STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165220	A. BUILDING _____ B. WING _____	07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PRAIRIE RIDGE	608 PRAIRIE STREET MEDIAPOLIS, IA 52637

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F 000	INITIAL COMMENTS Correction Date: 8-3-22 ✓ SS The facility's annual recertification survey and investigation of complaints #103229-C, #104023-C, and #104062-C was conducted July 6, 2022 - July 8, 2022. Complaint #103229-C was substantiated. Complaint #104023-C was substantiated. Complaint #104062-C was substantiated. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, document review, interviews, and facility policy review, the facility failed to ensure staff used safe and appropriate techniques to assist the resident in positioning on a bedpan for one (Resident #29) of one sampled resident reviewed for fractures. A facility Certified Nursing Assistant (CNA) pulled the resident's wrist while assisting the resident into an upright position on a bedpan, resulting in a fracture. The facility identified a census of 36 current residents.	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/20/2022

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

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	165220	A. BUILDING _____ B. WING _____	07/08/2022

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F 689	Continued From page 1 Findings include: A review of the facility's policy titled, "Azria Safe Lifting and Movement of Residents," dated July 2017, revealed, "In order to protect the safety and well-being of staff and residents and to promote quality care, this facility uses appropriate techniques and devices to life and move residents." The policy also indicated, "Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices." A review of Resident #29's "Admission Record" revealed the resident had diagnoses of hypertensive heart disease without heart failure, anxiety disorder, and other specified disorders of bone density and structure. A review of the quarterly Minimum Data Set, dated 06/02/2022, revealed Resident #29 scored 14 on a Brief Interview for Mental Status, indicating intact cognition. Additionally, the MDS indicated the resident was dependent upon limited supervision for bed mobility was dependent on extensive assistance of at least one person for toileting and was dependent on moderate assistance of at least one person for rolling from one side to the supine (lying on back) position in bed. A review of the care plan, dated 03/10/2022, revealed the resident was at increased risk for actual and potential limitations in the ability to perform activities of daily living due to impaired mobility secondary to ankle stability. Interventions included one-person physical assistance and use of a grab bar and gait belt for toileting.	F 689		

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F 689	Continued From page 2 A review of a, "Skin Alteration Evaluation," dated 03/10/2022, revealed bruising was identified to Resident #29's left hand. Edema and discoloration were also noted. Additional bruising was noted on Resident #29's left arm. Review of an undated "DIA [Department of Inspections and Appeals] Report" revealed there was dark purple bruising with swelling noted to the resident's left wrist and forearm. The resident denied pain unless the wrist was touched. The report indicated the resident was able to move the wrist freely with no discomfort voiced. Resident #29 reported the Certified Nursing Assistant (CNA) was trying to help the resident get up to go to the bathroom and pulled the resident by the hand. Resident #29 added, "I said 'that hurts' and [CNA] let go and got me under my arms." An ice pack was provided to the resident, and the doctor was notified by the charge nurse. On 03/10/2022, an x-ray was obtained which identified a non-displaced fracture of the left wrist. According to the CNA, once the resident was on the bedpan like a toilet, the CNA stood on the left side of the bed and held Resident #29's left hand and upper back to provide support while hoisting them up to the resident's preferred position. Review of a signed interview dated 03/10/2022 from Resident #29 revealed the CNA (Staff E) was trying to help him/her get up to go to the bathroom and held the resident by his/her hand. Resident #29 added he/she said that it hurt, and the CNA let go and got the resident under his/her arm. A review of the "Patient Report," dated and signed 03/10/2022, revealed three views of the	F 689		

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F 689	Continued From page 3	F 689		

left forearm. Findings included prominent soft tissue swelling at the level of the distal radius. The report indicated there was evidence of a small nondisplaced fracture.

