| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165205 | A. BUILDING _____ B. WING _____ | 01/11/2023 |

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| GOOD SAMARITAN SOCIETY - LEMARS | 1140 LINCOLN STREET NE LE MARS, IA 51031 |

| (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 |
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| F 000 | INITIAL COMMENTS | F 000 | | |
| x | Correction date: 2/9/23 | | | |
| x DC | The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #101822-C, #107370-C and incident #105139-I, conducted January 5, 2023 to January 11, 2023.<br><br>Complaint #101822-C was substantiated. Complaint #107370-C was unsubstantiated. Incident #105139-I was substaintiated.<br><br>See Code of Federal Regulations (42CFR) Part 483, Subpart B-C. | | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews and record review the facility failed to follow professional standards for 1 of 3 residents reviewed. Resident #25 was at risk for decline in status and required assistance with transfers and locomotion. Staff failed to assist the Resident to walk on a daily basis and failed to move him out of his wheel chair every 3 hours. The facility reported a census of 52 residents.<br><br>Findings include:<br><br>According to the Minimum Data Set (MDS) dated | F 658 | F000 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual<br><br>Compliance date 2/9/2023 | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | Administrator | 2/7/23 |

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 658 | Continued From page 1<br>10/28/22 Resident #25 did not have a Brief Interview for Mental Score (BIMS). Resident #25 required the help of one staff for toileting, hygiene, transfers and walking.<br><br>The Care Plan dated 4/24/22 showed that Resident #25 had impaired cognitive functioning related to history of cerebral infarction with aphasia. The resident was able to ambulate and staff were directed to assist him to walk 3-5 times a week. He had diagnosis that included hemiplegia, hemiparesis following cerebral infarction.<br><br>The electronic record included an order dated 10/25/21 at 11:53 AM that directed staff to assist with ambulation daily and to limit that resident's time in wheel chair to 3 hours at any time. The resident was to be transferred to the recliner after lunch and dinner.<br>The following was found on documents titled: Point of Care (POC) Response History, generated on 1/11/23 at 3:10 PM:<br>a. Walking in room from 12/13/22 - 1/11/23 was checked off that it did not occur 47 times and was completed 8 times.<br>b. Walking in the corridor from 12/13/22 - 1/11/23 did not occur 48 times and was completed 7 times.<br><br>On 1/10/23 at 7:05 AM Licensed Practicing Nurse (LPN) Staff D said that the Certified Nursing Assistants (CNA) would walk the resident throughout the day. She said that the family had hired a lady to come and do exercises with him (Staff E).<br><br>On 1/11/23 at 3:10 PM Staff E said she worked for an agency that typically would go into homes | F 658 | All residents who require assistance with ambulation/transfers have the potential to be affected with mobility decline.<br><br>Education was completed on 1/17/23 at CNA meeting on resident #25 with review of his current restorative nursing program.<br><br>Care plan reviewed and updated by DON to reflect resident's current status<br><br>To ensure that no other resident is affected by the deficient action random audits will be conducted to review current RNP program regarding ambulation/positioning<br><br>Audits will be completed 1x/week for 4 weeks, then 1x/month for 2 months then every quarter x3<br><br>All audits will be brought to the QAPI improvement committee for review and recommendations. | |

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| F 658 | | F 658 | | |

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and help elderly with their needs. She said that she had been working with Resident #25 for quite a while and assisted him to walk and with exercises twice a week. She said that on several occasions, she came into the facility and found the resident on the toilet and very upset. He was able to communicate with her that he had been waiting for 45 minutes. Staff E said that the resident's bottom had a purple ring around his buttocks from the pressure of sitting there so long. She said that the staff would tell her that they didn't have enough help to walk him twice a day as they should.

The following is documentation of an on-going observation of Resident #25 on 1/12/23:

a. At 7:23 AM the resident was at the table in the dining room eating breakfast in his wheel chair, (WC).
b. At 7:55 AM in the hallway in WC.
c. At 8:21 AM in room sitting in the WC in front of television (TV)
d. At 8:44 AM in room in WC in front of TV
e. At 9:05 AM in room in WC in front of TV
f. At 9:29 AM in room in WC in front of TV
g. At 9:49 AM on the toilet
h. At 10:10 AM in room in WC in front of TV
i. At 10:22 AM in room in WC in front of TV
j. At 10:42 AM in room in WC in front of TV
k. At 11:00 AM in room in WC in front of TV
l. At 11:16 AM wheeling self out to dining room
m. At 11:45 AM still at table eating
n. At 12:04 PM in room in WC in front of TV
o. At 12:24 PM in room in WC in front of TV
p. At 12:43 PM in room in WC in front of TV
q. At 12:47 PM hired aide was walking him down the hallway

