STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235324	A. Building B. Wing	07/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Healthcare Center	1149 West Monroe Rd Saint Louis, MI 48880

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This citation pertains to intake 129550 Based on observation, interview and record review, the facility failed to implement adequate pressure ulcer prevention and treatment protocols according to professional standards for 2 residents (Resident #1 and Resident #3), resulting in the worsening of a facility acquired pressure ulcer for Resident #3 and the potential for unrecognized deterioration and serious complications from unmonitored, untreated and worsening pressure ulcers for Resident #1. Findings include: Review of the Fundamentals of Nursing revealed, Continually assess a patient's skin for breakdown and color changes such as pallor or redness. Consistently use a standardized assessment tool such as the Braden Scale. The screening tool identifies patients with a high risk for impaired skin integrity or early changes in the condition of patients' skin. Early identification allows for early intervention. Observe the skin often during routine care (e.g., when the patient is turned, during hygiene measures, and when providing for elimination needs). Frequent skin assessment, which can be as often as every hour and is based on patients' mobility, hydration, and physiological status, is essential to promptly identify changes in their skin and underlying tissues. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 833). Elsevier Health Sciences. Kindle Edition Review of a policy Pressure Ulcer Treatment Level III revised on 3/17/22 reflected the purpose of the procedure is to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. In addition to outlining Pressure Ulcer Interventions/Care Strategies the policy specified required equipment and supplies and detailed steps for completing wound care including the appropriate use of Personal Protective Equipment (PPE), hand hygiene and glove use, documentation of the procedure to include all assessment data (i.e., color, size, pain, drainage, etc.) and any change in the resident status along with the requirement to report pertinent findings. During an interview on 7/19/2022 at 11:30 AM, the Director of Nursing (DON) reported that she and the Infection Control Nurse, Licensed Practical Nurse (LPN) D take weekly wound measurements, usually on Mondays. The DON said they do not have a wound care nurse but do consult with a wound care physician as ordered. Resident #1 (R1) (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a facility Face Sheet and Minimum Data Set (MDS) Admission assessment dated [DATE] reflected R1 admitted to the facility with diagnoses that included anoxic brain damage, acute respiratory failure, local infection of the skin and subcutaneous tissue, pressure ulcer of the sacral region, stage 4, pressure ulcer of the right hip, stage 4, pressure ulcer of the left hip, stage 4, muscle weakness, acute kidney failure, neuromuscular dysfunction of the bladder, fever, functional quadriplegia, elevated c-reactive protein, personal history of sudden cardiac arrest, tracheostomy, gastrostomy, sepsis, dementia and expressive language disorder. The MDS assessment reflected that R1 was severely cognitively impaired and required total assistance from two people for bed mobility, transfers, dressing and toilet use. Review of extensive hospital referral information sent to the facility on [DATE] prior to his admission on 6/7/22 reflected an order to have R1 follow up with a wound clinic within 2 weeks of discharge from the hospital. Review of hospital Wound Team Notes dated 5/26/22 (the most recent measurements prior to R1's admission to the facility on [DATE]) reflected the following: -Left Hip/Trochanter: healing stage 4 pressure injury. Serous drainage now measures 5 x 6 x 1.5 cm's, undermining 1.5 cm 5 to 11 o'clock. -Right Hip/Trochanter: healing stage 4 pressure injury. Serous drainage. Now measures 2 x 5 x 1 cm. wound base is red granulation tissue healing edges in -Sacrum/Coccyx: Healing stage 4 pressure injury that measures 7.5x5x0.5 cm. Red granulation tissue. -Right heel: Unstageable Pressure Injury that measures 2.5 x 2.5 x 0.2 cm's. Tissues yellow/tan slough. -Right medial great toe 1.75 x 1.0 cm purple/dark red nonblanchable suspected deep tissue injury. Left heel remains red and pink clean and healed. Review of the Admission Nursing Comprehensive Evaluation dated 6/7/22 and completed by the DON included the following assessment of R1's wounds: Resident had wounds x 4 evaluated, L (left) heel 1x1 cm diameter open area with no depth treated with hydrogel and allevyn R (right) heel skin prepped. L hip 6cmX5cm with 5cm tunneling bottom left corner. Coccyx 8cm x 4.5 cm with 2.4 depth packed with calcium alginate covered with bordered gauze. R hip 5.6 cm X 4.2 cm with 1.8 cm tunneling to right side. The DON's assessment was significantly different from the hospital records as evidenced by the findings at the left and right heels (left heel now open, right heel without a wound at all). The left hip reflected worsening of the wound as compared to the hospital record in depth; the coccyx wound had deteriorated as did the right hip. Review of a Care Plan initiated 6/7/2022 reflected Resident (R1) has multiple pressure ulcers due to underlying medical conditions, wounds may not heal and formation of more wounds may be unavoidable. The goal of the care plan is for the pressure ulcers to improve without any signs or symptoms of infection. Interventions to meet the goal of the plan of care included: treatment per orders, wound care services to evaluate and treat. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a Physician Order Report: 6/01/2022-7/20/2022 reflected the following orders for R1: Weekly skin assessment Special Instructions: Record skin assessment under observations started on 6/7/22; Weekly wound measurements Special Instructions: document measurements in progress notes with a start date of 7/19/2022 (nearly six weeks after R1 admitted to the facility). Review of progress notes for R1 for did not reflect detailed skin and wound assessments were being documented per the facility policy and professional standards. Review of Weekly Skin Assessments dated 6/21/22, 6/28/22, 7/5/22 and 7/12/22 did not reflect measurements or wound characteristics were being completed to track R1's wound progression or healing. An Admission Body Observation dated 6/7/2022 indicated R1 had pressure sores described as 4 in depth, no additional description or measurements were documented. Review of the Admission Nursing Comprehensive Evaluation dated 6/7/22 did include measurements of R1's wounds but follow-up measurements and descriptions were not documented in the clinical record again until 7/19/22 and on 7/20/22 and were incomplete and inaccurate as evidenced by not all wounds were reflected in each of the progress notes and a description of the characteristics and drainage were not recorded. No evidence in the clinical record reflected a wound care consultation was obtained for R1's extensive pressure ulcers. Review of a Progress Note written by LPN D on 7/19/22 at 8:18 PM reflected Wounds measured as follows R (right) hip 3cm x 4 cm L (left) hip 5.5 cm x 3 cm with 3 cm tunneling. L (left) heel 3 cm in diameter. No additional pertinent wound assessment findings were recorded and did not include evaluation of R1's coccyx wound. During an observation and interview on 7/20/22 at 4:15 PM, The Director of Nursing (DON) assisted Licensed Practical Nurse (LPN) C with wound care for R1. The following observations/assessments/measurements were obtained and verbalized by the DON and LPN C: A) R1's right heel was covered with an undated dressing. Upon removal of the dressing the DON reported the nurse who applied it did not use the 1/2 normal saline, 1/2 betadine solution per physician order. The right heel wound measured 2.5 cm x 2.5 cm with a depth of 0.5 cm, the wound bed covered in tan slough making the wound unstageable. The wound was cleaned with wound cleanser and packed with a solution of 1/2 normal saline and 1/2 betadine soaked gauze that LPN C cut to size with a rusty scissor that was not cleaned prior to use. The wound was covered with boarder foam dressing. B) R1's left heel was intact. C) R1's Right hip dressing was not dated. The right hip wound measured 5.5 cm long x 2.5 cm wide with 0.5 cm depth at 12 o'clock, 0.75 cm depth at 9 o'clock and 11 o'clock and 0.4 cm depth at 6 o'clock. The wound was cleaned with wound cleanser and packed with the 1/2 normal saline and 1/2 betadine soaked gauze and covered with a border foam dressing. LPN C removed her gloves and donned a clean pair without performing hand hygiene. D) R1's Left hip wound measured 3.5 cm x 5.5 cm with 1.0 cm undermining at 12 o'clock, 1.5 cm at 6 o'clock. Slough obscured a portion of the wound bed and bone was visible. A darkened area at the edge of the wound at 2 o'clock was suspicious for necrosis and the DON texted the doctor and obtained a new order to change the dressing from 1/2 normal saline and 1/2 betadine wet to dry dressing to an order for calcium alginate to be placed in the wound bed and covered with boarder foam. R1's wound was cleaned with wound cleanser and the new dressing was implemented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	E) R1's coccyx dressing and gauze packing was removed, the wound was cleansed and measured 7.0 cm x 5.0 cm with 0.5 cm tunneling at 12 o'clock and 0.2 cm tunneling at 6 o'clock. The wound bed was covered with calcium alginate and a boarder foam dressing. The DON said she would enter the new order into the medical record. When asked, the DON reported R1 had not been seen by the wound doctor since he admitted to the facility. The preceding observations reflected inaccuracies and incomplete documentation and worsening of wounds when compared to the progress note documentation on 7/19/22 Review of a Progress Note authored by the DON on 7/20/21 at 6:00 PM reflected L (left) heel 1.5 x 1 cm x 0. 2, Coccyx 7x4x0.5 (at12o'clock) X 0.2 at 6 o'clock. The measurements were not consistent with the observation of R1 made on 7/20/22 at 4:15 PM and did not reflect the wound on R1's left hip, right heel and related treatment order changes or any other pertinent assessment findings. Review of the most current physician ordered treatment for R1's wound care found on the Physician Order Report from 6/1/22-7/20/22 was as follows: Betadine and normal saline half and half wet to dry change QD (every day) and as needed to bilateral hips and coccyx cover with dry dressing. Once a day every other day; 05:00 AM-05:00 PM started on 6/22/2022 and ended on 7/20/2022. The order is unclear as to frequency of dressing changes (every day versus every other day). Review of the June and July 2022 Medication Administration Record and Treatment Administration Record reflected staff were documenting the treatment was completed every other day, potentially omitting half of the ordered treatments. No orders for the treatment of R1's right heel were in the clinical record. Resident #3 (R3) Review of a Face Sheet reflected R3 admitted to the facility with diagnoses that included end stage renal disease (ESRD), urinary tract infection, malignant neoplasm of the bladder, type 2 diabetes, dependence of renal dialysis, cystostomy (surgical creation of an opening to the bladder) and difficulty walking. Review of the facility Resident Matrix form CMS-802 dated 7/19/22 reflected R3 had a stage 2 facility acquired pressure ulcer. Review of a Care Plan initiated on 4/30/22 reflected R3 was at risk for skin breakdown related to impaired mobility, diabetes and ESRD. The goal of the plan was that R3 would be free of skin breakdown unless clinically unavoidable. Interventions to meet the goal included Float heels when in bed using using pillows or soft heel boots; observe skin daily with care; document a weekly skin assessment. During an observation and interview on 7/20/22 at 9:45 AM, R3 reported that he developed wounds on his heels while at the facility. R3's heels were resting on the bed and an undated dressing covered R3's right heel, R3's left heel was observed without a dressing covering an open wound with depth. R3 agreed to an observation of wound care and measurement with the nurse on duty. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation on 7/20/22 at 10:18 AM, The DON assisted LPN C with wound care for R3. R3 was lying on a bare mattress for the procedure, a clean barrier was not in place. The DON assisting with positioning and observation of the wound while LPN C measured the left heel wound and reported it was 1.5 cm x 1.2 cm with a depth of 0.4 cm. The DON said the observation was consistent with a stage 3 pressure ulcer. LPN C cleaned and dressed the wound by placing calcium alginate in the wound bed and covering it with boarder foam. The undated dressing was removed from R3's right heel and revealed no skin impairment. The DON reported that that area had healed and they would apply skin prep to the area instead of covering it. Review of Progress Notes dated 5/18/22 at 4:59 AM reflected the first observation of R3's left heel as follows: Left heel, 1.2 x 1.1 open area. Tx (treatment) written for calcium alginate with foam dressing q (every) 48 hours, and prn until healed. Keep heels up off bed at all times. The progress note does not describe depth or drainage or other pertinent assessment findings. Further review of progress notes from 5/18/22-7/20/22 do not reflect wound monitoring or assessment findings or an attempt to review the current treatment plan for efficacy. The progress notes and skin assessments never reflected R3 had a wound on his right heel. Review of a newer Care Plan focus area initiated 6/14/2022 (nearly 4 weeks after the development of a facility acquired pressure ulcer) reflected Resident (R3) has a pressure ulcer due to multiple underlying medical conditions, wounds may not heal and formation of more wounds may be unavoidable. The goal of the care plan is for the pressure ulcers to improve without any signs or symptoms of infection. Interventions to meet the goal of the plan of care included: treatment per orders, wound care services to evaluate and treat; utilize pressure reduction devices. Review of Weekly Skin Assessment reports dated 5/2/22, 5/3/22, 5/17/22, 5/23/22, 6/6/22 and 7/18/22 did not reflect an assessment of R3's left heel pressure ulcer.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This citation pertains to intake 129550 Based on observation, interview, and record review, the facility failed to ensure catheter tubing was secured to prevent pulling/trauma for 1 resident (Resident #1), resulting in urethral damage, pain/discomfort and in the potential for dislodgement of the catheter tubing. Findings include: Review of Fundamentals of Nursing ([NAME] and [NAME]) 9th edition revealed, Secure catheter with catheter securement device at catheter bifurcation (see manufacturer directions). Allow enough slack to allow leg movement and avoid any traction on catheter .Securing indwelling catheters reduces risk of urethral trauma, urethral erosion, CAUTI (Catheter Associated Urinary Tract Infection), or accidental removal . [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 68509-68515). Elsevier Health Sciences. Kindle Edition. Resident #1 (R1) Review of a facility Face Sheet and Minimum Data Set (MDS) Admission assessment dated [DATE] reflected R1 admitted to the facility with diagnoses that included anoxic brain damage, acute respiratory failure, local infection of the skin and subcutaneous tissue, pressure ulcer of the sacral region, stage 4, pressure ulcer of the right hip, stage 4, pressure ulcer of the left hip, stage 4, muscle weakness, acute kidney failure, neuromuscular dysfunction of the bladder, fever, functional quadriplegia, elevated c-reactive protein, personal history of sudden cardiac arrest, tracheostomy, gastrostomy, sepsis, dementia and expressive language disorder. The MDS assessment reflected that R1 was severely cognitively impaired and required total assistance from two people for bed mobility, transfers, dressing and toilet use. Review of a Care Plan dated 6/7/22 (date of admission to the facility) reflected R1 required an indwelling urinary catheter related to brain injury and pressure ulcers, a diagnosis of neuromuscular dysfunction of the bladder. The goal of the care plan was that R1 would have catheter care managed appropriately as evidenced by not exhibiting signs of infection or trauma through next review. Interventions included: Observe urinary output with daily care; notify nurse of abnormal findings; provide catheter care every shift. Review of R1's physician orders from 6/7/22-7/20/22 reflect the following treatment orders Foley catheter for protection of stage 4 wounds to coccyx. Special instructions: Indwelling catheter for protection of stage 4 wounds to bil (bilateral) hips and coccyx; Record foley output every 12 hours twice a day was started on 6/12/22 (5 days after admission). No additional foley catheter orders were noted. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	During an observation on 7/20/22 at 4:15 PM, The Director of Nursing (DON) assisted Licensed Practical Nurse (LPN) C with wound care for R1. Upon completion of wound care and measurements, R1's foley catheter was viewed and it was noted that there was not an anchor/securement device in place to stabilize the catheter tubing (reduces risk of pulling on the catheter which can cause pain and trauma). R1 had significant urethral erosion (urethral catheter had cut through the glans penis). The DON said she would let the doctor know about the observation. During an observation on 7/21/22 at 9:00 AM, LPN D completed wound care for R1 after being incontinent of bowel necessitating replacement of a dressing to the coccyx. Certified Nurse Aide (CNA) N assisted with incontinence care and also provided catheter care. R1's catheter was not anchored/secured and the glans penis was again observed to be split and the catheter tubing was pulling on the distal aspect of the erosion and onto the shaft of the penis. A significant accumulation of smegma was noted at the base of the glans penis and under part of the foreskin. The tubing of the catheter visible at the base of the urethra was noted to have blood/mucous on the catheter tubing. LPN D said she would let the physician know about the observation. Review of R1's progress notes from 6/7/22-7/21/22 did not reflect any mention of R1's glans penis injury or documented assessment of the finding, including notification to the physician. Review of R1's pre-admission to the facility hospital documentation reflected hat R1 had a chronic indwelling foley catheter due to his wounds. No evidence R1 had sustained injury to his glans penis was noted.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This citation pertains to intake 129550 Based on observation, interview and record review, the facility failed to provide appropriate and adequate tracheostomy care for 2 residents (Resident #1 and Resident #2) reviewed for tracheostomy care, resulting in an immediate jeopardy when (1) Resident #1 was admitted to the facility on [DATE] with a tracheostomy and no physician orders were in place for tracheostomy care or suctioning, (2) staff lacked knowledge regarding aseptic technique for suctioning and tracheostomy care increasing Resident #1's and Resident #2's chance for an infection, (3) staff lacked knowledge regarding emergency procedures in the event Resident #1 or Resident #2 decannulated, and (4) emergency supplies were not readily available in the facility in the event Resident #1 decannulated. This deficient practice placed residents receiving tracheostomy care at risk for serious harm, injury and/or death. Findings include: Resident #1 (R1) Review of a facility Face Sheet and Minimum Data Set (MDS) Admission assessment dated [DATE] reflected R1 admitted to the facility with diagnoses that included anoxic brain damage, acute respiratory failure, local infection of the skin and subcutaneous tissue, pressure ulcer of the sacral region, stage 4, pressure ulcer of the right hip, stage 4, pressure ulcer of the left hip, stage 4, muscle weakness, acute kidney failure, neuromuscular dysfunction of the bladder, fever, functional quadriplegia, elevated c-reactive protein, personal history of sudden cardiac arrest, tracheostomy, gastronomy, sepsis, dementia and expressive language disorder. The MDS assessment reflected that R1 was severely cognitively impaired and required total assistance from two people for bed mobility, transfers, dressing and toilet use. Review of a Care Plan initiated on 6/7/22 reflected R1 had Potential for complications related to tracheostomy with a goal of Resident will not exhibit signs of respiratory distress (restlessness, wheezing, dyspnea, difficulty with expectoration, diaphoresis, crackles, bubbling, tachycardia, cyanosis, decreased breath sounds) through the next review date. Approaches to meet the goal of the care plan included: Monitor and report signs of hypoxia, monitor and report signs of respiratory distress, monitor respiratory status, position resident in upright/sitting position (as tolerated) for optimal breathing, provide a calm environment free of stimuli to reduce/prevent anxiety, provide oxygen per physician order, provide tracheostomy care as ordered and PRN (as needed), change trach ties as ordered and PRN. The care plan did not reflect any instruction for emergency situations. Review of R1's clinical record revealed there were no physician orders pertaining to R1's tracheostomy, tracheostomy care or endotracheal suctioning. Medication Administration Records (MARs) and Treatment Administration Records (TAR) were reviewed and no evidence of tracheostomy orders of any kind were identified. Progress Notes were reviewed and did not show nurses were regularly documenting pre and post procedure respiratory assessments and tracheostomy care or suction. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policies Tracheostomy Care revised 4/27/2018, Changing the Tracheostomy Tube last revised 4/27/2018 and Managing Tracheostomy Emergencies last revised 4/27/2018 reflected acceptable professional standards were used to formulate the procedures. During an observation and interview on 7/19/2022 beginning at 10:48 AM, Licensed Practical Nurse (LPN) C was asked to assess R1's room and identify standard and emergency supplies that would be required to manage R1's tracheostomy. LPN C was not able to locate a spare tracheostomy and there was not a resuscitation bag in the room. LPN C said she was not sure what she would do in the event R1 had a tracheostomy emergency. During an interview and observation on 7/19/22 beginning at 12:15 PM, the Director of Nursing (DON) evaluated the supplies in R1's room and it was identified there was not a spare sterile tracheostomy in the size needed by R1. The top drawer of a dresser in the room contained an open tube of santyl, a tube of petroleum jelly, wound cleanser, a tube of medihoney (wound treatment) ointment, 2 plastic containers of normal saline that had been opened and used, an open package of hydrofoam dressing, an uncovered roll of gauze, a visibly soiled and open package of 4x4 gauze dressings, a leaking bottle of hydrogen peroxide, clear fluid was pooled in the drawer, a size 16 Fr straight catheter and an open and unsterile spare tracheostomy tube. The DON threw the contaminated supplies into the garbage and confirmed there were no spare tracheostomies in the room. The DON obtained keys to the supply room situated on the other side of the building and confirmed along with Human Resources/Supply Clerk (HR) G (the employee responsible for ordering and organizing the supply room) that there were no tracheostomies in the sizes required by R1 in the building. The DON reported she was aware of a resident (R2) extubating twice in the past. Resident #2 (R2) Review of a Face Sheet reflected R2 admitted to the facility with diagnoses that included anoxic brain injury, acute respiratory failure, had a tracheostomy, a history of pneumonia and COVID-19 infection and was in a coma. During an observation and interview on 7/19/22 at 1:13 PM, LPN B said if R2 decannulated she would replace the inner cannula but was not sure what she would do if R2 extubated completely. LPN B said she was never trained on emergency tracheostomy procedures. LPN B said she had not done R2 tracheostomy care that day and proceeded to don gloves without first performing hand hygiene and did not don a gown or face shield as would be standard during a procedure with the high likelihood for droplet production, LPN B did not assess or provide suction to R2 who had sputum accumulated and draining on and around the tracheostomy. LPN B then removed and discarded the disposable inner cannula and replaced the inner cannula without changing her gloves and performing hand hygiene in between steps. LPN B removed the soiled split dressing from under the base of the tracheostomy and used a clean washcloth moistened with tap water to clean around the base of the tracheostomy and in the skin folds around R2's neck, then dried the areas with another dry towel. LPN B then began to replace the tracheostomy tie and reported she was not familiar with the process, incorrectly believing there were two separate ties. LPN B then tucked a split dressing under the base of the tracheostomy. LPN B was not observed assessing R2 after the process and did not document the procedure in the clinical record. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a follow-up interview on 7/19/22 at 1:45 PM, LPN C reported that she never went through the entire nurse orientation skills checklist when she was most recently hired in 2021 and was never educated about tracheostomy care or emergency tracheostomy care. LPN C said when she worked at the facility previously, R2 extubated and she did not know what to do, instead she called the former DON and then called emergency medical services. On 7/19/2022 at 4:36 PM, the facility Administrator and Director of Nursing were notified of the Immediate Jeopardy that was identified on, and began on, 7/19/2022. On 7/21/22 the State Agency attempted to verify the facility completed the following to remove the immediacy: 1. On 7/19/22 Back up trach Shiley 6XLT was placed in R1's room to replace the residents opened un-sanitized back up trach. 2. On 7/19/22 Policies for Tracheostomy; Management of Tracheostomy Emergencies NP 146 and Changing the Tracheostomy tube NP 000 were verbally reviewed and understood by nurses currently working the floor by DON and LPN D. 3. Beginning on 7/19/22 Tracheostomy care competency was verbally reviewed and understood by nurses currently working the floor by DON and LPN D understanding that in the event of an emergency they call 911. There are 3 RNs, 9 LPNs. No employee will be allowed to work without receiving education 4. On 7/19/22 policies for Tracheostomy; Management of Tracheostomy Emergencies NP 146 and changing the Tracheostomy tube NP 000 were reviewed by Regional Director of Clinical Registered Nurse?Masters of Nursing Science (RN/MSN) T and deemed appropriate. 5. On 7/19/22 Emergency cart set up, to include: -a one sized smaller Tracheostomy -suction kit -Trach care kit -Water soluble lubricant -Trach holder -Sterile gloves -Pulse Oximeter was placed in R1's room to mirror R2's room to ensure that staff felt familiar with same set up in both rooms and knew where items were located regardless of which room they were in. 6. On 7/19/22 R1 and R2 were assessed by nurse for respiratory distress and no concerns were noted. (continued on next page)

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	235324	A. Building B. Wing	07/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. On 7/19/22 R1 and R2's care plans were reviewed and updated to identify current tracheostomy size and one size smaller to utilize in the event of an emergency. 8. On 7/19/22 orders were added to the MAR for the nurse to validated that the emergency backup supplies are present and functioning. 9. Beginning on 7/19/2022 all new hire nurses will complete trach care competency as part of orientation check off. 10. Beginning on 7/19/22 attempts to find an instructor specializing in trach care to complete hands on return demonstration with nurses was initiated. 11. On 7/20/22 the facility Medical Director and the DON from a sister facility began hands on return demonstration with nurses prior to them working. 