A review of a "Progress Note," dated 03/11/2022 at 7:03 AM, indicated a visual inspection of the resident's left wrist revealed bruising and swelling. The nurse asked the resident if he/she was in pain and if the resident wanted any Tylenol. The resident declined and stated, "no, it don't hurt unless I touch it." The resident denied pain. Review of the notes for the same day at 11:19 AM and 2:24 PM revealed the resident was sent to the doctor per the doctor's request. A note at 4:19 PM indicated new orders to keep the resident's arm elevated, use ice for pain or swelling, and follow up next Tuesday (03/15/2022).

A review of a "Final Report," dated 03/11/2022 and signed 03/12/2022, revealed a left wrist fracture. The report indicated recommendations for follow-up in three to five days for repeat x-rays and a splint to check alignment.

A review of a "Progress Note," dated 03/14/2022 at 5:39 PM, revealed new orders were received for x-rays in three days and repeat in 10 days. The note indicated the radiology provider was notified. Notes at 11:07 PM revealed the physician was doing the x-rays at the clinic, according to the transportation scheduler.

A review of Staff E's signed statement, dated 03/16/2022, revealed Staff E noted that the resident rolled from side to side to get on the bedpan. She reported that once the resident was on the bedpan, the resident preferred to sit up, as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 4	F 689		

if on a toilet, so the CNA stood on the left side of the bed and held the resident's left hand and upper back to provide support while hoisting the resident up to the resident's preferred position.

A review of a "Progress Note," dated 03/18/2022, revealed the resident's circulation, motion, and sensation to the left upper extremity was within normal limits. The left hand was edematous with bruising noted.

During an interview on 07/06/2022 at 10:18 AM, Resident #29 stated he/she was needing assistance at night to use the restroom. Resident #29 preferred to use a bedpan. The CNA helping the resident "grabbed" Resident #29's wrist to help him/her get onto the bedpan. When this happened, Resident #29 said it hurt "a little." Additionally, Resident #29 stated he/she was seen by the doctor.

During an interview on 07/08/2022 at 2:14 PM, Staff E, CNA, revealed she was an agency CNA. When she helped Resident #29 use the bedpan, she knew Resident #29 used the bedpan in an unconventional way. The resident liked to sit on it as one would sit on a toilet. Because of this, Resident #29 used Staff E's arm "for balance." Staff E stated Resident #29 would roll onto the bedpan from his/her side and use the staff's arms for balance to sit up. Staff E stated Resident #29 did not give any indication he/she was hurt during the process. The process was "not really a transfer;" however, Staff E went through all the normal transfer training for a resident during her CNA classes.

During an interview with Staff D, CNA, on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 5 07/08/2022 at 4:15 PM, she revealed there was continued communication between facility nurses, CNAs, and agency staff, regarding residents' status and needs related to transfers and residents' preferences. During an interview on 07/08/22 at 4:49 PM with the Administrator (ADM) and Director of Nursing (DON), they revealed they were not working in the facility when the incident occurred. Since their arrival, there was an expectation that agency staff had the same training as facility staff. When a new agency worker worked in the facility, if allowed, they were to come in to work an hour or two prior to their shift to shadow another staff member working with the residents they would be working with. Staff E's agency did allow staff to come in two hours before their shift. Since the ADM and DON arrived, they had implemented some new systems to help agency staff know the residents more. A KARDEX was now on the inside of the wardrobe of each resident. Their preferences and needs were outlined on this.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		

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F 690	Continued From page 6 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, and staff and provider interviews, the facility failed to ensure care and services related to urinary catheter care were provided in accordance with accepted standards of practice to prevent potential urinary tract infection or other complications for one (Resident #3) of one sampled resident reviewed for an indwelling urinary catheter. Specifically, the facility failed to ensure the urinary catheter was changed at the frequency ordered by a physician and failed to ensure a physician's order was obtained and documented prior to irrigating the urinary catheter to address blood in the urine for one (Resident #3) of one sampled resident reviewed for a	F 690		

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F 690	Continued From page 7 urinary catheter. The facility identified a census of 36 current residents. