July 2020 Survey Findings

**March, 2020 Findings**

**F550 Resident Rights/Exercise of Rights**

NW: SS=D: Failed to provide dignity & quality of life for 1 resident

* Observed resident in bed with uncovered urinary dignity bag hanging on side of bed with urine in tubing & bag on multiple occasions; failed to cover resident’s urinary catheter bag placing resident at risk for embarrassment & an undignified living enviornment

**F561 Self-Determination**

SE: SS=D: Failed to provide choices for 1 resident r/t preferences for number of bathing opportunities received per week

* Bath schedule revealed resident on schedule for 3 baths per week; bath sheets with documentation of baths revealed resident did not received baths 3x/wk as scheduled; resident reported staff did not bathe residents often enough & staff did not give resident a reason why they had not given bath as requested; failed to ensure resident received baths/showers according to IDd preferences/choices

**F583 Personal Privacy/Confidentiality of Records**

NW: SS=D: Failed to provide private telephone for resident use for 1 resident

* Failed to provide a place for resident’s telephone use, placing resident at risk for lack of privacy

**F584 Safe/Clean/Comfortable/Homelike Environment**

SE: SS=E: Failed to maintain an orderly, sanitary & comfortable environment on 1/2 hallways for residents of facility

* Observed black grime build up in corners & outside edges of floors; stained tiles; black stained toilets on inside perimeter of toilet bowls; marred door jams; cracked floor tiles

NE: SS=E: Failed to provide a safe, clean, comfortable environment on 4/5 hallways

* Observed floor tile with dull finish; stained ceiling tiles; soiled floor tiles

NW: SS=D: Failed to provide a safe/clean/comfortable environment for 2 residents on 1 hall when 2 recliners were in disrepair

* Failed to provide clean, comfortable, undamaged recliners in 2 resident rooms, placing residents at risk for injury

NW: SS=E: Failed to provide a safe, clean, comfortable environment for 2/2 hallways in facility

* Observed cracked floor tile, dull floor finishes, broken light fixture cover, stained ceilings, buckled floor tiles

**F636 Comprehensive Assessments & Timing**

SE: SS=E: Failed to complete a timely MDS for 5/15 residents; failed to complete CAAs with analysis of findings for 7/15 residents

* Failed to complete a comprehensive assessment timely for multiple residents as required which includes the completion of the MDS as well as CAA process to ensure resident received needed cares for multiple residents

**F641 Accuracy of Assessments**

SE: SS=E: Failed to complete an accurate MDS for 12/15 residents r/t restorative nursing program for communication, restraints & toilet use, falls, anticoagulant use & accurate diagnosis

* Staff reported being taught that visiting with residents & talking to them should be documented as a communication restorative nursing program & resident did not have a formal restorative nursing program for communication & documentation was not accurate & resident communicates verbal w/o problem; failed to complete accurate assessment/MDS for resident r/t restorative nursing program for communication for multiple residents
* The coding of the siderails as restraints was inaccurate. She is incontinent of bowel on occasion and the staff provide her with incontinence care and routinely check and change her. The coding on the MDS as toilet use did not occur was inaccurate; failed to complete accurate MDS for resident r/t restorative nursing program for communication, toilet use, & physical restraints
* Failed to complete accurate MDS for resident r/t restorative program for communication & falls
* Failed to complete an accurate MDS for resident r/t restorative nursing program for communication & anticoagulant medication
* Failed to complete accurate MDS for resident r/t new diagnosis of schizophrenia

**F644 Coordination of PASARR & Assessments**

SW: SS=D: Failed to follow recommendations of Level II PASARR for 1 resident which recommended instruction & education on resident’s medication administration

* Resident with major depressive d/o, major mood d/o, bipolar, anxiety, persistent mood d/o & nightmare d/o; PASARR determination letter documented facility were to educate resident on medication regimen, need for each medication, impact it had on health & mental health & impact that occurred when it was not taken as prescribed; observed staff administered medication with no instruction or education to resident r/t administered medications; staff stated facility had not initiated recommendations from PASARR; failed to incorporate recommendations from PASARR & Level II determination letter into resident’s CP to include education on medication administration & side effects of those medications