On 1/12/23 at 1:45 PM the Director of Nursing

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| F 658 | Continued From page 3<br>(DON) said she understood that Resident #25 had a doctor's order to be up out of his wheel chair on a regular basis. She said he had gone to see a vascular specialist that recommended this intervention. She said that the hired helper did not substitute for what staff were to provide in way of positioning, exercise and walking. | F 658 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews and record review the facility failed to prevent accidents and hazards for 1 of 3 residents reviewed. Resident #17 sustained an injury from a mechanical lift Sit to Stand sling that was too small for her. The facility reported a census of 52 residents.<br><br>Findings include:<br><br>According to the Minimum Data Set (MDS) dated 12/23/22, Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability). The resident required extensive assistance with the help of two staff for bed mobility and toileting and required extensive assistance with the help of one staff for transfers and dressing. | F 689 | F000 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual<br><br>Compliance date 2/9/2023 | |

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| F 689 | Continued From page 4<br>The Care Plan updated on 2/3/22 showed that Resident #17 had an Activities of Daily Living (ADL) self-care performance deficit related to a history of Cerebrovascular Attack (CVA) and right sided weakness. The resident was a non-ambulatory and required the Sit to Stand mechanical lift for transfers. Staff were directed to use the extra-large size harness for all transfers. Resident #17 had diagnosis that included congestive heart failure, chronic kidney disease, stage 3, obesity and peripheral vascular disease.<br><br>On 1/09/23 at 1:15 PM Certified Nursing Assistant (CNA) Staff C prepared the Sit to Stand mechanical lift to transfer Resident #17 from the wheel chair to the bedside commode. Before the sling was attached, the resident lifted her blouse and revealed a large, dark purple bruise on her right breast. The resident said that on the previous day, a CNA put a sling on her that was too small and "I felt like I was in a strait jacket". The resident said that she told the CNA that it was the wrong size before she attached it, but the CNA responded that they couldn't find the larger sling that they would usually use to transfer her.<br><br>A review of the record revealed a Nursing Note dated 1/9/2023 at 10:33 PM that showed the resident had a bruise, light to dark purple noted to the right breast measuring 17.0 centimeters (cm) x 25.0 cm. in size.<br><br>According to the Sit to Stand Harness Sizing Guide, for a resident weighing 190-320 pounds, staff were to use a large sling.<br><br>The Vitals tab in the electronic chart showed on 1/8/23 at 1:03 PM Resident #17 weighed 247.9 pounds. | F 689 | All residents who require use of transfer aid have the potential to be affected with wrong size of sling/harness.<br><br>Resident #17 care plan was reviewed at CNA meeting on 1/17/23 and appropriate size of harness to be used. Care plan was reviewed by DON and updated to reflect current size needed for resident according to her current status/weight.<br><br>Education and proper sizing of transfer aid sling/harness to nursing staff at nursing staff meeting on 1/31/23 and CNA meeting on 2/7/23. Reference chart placed in pocket of transfer aid machines and in all CNA communication books. Care plans reviewed by DON on 1/12/23 and updated to reflect current status/sizing.<br><br>To ensure that no other resident will be affected by deficient action, random audits will be completed to ensure proper transfer aid device and size is in resident's room. Audits will be completed 1x/wk x 4 weeks. Then 1x/month x2, then every quarter x3.<br><br>All audits will be brought to the QAPI improvement committee for review and recommendations. | |

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| F 689 | Continued From page 5<br><br>On 1/12/23 at 1:45 PM the Director of Nursing (DON) said that she had asked the physical therapy department to evaluate the resident for transfer status. The DON said she was not sure that the bruising on the right breast had been caused by the sling, but she did understand that the resident is not bearing weight very well on the Sit to Stand and may need to be changed to a Hoyer transfer. | F 689 | | |
| F 725 SS=D | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must | F 725 | F000 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual<br><br>Compliance Date 2/9/2023 | |

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| F 725 | Continued From page 6<br>designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews and record review the facility failed to provide sufficient staffing to respond to residents needs in a timely fashion for 2 of 16 residents reviewed. Resident #17 and Resident #30 reported that many times it took over 30 minutes for staff to respond to the call lights. The facility reported a census of 52 residents.<br><br>Findings include:<br><br>1) According to the Minimum Data Set (MDS) dated 12/23/22, Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability). The resident required extensive assistance with the help of two staff for bed mobility and toileting and required extensive assistance with the help of one staff for transfers and dressing.<br><br>The Care Plan updated on 2/3/22 showed that Resident #17 had an Activities of Daily Living (ADL) self-care performance deficit related to a history of Cerebrovascular Attack (CVA) and right sided weakness. The resident was non-ambulatory. Resident #17 required the Sit to Stand mechanical lift for transfers and staff were directed to use the extra-large size harness for all transfers. Resident #17 had diagnosis that included congestive heart failure, chronic kidney disease, stage 3, obesity and peripheral vascular disease.<br><br>On 1/5/23 at 1:16 PM Resident #17 said that at times, she had waited an hour for staff to respond | F 725 | All residents have the potential to be affected by not having there call light answered in a timely manner. Call lights will be answered as quickly as possible utilizing all staff in all departments to ensure the needs of the residents are met.<br><br>Continued efforts to recruit and retain staff remain in place. On site NA program, recruitment letters, hiring bonuses, recruitment talks/fairs at local colleges, requests to outside agencies. CNA clinicals are held at facility from community colleges.<br><br>To ensure that call lights are answered in a timely manner resident #17 and resident #30 call light times and other random resident call light times will be audited 1x/wk x 4 weeks, then 1x/month x2, then every quarter x3.<br><br>All audits will be brought to the QAPI improvement committee for review and recommendations. | |

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| F 725 | | F 725 | | |

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to her call light. She pointed to a clock on her dresser and said she watched the clock to see how long it would take and many times she had been incontinent because it took too long for them to get to her.

The Census Report tab showed that Resident #17 was in room 306

A document titled: Device Activity Report generated on 1/9/23 at 1:10 PM included the following for room 306:

a. On 12/11/22 at 12:37PM the call light was on for 18 minutes and 39 seconds.

b. On 12/17/22 at 9:38 AM the call light was on for 28 minutes and 45 seconds.

c. On 12/25/22 at 9:07 AM the call light was on for 25 minutes 46 seconds.

d. On 12/25/22 at 3:30 PM the call light was on for 28 minutes and 46 seconds.

e. On 12/24/22 at 11:12 AM the call light was on for 25 minutes and 20 seconds.

F. On 12/24/22 at 5:15 PM the call light was on for 30 minutes and 47 seconds.

2) According to the MDS dated 11/18/22, Resident #30 had a BIMS score of 14 (intact cognitive ability). The resident required extensive assistance with the help of two staff for bed mobility, locomotion and toileting.

The Care Plan for Resident #30 updated on 11/23/22 showed that she was incontinent of bowel related to malignant neuroleptic syndrome and dementia. Staff were directed to provide a bed pan or bedside commode and to check the resident for toileting needs before and after meals and throughout the night.

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| F 725 | Continued From page 8<br>On 1/5/23 at 1:30 PM Resident #30 said at times, it would take staff close to an hour to respond to her call light. She pointed to her clock and said that she could see it from her bed and said she would watch how long it took.<br><br>The Census Report tab showed that Resident #30 was in room 307<br><br>A document titled: Device Activity Report generated on 1/9/23 at 1:10 PM included the following for room 307:<br><br>a. On 1/7/23 at 7:16 AM the call light was on for 16 minutes and 45 seconds.<br>b. On 1/7/23 at 7:44 AM the call light was on for 15 minutes and 33 seconds.<br><br>A facility policy last updated on 10/21/22 titled; Call Light showed that when a resident's call light was observed/heard, staff were to go into the resident's room promptly.<br><br>On 1/12/23 at 1:45 PM the Director of Nursing said she understood that the call light response was slow over Christmas because they had a fire alarm going off. Staff were expected to respond as soon as possible. | F 725 | | |
| F 755 SS=E | Pharmacy Services/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of | F 755 | F000 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual<br><br>Compliance Date 2/9/2023 | |

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a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record review the facility failed to maintain safegaurds and systems to control and account for scheduled medications for 4 of 6 residents reviewed. Resident #254 and Resident #306 had orders for
Ativan to be used as needed for seizure disorders. The medication cassettes were tampered with and replaced with different medications. Staff removed 2 Hydrocodone tabs from the emergency kit (ekit) for Resident #307 and the Medication Administration Record (MAR) lacked documentation that these had been given. On 1/12/23, a medication cart contained a

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| F 755 | Continued From page 10<br>cassette with an as needed (PRN) Tramadol for Resident #43, the medication had been discontinued the end of December. The facility reported a census of 52 residents.<br><br>Findings include:<br><br>1) The Minimum Data Set (MDS) dated 9/9/22 showed Resident #254 had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive deficits). The resident required extensive assistance with the help of two staff for bed mobility, toileting and hygiene needs.<br><br>According to the Admission Record, Resident #254 was admitted on 12/5/19 and had diagnosis that included malignant neoplasm, spinal stenosis, and essential tremor.<br><br>According to the Care Plan updated on 10/28/21, Resident #254 had impaired cognitive function and impaired thought processes related to metastatic lung cancer. The resident used psychopharmacological medications related to dysthymic disorder.<br><br>An email message was sent to the facility from the pharmacy, on June 7th at 9:18 AM and stated a cassette containing 3 pills for Resident #254 had been sent back to the pharmacy in error. The pharmacist examined the cassette that was noted to contain a PRN order of Ativan 2 milligrams (mg) tabs. The pharmacy chief noticed 2 of the lids of the cassette showed evidence of having been removed and replaced. He found that one tablet was not Ativan and identified it as melatonin. This was reported to the nursing home on 6/6/22 around 10:00 AM. | F 755 | All residents have the potential to be affected by not having a medication destroyed or returned according to policy.<br><br>Resident #43 PRN Tramadol cassette was destroyed by 2 charge nurses<br><br>To ensure that all controlled medication is monitored and signed out correctly. Education was provided to charge nurses by DON on 1/31/23 regarding new e-kit sign out sheet provided by pharmacy.<br><br>Audit of e-kit sign out sheets to be completed by Director of Nursing or designee weekly x4 weeks then monthly x2 months, then quarterly x3.<br><br>All audits will be brought to the QAPI improvement committee for review and recommendation. | |

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A review of the record showed Resident #254 had an order for a PRN Ativan dated 3/9/22 at 2:46 PM to be taken every 15 minutes as needed for seizure activity. The Medication Record (MAR) showed the medication had not been used.

A facility initiated investigation revealed that no staff members were aware of or had any knowledge of misappropriation of medications. As of 6/13/22 the facility did not have any suspects in the matter. They concluded that because the cassette tabs were easily popped out and replaced, it was difficult to recognize tampering at a glance. The pharmacy planned to send out bubble packs instead of cassettes after the incident.

2) According to an MDS dated 6/17/22, Resident #306 did not have a BIMS score. The resident required extensive assistance with the help of two staff for dressing, toileting and bed mobility.

The admission record showed the resident was admitted on 8/10/17 with diagnosis that included neoplasm, Parkinson's' disease, dysphagia, and carcinoma of the skin.

The Care Plan updated on 6/20/22 showed the resident had impaired cognitive functioning related to dementia. Resident #306 had a seizure disorder related to neoplasm of the brain and was on seizure precautions. The resident had a terminal prognosis and Hospice services were initiated on 7/22/21.

According to a facility investigation dated 6/11/22 the nursing staff had concerns of another cassette of Ativan that possibly had medication in the cassette that was not Ativan. On 6/13/22 the

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cassette was found to have been disturbed. The facility completed an audit of all Ativan doses and found no other concerns.

According to a written statement from LPN Staff F examined the pills and found them to be metoprolol and busperone.

According to the MAR, Resident #306 did not receive any PRN Ativan doses.

3) An MDS dated 11/25/22 showed Resident #43 had a BIMS score of 15 (intact cognitive ability). He was independent with transfers and walking, and required extensive assistance with the help of one for toileting. The resident had diagnosis that included cellulitis of the buttock, pressure induced deep tissue damage to sacral area, and Type II diabetes.

The Care Plan showed the resident was admitted to the facility on 6/20/22 with a fistula colostomy to the lower abdomen. He had acute pain related to deep tissue pressure sores.

The Orders tab showed Resident #43 had an order dated 12/15/22 at 11:57 PM for Tramadol 50 mg PRN for pain. The order was discontinued on 12/30/22.

On 1/12/23 at 8:10 AM with Registered Nurse (RN) Staff G looked at the medications in the cart for Resident #43 and discovered a cassette with the PRN Ativan was still in the medication cart. Staff G admitted it should have been destroyed at the time that it was discontinued.