12. On 7/20/22 R1's orders for tracheostomy care were entered into the medical record to reflect appropriate plan of care. 13. On 7/21/22 the DON continued with hands on return demonstration with nurses prior to them working. Nurses signed documentation stating that they understood trach care and emergency situations as well as completed hands on return demonstration. On 7/21/22 the state agency was not able to validate the removal plan had been effective as evidenced by the following observations and interviews: On 7/21/22 beginning at 9:47 AM, LPN O reported the Director of Nursing (DON) only verbalized tracheostomy care and procedures with her. LPN O signed a form indicating she did perform a hands on return demonstration to establish competency but reported she did not demonstrate the procedures to the DON. LPN O did not demonstrate competency or familiarity with standard procedures during an observation of tracheostomy care for R2 beginning at 10:20 AM on 7/21/22. On 7/21/22 at 10:43 AM, LPN D (involved in the removal plan noted above) reported that she never performed hands on return demonstration pertaining to tracheostomy care and only verbally reviewed the policies and procedure with the DON that morning before assuming care of R1. LPN D was unable to identify the emergency back up tracheostomy for R1 upon request and did not demonstrate competency with tracheostomy procedures during the observation on 7/21/22, including failing to assess or reassess R1 before and after the attempted tracheostomy care. LPN D reported that she signed a form indicating she had received hands on education and completed a return demonstration despite not being shown or demonstrating competency related to tracheostomy care that morning. During an interview on 7/21/22 at 11:05 AM, the DON was asked how she educated LPN D and LPN O prior to their shift. The DON reported that she conducted a review of the tracheostomy care policies and had the LPN D and LPN O do hands on return demonstration for tracheostomy care. The DON provided signed copies of forms Tracheostomy Care Competency signed by LPN O and the DON on 7/21/22 and LPN D and DON signed on 7/21/22. The DON's report conflicted with the observations and interviews conducted with LPN O and LPN D on 7/21/22. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/21/22 at 11:10 AM, the DON, Nursing Home Administrator (NHA) and Regional Director of Operations (RDO) F were informed the Immediate Jeopardy (IJ) was not removed. The facility amended the removal plan to include the following: 14. On 7/22/22 at 11:30 AM a Respiratory Therapist (RT) conducted hands on training with return demonstration to nurses on duty. On 7/25/22 the State Agency validated the removal of Immediate Jeopardy as of 7/22/22. Although the immediate jeopardy was removed on 07/22/2022, the facility remained out of compliance at a scope of isolated and severity of no harm that is not immediate jeopardy due to the fact that sustained compliance had not yet been verified by the State Agency and all education had not yet been completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This citation pertains to intake 129550 Based on observation, interview and record review, the facility failed to implement appropriate Infection Control measures according to the Centers for Disease Control and Prevention (CDC) guidelines, including appropriate hand hygiene and glove use, utilization of Personal Protective Equipment (PPE) and ensure clean storage of supplies, resulting in the potential for cross contamination and the spread of infection throughout the facility. Findings: Review of a facility policy Isolation-Categories of Transmission Based Precautions last revised 7/2022 reflected Transmission-Based Precautions should be used whenever measures more stringent than Standard Precautions are needed to prevent or control the spread of infection. The policy also specified Signs-The facility should implement a system to alert staff to the type of precautions resident requires. 1. The facility should ensure that the resident's care plan and care specialist communication system indicate the type of precautions implemented for the resident .In addition to Standard Precautions, implement droplet precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets that can be generated by the individual coughing, sneezing or talking or by the performance of procedures such as suctioning. The policy did not include a description of enhanced barrier precautions. Review of a CDC document Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug resistant Organisms (MDROs) last updated 7/12/22 reflected Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing [11-15]. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs [3,5,6]. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization Resident #1 (R1) Review of a facility Face Sheet and Minimum Data Set (MDS) Admission assessment dated [DATE] reflected R1 admitted to the facility with diagnoses that included anoxic brain damage, acute respiratory failure, local infection of the skin and subcutaneous tissue, pressure ulcer of the sacral region, stage 4, pressure ulcer of the right hip, stage 4, pressure ulcer of the left hip, stage 4, muscle weakness, acute kidney failure, neuromuscular dysfunction of the bladder, fever, functional quadriplegia, elevated c-reactive protein, personal history of sudden cardiac arrest, tracheostomy, gastrostomy, sepsis, dementia and expressive language disorder. The MDS assessment reflected that R1 was severely cognitively impaired and required total assistance from two people for bed mobility, transfers, dressing