**F645 PASARR Screening for MD & ID**

SW: SS=D: Failed to renew in a timely manner the PASARR determination letter for 1 resident

* Cited findings noted in F644 r/t PASARR; PASARR determination letter dated 11/15/18 documented resident would benefit from a temporary stay of 12 months in order to better meet care needs & another assessment would be needed to extend the stay; assessment & letter was valid for 12 months from date of letter; staff confirmed facility had not renewed PASARR letter & currently had no way of tracking renewals; failed to renew PASARR level II determination letter for 1 resident in timely manner as directed in letter

**F646 MD/ID Significant Change Notification**

SW: SS=D: Failed to inform state mental health authority in a timely manner of resident’s significant change

* Review of record revealed lack of notification to state mental health authority r/t resident’s significant change; staff confirmed unaware of need to inform anyone of significant changes in residents; failed to notify state mental health authority promptly after resident’s significant change

**F655 Baseline Care Plan**

NW: SS=D: Failed to provide a baseline skin care plan for 1 resident who admitted to facility with wounds on buttocks

* Failed to provide a baseline skin care plan for 1 resident when facility admitted resident with 2 wounds on buttocks placing resident at risk for inappropriate skin care

**F656 Develop/Implement Comprehensive Care Plan**

SE: SS=D: Failed to develop & implement a plan of care for respiratory cares r/t oxygen use for 1 resident

* Failed to develop & implement a CP for respiratory care r/t oxygen use for resident r/t CP lacked guidance for staff r/t use of O2 for resident including monitoring O2 sats to determine need for PRN O2 & effectiveness of use of O2 & care of equipment including cannula & humidifiers & changing filters

NW: SS=D: Failed to develop a comprehensive CP for use of antipsychotic medication for 1/5 residents

* Resident with Zoloft & Seroquel; record lacked documentation of CP or behavior documentation to monitor use of antipsychotic medication; failed to develop CP for use of Seroquel placing resident at risk for adverse side effects

**F657 Care Plan Timing & Revision**

SE: SS=D: Failed to update a CP for 1 resident reviewed for non-pharmacological interventions for staff to attempt r/t medication for depressive d/o & appropriate intervention post fall to prevent further falls

* Failed to ID nonpharmacological interventions r/t resident’s antidepressant medication usage & failed to implement an appropriate intervention for resident to prevent further falls from occurring when staff implemented to reeducate resident to use of call light for assistance; resident’s cognition would not allow resident to remember that prior to getting up unassisted

SE: SS=D: Failed to review & revise CP for 1 resident to direct staff to provide fluids during cares to ensure adequate hydration for dependent resident

* Resident with tube feeding; CP failed to direct staff to provide fluids during direct resident cares; failed to review & revise hydration CP to direct staff in providing fluids during cares to ensure resident received adequate fluids

SW: SS=D: Failed to revise CP for 1 resident r/t use of Eliquis to include monitoring for bruising

* CP lacked instruction to staff for resident’s anticoagulant use & possibility of bruising easily, higher risk for bleeding & no interventions to prevent bruising were in place; observed resident with several bruises on both hands & lower arms & arm with blood-soaked gauze bandage in place due to a skin tear; resident did not have anything in place to help protect arms from getting bruised; failed to revise CP for 1 resident to include information r/t use of an anticoagulant medication, monitoring for bleeding & bruising & interventions to help prevent bruising for 1 resident

**F661 Discharge Summary**

NE: SS=D: Failed to document a recapitulation of facility stay upon discharge from facility for 1 resident with discharge

* Failed to document a recapitulation for 1 resident’s stay at facility after discharge to community

**F677 ADL Care Provided for Dependent Residents**

SE: SS=D: Failed to consistently provide resident oral care resulting in thick white substance on teeth & in corners of lips

* Failed to provide adequate assistance to dependent resident with oral hygiene needs

**F684 Quality of Care**

SW: SS=D: Failed to ensure 1 resident received treatment & care in accordance with professional standards of practice by failure of staff to ID, document & monitor bruises & failure to put into place measures to help prevent resident from bruising while on anticoagulant medication

* Cited findings noted in F657 r/t use of Eliquis & observation of bruising & bleeding from skin tear; failed to have a system in place to assess, document & follow-up on bruises; failed to implement interventions to help prevent bruises for 1 resident who received anticoagulant medication

**F686 Treatment/Services to Prevent/Heal PUs**

NW: SS=D: Failed to provide care & services to promote healing & prevent infection for 1/3 residents; 1 who admitted with 2 PUs & developed infection in 1 PU

* Failed to weekly assess 1 resident’s PUs & resident developed an infection in hip PU placing resident at risk for complications resulting from infection

**F689 Free of Accident Hazards/Supervision/Devices**

SE: SS=D: Failed to implement appropriate interventions following a fall to prevent further falls

* Failed to implement an appropriate intervention for 1 resident to prevent further falls from occurring when staff implemented to reeducate resident to use call light for assistance & resident’s cognition would not allow resident to remember that prior to getting up unassisted

NE: SS=D: Failed to assess & provide supervision to prevent accident for 2/7 residents; resident lacked a smoking assessment & 1 resident fell from bed

* Resident record lacked smoking assessment & staff verified facility was smoke free building but resident did leave facility premises if smoked; failed to complete a smoking assessment for 1 resident who exited building unattended to smoke a cigarette, placing resident at risk for accidents & injury
* Failed to investigate, report & prevent resident from falling, placing resident at risk for further falls & injury

NW: SS=E: Failed to provide an environment free of accident hazards on 1/3 halls for 10 cognitively impaired, independently mobile residents who resided in facility

* Observed kitchenette & commons area nurses’ desk revealed pair of pip pliers in unlocked drawer; pair of scissors in top drawer of cabinet in kitchenette; pair of scissors in unlocked drawer in nurses’ desk; failed to provide an environment free of accident hazards on 1/3 halls for 10 cognitively impaired, independently mobile residents in facility placing residents at risk for injury

**F690 Bowel/Bladder Incontinence, Catheter, UTI**

NW: SS=D: Failed to provide care & services to prevent UTIs for 1 resident when providing cares & during transfers

* Failed to keep urinary catheter bag below level of resident’s bladder during transfer, failed to disinfect port when emptying collection bag & failed to offer resident a leg strap to prevent unnecessary pulling on catheter tubing, placing resident at risk for infection & discomfort

**F692 Nutrition/Hydration Status Maintenance**

SE: SS=D: Failed to consistently provide resident with fluids to drink when providing cares & meal assistance to ensure adequate hydration

* Resident with G-tube; EMR lacked documentation of amount of liquids resident received other than 60 mL flushes with bolus feedings & medications; EMR lacked dehydration risk assessment; observed resident with dry cracked lips & dry skin on arms; failed to consistently provide resident with fluids to drink when providing cares & during meal assistance to ensure adequate hydration

**F693 Tube Feeding Management/Restore Eating Skills**

NW: SS=D: Failed to administer appropriate amount of water flushes after each medication administered per G-tube for 1 resident

* Failed to follow physician orders for resident’s G-tube medication administration, placing resident at risk for fluid overload

**F695 Respiratory/Tracheostomy Care & Suctioning**

SE: SS=D: Failed to ensure residents who needed respiratory care received such care consistent with professional standards of practice for 2 residents r/t use of O2