According to facility policy titled: Medications: Controlled last reviewed on 12/7/21, controlled

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medication that have been discontinued should be placed in a locked box in the medication room as soon as they have been discontinued.

4) The MDS for Resident #307 dated 6/7/22 did not include a BIMS score.

The Census tab showed that he was admitted to the facility on Hospice services.

The Care Plan dated 6/7/22 showed the resident had an ADL self-care performance deficit related to a diagnosis of malignant neoplasm of the left bronchus or lung, malignant neoplasm of bone, and malignant neoplasm of the liver. The resident had chronic pain needed scheduled and PRN pain management.

According to the Orders tab the resident had an order dated 6/7/22 at 12:45 PM for Hydrocodone 5/325 milligrams (mg) 1-2 tabs every 6 hours.

An Emergency Kit Log showed on 6/7/22 (untimed and unsigned) 2 tabs of Hydrocodone had been removed from the emergency kit. The document lacked information regarding who dispensed the medications and according to the MAR the resident did not receive the medication.

A review of the facilities process for the dispensing of controlled substances from the emergency kit revealed the use of one form titled: Emergency Kit Log for three ekits stored in a closet; one with intravenous medications, one with controlled substances and one for all other medications.

Another form titled: Control E-Kit sign off, included columns for the date, tag number on the

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| F 755 | Continued From page 14<br><br>kit, night/day shift change, tag number, and shift. Upon investigation, it was discovered that the tag numbers on this form many times did not match the tag numbers on the Emergency Kit Log.<br><br>On 1/10/23 at 11:36 AM the DON acknowledged the ekit document did not have a column for staff signature and that this was problematic. She was not sure why the Control Kit sign off numbers did not match the emergency kit log. Upon further investigation, it was discovered the tag numbers changed when the kit went back to the pharmacy for updating.<br><br>According to facility policy titled: Medications: Controlled last reviewed on 12/7/21, The facility will along with their consultant pharmacist establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation that determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled and meets all state and federal requirements for controlled medications. | F 755 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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 development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program. | F 880 | F000 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual<br><br>Compliance date 2/9/2023 | |

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| F 880 | Continued From page 15<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(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<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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 | F 880 | Root Cause Analysis completed on 2/2/23 by Governing body: Regional Clinical Director, Infection Preventionist, Administrator, Director of Nursing, Quality Coordinator<br><br>All residents have the potential to be affected by a transmission or infection if improper hand hygiene or non-covered linen carts<br><br>Education on Hand hygiene was completed on 1/11/23 by facility's Licensing, Development Specialist. Director of Nursing provided hand hygiene education to CNA's on 1/17/23 and charge nurses on 1/31/23. Hand hygiene and linen coverage and storage/handling to be provided on 2/7/23.<br><br>Hand Sanitizer will be placed on snack cart<br><br>Signs will be posted on linen carts regarding coverage<br><br>Audits on linen cart coverage and hand hygiene will be completed by Director of Nursing or designees weekly x 4weeks, then monthly x2 months, then quarterly x3<br><br>All audits will be brought to the QAPI improvement committee for review and recommendations. | |

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(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:
Based on observation, clinical record review, and staff interviews the facility failed to ensure staff followed infection control policy and procedures for 1 out of 16 residents, (Resident #50). The facility also failed to follow infection control policy and procedures by not covering clean linen carts. The facility reported a census of 51 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 11/14/22 for Resident #50 identified a Brief Interview for Mental Status (BIMS) of 13 which indicated cognitively intact. The MDS documented diagnoses of cognitive loss/dementia and cancer.

Observation on 1/9/23 at 2:53 PM showed Staff A delivering snacks in 100 hall. As Staff A walked past Resident #50's room, she noticed they were attempting to ambulate unassisted from the recliner to the bed. Staff A went into Resident #50's room,

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| F 880 | Continued From page 17<br>took a hold of their arm, touched their bare back and assisted them into bed. Staff A then exited the room without washing their hands and entered two other rooms passing out snacks.<br>In an interview with the Administrator on 1/10/23 at 2:45 PM, he stated the expectation would be that hand hygiene be performed prior to continuing to deliver snacks.<br><br>2. Observation on 1/9/23 at 9:46 AM showed clean linen carts tucked back into alcoves on 100 and 300 hallways with the front covers laying on top of carts exposing clean laundry. In an interview with Staff B, she stated that the expectation was for the carts to be covered. | F 880 | | |