure reading or blood sugar outside of the ordered parameters. Physician notification was documented on the back of the MAR but some nurses documented in nurses notes too. On 02/07/22 at 02:49 PM, Administrative Nurse D stated if an order had parameters and there was a reading that was outside the parameters, the physician was notified, and notification was documented on the back of the MAR. She stated staff have had education on where notification to provider was documented. The facility's "Physician Notification of Change of Condition" policy, not dated, directed the physician was notified immediately of any adverse changes in the patient's condition. The policy does not address outside ordered parameters physician notifications. The facility failed to ensure the physician was notified when blood glucose readings were	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/07/2022
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F 757	Continued From page 27	F 757			
F 812 SS=D	outside of parameters as ordered. This deficient practice had the risk for unwarranted physical complications and unnecessary medication use. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility identified a census of 23 residents. The facility had one main kitchen. Based on observation, record review and interview, the facility failed to store food (opened food items in dry storage and the walk-in freezer that were not in a sealed package the was labeled or dated), and failed to properly wash and sanitize food equipment before use. This deficient practice left residents at risk for food borne illness and contamination.	F 812			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/07/2022
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F 812	Continued From page 28 Findings included: - During the initial tour of the facility kitchen on 02/01/22 at 07:22 AM, observation in the dry storage area revealed an opened package of noodles that was wrapped in plastic wrap and not in a sealed bag, and there was no labeling or date opened on the package. There was also an opened bag of rice that had been wrapped in plastic wrap that was not in a sealed bag, and there was no label or date opened on the package. The walk-in freezer had an opened bag of ham cubes that was not placed in a sealed bag, or labeled with an opened date. The walk-in freezer also had an opened bag with eight salmon fillets which were not in sealed bag and not dated or labeled. Observation in the kitchen preparation area revealed bottles of barbeque sauce, ketchup, and numerous spice containers did not have an open date on them. During observation of modified food preparation on 02/07/22 at 10:27 AM dietary staff BB used the Robot Coupe (a machine used to process food into small pieces), then only rinsed off the cutter cup and blade with hot water, and not properly washing and sanitizing this item before each of the next two uses (there was still noted food on the cutter cup and lid when he returned to the food preparation area). On 02/01/22 at 07:49 AM Registered Dietician GG stated that she was at the facility daily during the week and occasionally on the weekends. She stated that she would pass the information on to the new kitchen manager about the opened and unlabeled items. On 02/07/21 at 12:02 PM GG stated that kitchen	F 812			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 812	Continued From page 29 equipment should be properly washed and sanitized in the dishwasher after each use to ensure that the items are cleaned appropriately. The facility policy "Food Storage: Dry Goods" revised 09/2017 documented: All packaged and canned food items will be kept clean, dry and properly sealed. Storage areas will be neat, arranged for easy identification, and date marked as appropriate. The facility policy "Food Storage: Cold Foods" revised 04/2018 documented: All foods will be stored wrapped in or covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. The facility policy "Food: Preparation" revised 09/2017 documented: All utensils, food contact equipment, and food contact surfaces will be cleaned and sanitized after every use. The facility failed to ensure that dry food goods and frozen meats were appropriately bagged, labeled and dated after being opened, and failed to ensure that dietary staff properly cleaned and sanitized food contact equipment after each use. This deficient practice placed facility residents at risk of possible food borne illnesses and cross contamination.	F 812			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 30 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 31 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 23 residents. Based on observations, record reviews, and interviews, the facility failed to ensure proper personal protective equipment (PPE- gloves, gowns, face shields and/or eye glasses/goggles) usage and failed to ensure adequate hand hygiene was performed. This deficient practice had the risk to spread illness and infection to all residents. Findings included: - On 02/01/22 at 07:05 AM, Licensed Nurse (LN) G and an unidentified male staff member stood at the nurse's station. It was noted that they were not wearing a face mask. An unidentified female staff member sat behind the nurse's station with	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 32 her face mask pulled below her chin. The staff members were within six feet of each other. On 02/07/22 at 08:56 AM, LN I donned (put on) gloves then donned gown. He entered Resident (R) 14's room for medication pass then exited room. He doffed (remove) gloves then gown and performed hand hygiene. On 02/07/22 at 09:05 AM, LN H donned gloves and prepared medications for administration for R5. After medication preparation, he started donning a gown and doffed gloves. He did not perform hand hygiene after doffing gloves and before donning the gown. He finished donning the gown and performed hand hygiene then donned new gloves. On 02/07/22 at 11:51 AM, LN H donned gloves and cleansed glucometer (instrument used to calculate blood glucose) with a bleach wipe. He gathered his supplies to obtain a blood sugar level then entered R17's room. After procedure, he doffed his gloves but did not perform hand hygiene after doffing gloves or exiting R17's room. On 02/07/22 at 01:36 PM, Certified Nurse Aide (CNA) M stated the proper procedure for donning PPE was gown then gloves and procedure for doffing PPE was gloves then gown. She stated hand hygiene was performed before entering and upon exiting patient rooms, after removing PPE, and before donning gloves. She stated a mask was worn in the facility at all times unless eating or drinking by herself. On 02/07/22 at 02:09 PM, LN I stated the proper procedure for donning PPE was hand hygiene	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 33 was performed, don gown, then don gloves. Proper procedure for doffing PPE was gloves, gown, then hand hygiene after removing PPE. Hand hygiene was performed between every patient room, before entering and after exiting, after touching anything suspicious, and after doffing gloves. He stated a mask was worn in the facility. On 02/07/22 at 02:49 PM, Administrative Nurse D stated the proper procedure for donning PPE was gown then gloves, a mask was always worn in the facility. Proper doffing procedure for PPE was gloves then gown. She stated hand hygiene was performed before entering and upon exiting rooms, after touching objects, after performing cares, and after doffing PPE. She stated PPE worn throughout the building in the hallways was a mask, staff should not be without masks. The facility's "Isolation" policy, not dated, directed hand hygiene was the single most important strategy to reduce the risks of transmitting organisms from one person to another or from one site to another on the same patient and directed hand hygiene was performed promptly and thoroughly before and after removing gloves, between patient contact, and after contact with blood, body fluids, secretions, excretions, and potentially contaminated equipment including computer keyboards and telephones. The policy directed hand hygiene was performed before and after removing the initial pair of gloves and prior to donning a second pair of gloves. The policy directed the proper removal of PPE as gloves, gown, then hand hygiene. The policy did not address proper donning of PPE. The facility's "Hand Hygiene Policy," not dated,	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 34 directed standard precautions were followed, avoiding contamination of hands and performing appropriate hand hygiene to prevent the spread of microorganisms. Indications for hand hygiene included the following: before patient contact, after contact with inanimate environmental sources likely to be contaminated, after contact with all patients and equipment, and after removing gloves. The facility failed to ensure proper usage of PPE and proper hand hygiene performance. This deficient practice had the risk to spread illness and infection to all residents.	F 880			