* Resident received O2 @ 3l/m per nasal cannula; humidifier bottle & tubing were not marked to reflect date of most recent change of tubing & humidifier bottle; observed humidifier bottle was almost empty & lacked water to cover internal tube that humidified air to nasal cannula; resident pulled cannula from nose & left it across forehead; failed to ensure resident who needed respiratory care received such care consistent with professional standards of practice r/t monitoring for need & effectiveness of O2 therapy
* Observed O2 tubing lacked date staff changed it; nebulizer mask kit lacked date staff changed it; nebulizer mask kit remained connected together & hanging from strap that connected to mask from nebulizer machine; failed to store O2 tubing in a plastic bag when not in use; failed to date tubing of O2 & nebulizer kit when changed, failed to clean & store nebulizer kit per facility procedure to prevent further respiratory infections for resident

**F698 Dialysis**

SW: SS=D: Failed to ensure staff obtained vital signs before & after resident received dialysis

* Review of clinical record revealed multiple documentation of vital signs upon return from dialysis in multiple months; failed to ensure staff obtained vital signs before & after dialysis

**F730 Nurse Aide Perform Review-12 hr/yr In-Service**

SW: SS=F: Failed to complete required nurse aide performance reviews for 3/5 CNAs in order to provide in-service education based on outcome of reviews

* Failed to complete performance reviews on 3/5 CNAs reviewed to ensure adequate cares provided to residents of facility

**F755 Pharmacy Services/Procedures/Pharmacist/Records**

NE: SS=D: Failed to provide routine medication for resident as ordered

* Resident with order for Biotin & multiple occasions eMAR indicated med not given; staff reported medication was not covered by resident’s insurance & pharmacy could not provide the medication; physician not notified of medication not administered as ordered; failed to ensure medication was available to be administered as ordered by physician for 1 resident placing resident at risk for adverse consequences of medical complications

**F756 Drug Regimen Review, Report Irregular, Act On**

SE: SS=D: Failed to timely act on pharmacy recommendations for 2/5 residents

* Failed to timely act on pharmacy recommendations for resident on Remeron & amiodarone
* Failed to act timely on pharmacy recommendations with medications that could damage kidney functions in residents

SW: SS=D: Failed to ensure pharmacist IDd lack of parameters & monitoring for blood pressure for 1 resident

* Resident with Lisinopril for HTN & MAR lacked documentation of BP or parameters for medication; staff reported did not have parameters for BP monitoring & did not monitor BP before giving medication since resident had lived at facility; failed to ensure pharmacist IDd lack of parameter for BP & lack of monitoring BP medications for 1 resident

NE: SS=D: Consultant pharmacist failed to ID resident’s inappropriate diagnosis for Zyprexa

* Consultant pharmacist failed to alert facility of resident’s inappropriate diagnosis for Zyprexa which was agitation, placing resident at risk for adverse side effects

NE: SS=D: Failed to ensure consultant pharmacist IDd facility’s failure to notify physician of weights outside physician ordered parameters for 1 resident; failed to ensure pharmacist IDd lack of BP monitoring for antihypertensive medication & an inappropriate dx for medication use

* Communication book revealed lack of documentation for physician notification of weights being out of physician ordered parameters; failed to ensure pharmacist IDd & reported weights out of physician ordered parameters for 1 resident placing resident at risk for complications from increased edema
* Failed to ensure pharmacist IDd & reported lack of adequate monitoring & appropriate dx for antihypertensive medication which put resident at risk for adverse consequences of unnecessary medications as resident with hx of pulmonary embolism

NW: SS=E: Pharmacist failed to review medications for 4/5 residents

* Record review revealed pharmacist failed to review medications for 2/12 months for multiple residents; Consultant pharmacist failed to complete monthly review for medications, placing multiple residents at risk for adverse reactions from medications

**F757 Drug Regimen Is Free from Unnecessary Drugs**

SW: SS=D: Failed to ensure 1 resident did not receive unnecessary medication due to failure of staff to notify physician when resident’s blood glucose levels were less than 70 & greater than 300 as ordered; failed to obtain BP parameters r/t use of Lisinopril & failed to monitor BPs weekly as ordered by physician for 1 resident