and toilet use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of extensive hospital referral documentation sent to the facility on [DATE] reflected R1 had a history of Multidrug Resistant Organism (MDRO) urinary tract infection (UTI) and MDRO decubitus ulcer infections prior to admission to the facility. During an observation and interview on 7/19/22 at 12:15 PM, the Director of Nursing (DON) evaluated the supplies in R1's room. The top drawer of a dresser in the room contained an open, uncapped tube of santyl, a tube of petroleum jelly, wound cleanser, a tube of medihoney (wound treatment) ointment, 2 plastic containers of normal saline that had been opened and used, an open package of hydrofoam dressing, an uncovered roll of gauze, a visibly soiled and open package of 4x4 gauze dressings, a leaking bottle of hydrogen peroxide, clear fluid and other debris was pooled in the drawer, a size 16 Fr straight catheter and an open and unsterile spare tracheostomy tube. A graduated cylinder dated 7/16/22 containing a large bore syringe used to administer medications and formula to R1 through his feeding tube was on R1's nightstand. The bottom of the container had watery/brownish fluid accumulated with dried brownish substance and residue on the sides of the container, the tip of the syringe was resting in the fluid. No signage directing caregivers to don PPE was noted outside R1's room and appropriate PPE for procedures such as tracheostomy care and suction, tube feeding maintenance, foley catheter care or wound care was readily available. The DON reported supplies should not be stored this way and placed the contaminated items from the drawer into the trash can. During an observation of wound care on 7/20/22 at 4:15 PM, the Director of Nursing (DON) assisted Licensed Practical Nurse (LPN) C clean, assess, measure and dress wounds on R1's right heel, right hip, left hip and coccyx. Neither the DON or LPN C donned a gown despite extensive physical contact and manipulation of the resident during the procedures. LPN C had to leave the room during the procedure to obtain scissors and returned with a visibly rusty pair of trauma shears that was not cleaned prior to cutting gauze from a roll to pack the wounds for the wet to dry dressings. Resident #2 (R2) Review of a Face Sheet reflected R2 admitted to the facility with diagnoses that included anoxic brain injury, acute respiratory failure, tracheostomy status, a history of pneumonia, COVID-19 infection and was in a coma. Review of a hospital record dated 10/15/21 revealed that R2 had gone to the hospital for replacement of a feeding tube that had become dislodged and was subsequently diagnosed with acute hypoxic respiratory failure etiology likely mucus plugs. During the hospitalization R2's sputum was cultured and grew multidrug resistant pseudomonas (bacteria), establishing R2's history of a multidrug resistant organism (MDRO). Review of the complete Care Plan last reviewed 7/19/2022 did not reflect any interventions to address the requirement for standard transmission based precautions based on the anticipated exposure to blood, body fluids, mucous membranes, non-intact skin or potentially contaminated environmental surfaces or equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 7/19/22 at 1:13 PM, LPN B said she was going to complete tracheostomy care for R2. LPN B donned gloves without first performing hand hygiene and did not don a gown or face shield as would be standard during a procedure with the high likelihood for droplet production. R2 had sputum accumulated and draining on and around the tracheostomy. LPN B then removed and discarded the disposable inner cannula and replaced the inner cannula without changing her gloves and performing hand hygiene in between steps. No signage was present outside R2's room indicating the need for any form of transmission-based precautions and appropriate PPE was not readily available. Resident #3 (R3) Review of a Face Sheet reflected R3 admitted to the facility with diagnoses that included end stage renal disease (ESRD), urinary tract infection, malignant neoplasm of the bladder, type 2 diabetes, dependence of renal dialysis, cystostomy (surgical creation of an opening to the bladder) and difficulty walking. During an observation on 7/20/22 at 10:18 AM, The DON assisted LPN C with wound care for R3. R3 was lying on a bare mattress for the procedure, a clean barrier was not in place. The DON assisting with positioning and observation of the wound while LPN C measured, cleaned and dressed the wound. LPN C changed her gloves and did not perform hand hygiene before completing a measurement on R3's left heel. LPN C had to leave the room to get a scissor to cut a piece of a dressing to fit into the wound bed of R3's left heel. LPN C returned with a pair of visibly dirty office scissors and did not clean the scissor prior to cutting the dressing.