* Record revealed staff did not notify physician on multiple occasions when resident’s blood sugars were outside ordered parameters in multiple months; failed to ensure staff notified physician as ordered r/t blood sugar levels outside parameters for 1 resident
* Cited findings noted in F756 r/t failure to monitor & BP before administering medication for BP; failed to ID lack of parameter for BP & lack of monitoring BPs for 1 resident

NE: SS=D: Failed to notify physician of weights outside of physician ordered parameters for 1 resident; failed to ID lack of BP monitoring for antihypertensive medication & an inappropriate dx for use of antihypertensive

* Cited findings noted in F756 r/t same findings; Failed to follow physician ordered weight parameters for 1 resident placing resident at risk for complications from increased edema
* Failed to ID lack of adequate monitoring & appropriate dx for antihypertensive medication placing resident at risk for adverse consequences of unnecessary medications

NW: SS=D: Failed to provide interventions to keep resident’s O2w saturation at 94% or below per physician order

* Failed to provide resident interventions as physician ordered when O2 level exceeded 94% placing resident at risk for respiratory complications

**F758 Free from Unnecessary Psychotropic Meds/PRN Use**

SE: SS=D: Failed to monitor for use of psychotropic medications for 2/5 residents

* Failed to monitor use of psychotropic medications for resident with Remeron
* Failed to monitor use of psychotropic medications for resident with Remeron, Risperidone, & Sertraline

NE: SS=D: Failed to ensure 1/5 residents had a 14 day stop date on PRN Xanax; failed to ensure 2/5 residents had appropriate diagnosis for Risperdal & Zyprexa

* Failed to ensure resident’s PRN Xanax had a 14 day stop date placing resident at risk for adverse medication side effects
* Resident with order for Risperdal for Alzheimer’s; failed to ensure an appropriate dx for resident’s Risperdal placing resident at risk for adverse reactions & decline in status
* Resident with Zyprexa for agitation; failed to ensure appropriate dx for Zyprexa placing resident at risk for adverse side effects

NW: SS=D: Failed to follow up on pharmacy recommendations for 2/5 residents

* Resident with Zyprexa BID for Alzheimers disease; monthly DRR recorded pharmacist recommended facility obtain an appropriate dx for use of Zyprexa; facility did not follow up on recommendation; failed to ensure an appropriate dx for resident’s use of Zyprexa placing resident at risk for adverse side effects
* Resident with Seroquel for dementia with behavioral disturbance; pharmacy review recorded Seroquel with inappropriate dx for use of medication; facility had not sent recommendation to physician; failed to ensure appropriate dx for use of Seroquel placing resident at risk for adverse side effects

**F801 Qualified Dietary Staff**

NW: SS=C: Failed to provide services of a full time CDM for all residents residing in facility & received meals from facility kitchen

* Failed to employ a full time CDM to evaluate residents’ nutritional concerns & oversee ordering, preparing, & storage of food for all residents in facility who received meals from facility kitchen placing residents at risk for inadequate nutrition

**F812 Food Procurement, Store/Prepare/Serve-Sanitary**

SE: SS=F: Failed to store, prepare & serve food under sanitary conditions to residents of facility

* Observed air vents over food prep area with rust & dust; dusty ceiling tiles; cabinets with peeling paint; soiled stove/grill; grease build up on oven; microwave with peeling paint

NE: SS=F: Failed to prepare, store, distribute & serve food under sanitary conditions for all residents who received meals from facility kitchen

* Observed light fixture with bulbs with lint; plaster & paint peeling in food prep area; stained ceiling tiles in kitchen; vent with hanging lint above food prep area

NW: SS=F: Failed to store & prepare food in accordance with professional standards for food service safety in kitchen

* Observed undated food items, expired food items

**F880 Infection Prevention & Control**

SE: SS=F: Failed to maintain an effective infection control program when facility failed to utilize appropriate hand hygiene during resident ice pass & failed to maintain sanitary conditions of residents’ ice pass cart, to reduce transmission of infections to residents in facility

* Failed to use appropriate hand hygiene measures during ice pass & failed to maintain sanitary conditions of ice cart to reduce transmission of infection to residents in facility when staff failed to perform hand hygiene between handling of resident water pitchers & failed to clean ice cart

SE: SS=F: Failed to maintain an effective infection control program when facility failed to use appropriate hand hygiene during a wound treatment for 1 resident & during handling, storage, processing & transporting linens in manner to prevent spread of infection for residents of facility

* Laundry with dust build up on vents; washing machine with lint & dust build up; failed to ensure proper handling, storage, & processing of laundry to prevent spread of infection & cross contamination for residents of facility
* Observe IV dressing change & gloves were not removed, hand hygiene performed, and new gloves applied before cleaning and accessing the intravenous site, after she had entered the room and touched multiple objects with the same gloved hands; failed to remove contaminated gloves, perform hand hygiene & apply new gloves after touching multiple objects before accessing IV site of 1 resident to reduce transmission of infection to resident

SE: SS=E: Failed to ensure sanitary wound dressing for 1 resident; failed to ensure staff handled soiled hand wash cloths in sanitary manner to prevent spread of infection for residents of facility during meals

* Observed nurse removed soiled dressing then donned new gloves w/o performing hand hygiene; placed supplies directly on bed w/o barrier then placed back on cart w/o barrier; failed to ensure dressing change in sanitary manner to prevent spread of infection for resident that required a wound dressing treatment
* Observed staff handed wet washcloths to residents to sanitize hands & staff did not wear gloves & did not perform hand hygiene after touching soiled washcloths & providing a clean washcloth to next resident; failed to ensure staff handled soiled washcloths in sanitary manner to prevent spread of infection amongst residents

NW: SS=F: Failed to use appropriate infection control guidelines for laundry services, housekeeping services, wound care & contact isolation for C-diff

* Failed to change gloves after removing a soiled wound dressing & before applying a new dressing, placing resident at risk for receiving an infection
* Failed to follow IC guidelines for 1 resident who had c-dif placing other residents in facility at risk for infection r/t cleaning agent not effective against C-dif

NW: SS=E: Failed to maintain an IC program designed to provide a safe, sanitary & comfortable environment to help prevent development & transmission of disease & infection for all residents residing in facility

* Infection Control program revealed lack of documentation of tracking infections for 6 months which included type of infection, antibiotic usage, resolution of infection & additional cultures; lack of IDing, tracking, monitoring &/or reporting of infections; failed to maintain an IC Program designed to provide a safe, sanitary, & comfortable environment & to help prevent development & transmission of diseases & infection for all residents residing in facility

**F883 Influenza & Pneumococcal Immunizations**

NW: SS=D: Failed to provide documentation for 3/5 residents pneumococcal vaccination

* Records lacked documentation staff administered each resident pneumococcal vaccination or resident received pneumococcal vaccination prior to admission to facility for multiple residents; failed to obtain or provide documentation that multiple residents received pneumococcal vaccination, placing residents at risk to develop pneumococcal infections

**F921 Safe/Functional/Sanitary/Comfortable Environment**

SE: SS=F: Failed to provide maintenance services in kitchen to ensure a safe & sanitary environment

* Observed colored stains on floor in kitchen; under storage shelves with build up of debris; floor tiles with round depressions & build up of grime; walk in fridge floor with debris & black grime; dish room with build up of grime & debris; failed to ensure appropriate maintenance services necessary to maintain a sanitary, orderly & environment for kitchen

NE: SS=F: Failed to provide a safe, functional, sanitary & comfortable environment in facility kitchen

* Observed kitchen with missing floor tiles under sink; stained & rusty floor tiles; baseboard & kitchen floor with grime between tiles & along baseboard

**S1174 Door Monitoring System**

NW: SS=E: Failed to provide a functioning electronic door system on 1 hallway exit door

* Observed hallway exit door failed to alarm & staff reported door did not alarm when opened; failed to provide a functioning exit door alarm placing residents at risk for injury if exiting that door

**May, 2020 Findings**

**F689 Free of Accident Hazards/Supervision/Devices**

*SE: SS=J: Failed to provide adequate supervision to prevent 1 resident from leaving facility w/o staff knowledge; resident exited through a locked door, walked away crossing a busy highway (speed limit of 55 mph) & walked approximately 3-1/2 miles from facility; a community member noted resident lying face down in ditch & called local law enforcement & EMS for assistance placing resident in immediate jeopardy*

* *Resident stated he exited a locked door by pushing on the door until it opened; no staff member admitted they heard or shut off the door alarm; resident with minor scrapes & cuts upon return; failed to adequately monitor cognitively impaired resident, resident left facility w/o staff knowledge, walked 3-1/2 miles away from facility, crossing busy highway with speed limit of 55 mph & was found face down in a ditch; deficient practice placed resident in immediate jeopardy*
* *Abatement plan included:*
	+ *1:1 supervision for resident until resident transported to psychiatric hospital*
	+ *All door alarms were checked & found to be in working order; door alarms were changed to be checked daily*
	+ *All resident reassessed for elopement risk & CPs updated appropriately*
	+ *Held QAPI meeting which included medical director, Adm, DON, SSD & maintenance director*
	+ *Re-education of all staff r/t door alarms & re-setting of door alarms, unsafe resident wandering & what had the potential to make a resident unsafe*
	+ *Implemented elopement drills for each shift weekly & daily checking of door alarms*

**June, 2020 Findings**

**F880 Infection Prevention & Control**

SE: SS=L (Abated to F): Failed to follow CMS & CDC recommended practices to prevent transmission of COVID-19; failed to perform appropriate visitor screening that included screening questions & assessment of illness for 2/58 visitors starting 3-13-20 to date of survey; failure to perform appropriate visitor screening increased risk of transmission of pandemic COVID-19 virus to vulnerable residents of facility, placing them in immediate jeopardy; furthermore, facility reported 10 residents that received blood sugar checks from a shared glucometer; based on observation, interview & record review, facility failed to appropriately clean glucometer for 2/2 residents observed after use; failure to appropriately clean glucometer can lead to transmission of disease-causing pathogens or other harmful microorganisms

* Observed 2 visitors rang doorbell & entered first set of doors; 2nd set of doors remained locked; nurse came to door & checked visitors’ temperatures & had visitors date & sign visitor log in sheet; nurse then entered visitors’ temperatures on log; no further screening questions were asked or information provided by visitors; review of visitor log ins indicated all previous visitors had been appropriately screened; failed to complete visitor screening log questions before allowing 2 visitors with exception of temperature that was recorded on visitor log sheet; failed to perform appropriate visitor screening questions & assessment of illness for 2/58 visitors since beginning of pandemic; failure to perform appropriate visitor screening increased risk of transmission of pandemic COVID-19 virus to vulnerable residents of facility
	+ Abatement plan included:
		- All staff completed re-education r/t wellness check policy
		- QAPI committee reviewed & approved plan
		- Adm/designee will monitor wellness check station twice/day over next 30 days; concerns will be IDd with on-the-spot education provided; residents of monitoring will be reviewed by QAPI Committee & additional interventions made as indicated
* Observed nurse cleaned glucometer with alcohol prep; nurse failed to properly clean glucometer after use; observed nurse obtained blood sugar level then pumped hand sanitizer into hand & cleansed glucometer with hand sanitizer & returned glucometer to basket; failed to ensure & maintain an infection control program to reduce transmission of infections for 10 residents when facility staff failed to properly disinfect glucometer after each use

SE: SS=F: Failed to ensure cleaning of isolation resident rooms in a sanitary manner & failed to ensure staff sanitized a blood glucose meter used for 4 residents in an appropriate manner to prevent spread of infections to residents of facility

* Observed housekeeping staff cleaning a room; staff placed plastic cleaning caddy containing cleaning products & a sponge into resident’s room & placed it on top of isolation trash can lid; staff used a sponge to scrub sink & returned sponge into cleaning caddy beside bottles of cleaning products;; placed rags used to wipe toilet beside sponge in cleaning caddy; w/o changing gloves staff used spray cleaning product & prayed skink then obtained a rag to wipe sink with same gloves; staff reported used sponge for multiple resident sink cleanings & would discard it after 3-4 uses
* Observed housekeeping staff prepared to clean droplet isolation room; donned PPE, took cleaning caddy into room & Placed it directly on floor then used a sponge to clean sink & placed it into cleaning caddy next to cleaning products used for cleaning toilet; after cleaning toilet, w/o changing gloves, staff picked up spray bottle of cleaning product & sprayed a rag for cleaning toilet then place drag in bag which was on floor onto sponge used to clean sink & stated used sponge to clean other residents’ sinks; failed to provide isolation room cleaning in a sanitary manner to prevent spread of infection by reusing sponges & placing cleaning caddies directly on isolation room floors
* Observed nurse prepared to obtain blood glucose for resident; cleaned glucometer with an alcohol wipe; staff reported multi-use glucometer; DON stated facility uses single use glucometers & staff should sanitize glucometer per manufacturer recommendations which included 70% alcohol wipes but manufacturer list did not include alcohol wipes; failed to ensure staff utilized single resident use glucometers for designated resident & failed to provide effective sanitation of glucometers to prevent spread of infection for 4 residents

SE: SS=F: Failed to follow CMS & CDC recommended practices to prevent transmission of COVID-19; record review revealed facility failed to ensure all staff & visitors were screened appropriately on 20 occasions during 1 month; per observation, facility failed to ensure hand hygiene performed appropriately during ice pass & failed to ensure all staff donned & doffed PPE appropriately when entering & exiting a room of resident that was on quarantine; failure to screen appropriately, perform hand hygiene & don/doff appropriate PPE increased risk of transmission of pandemic COVID-19 virus to vulnerable residents of facility

* Review of 30 days of screening forms revealed forms lacked documentation of temperature recorded &/or symptoms &/or other screening questions answered on 20 occasions
* Observed CNA exited a resident room after adding ice to water pitcher & assisting with a blanket w/o performing hand hygiene then CNA entered another room, brought pitcher out to ice cart & added ice, returned pitcher to room & exited room with performing hand hygiene; CNA then entered another resident room that was on quarantine & failed to change mask when going in room & when exiting; then entered another room, performed multiple tasks, left the room & did not perform hand hygiene before moving on to another room & did not change mask when left quarantine room; failed to screen appropriately, perform proper hand hygiene & don/doff appropriate PPE which increased risk of transmission of pandemic COVID-19 virus to vulnerable residents of facility

SW: SS=F: Failed to ensure Dietary staff sanitized hands upon entering & exiting multiple resident rooms in 1/3 hallways; failed to ensure staff were thoroughly screened for COVID-19 prior to entering facility to work

* Observed dietary staff exited resident room w/o performing hand hygiene, held a cell phone to ear then placed the phone into pocket as approached another resident room
* Observed dietary staff held a meal tray ticket staff had picked up in resident’s room, entered another resident’s room w/o performing hand hygiene, touched door then touched resident’s knee while getting the tray ticket then exited room w/o performing hand hygiene; staff entered another room w/o performing hand hygiene, held tray tickets from previous 2 residents, picked up the tray ticket from 3rd resident from over bed table & exited room w/o performing hand hygiene; staff entered 4th room w/o performing hand hygiene, immediately exited room w/o performing hand hygiene
* Review of facility screening tool revealed: 5/35 employees did not have a temperature recorded upon entry to facility & 1/35 employees was IDd on screening tool by first name only on 1 day; 2 days later 2/18 employees did not have a temperature recorded upon entry to facility & 1/18 employees was IDd by first name only; next day 1/18 employees did not have a temperature recorded upon entry & 1 unnamed employee was screened upon entry to facility; next day 6/34 employees did not have a temperature recorded upon entry to facility & 2/34 employees were IDd by first name only…similar findings for multiple days reviewed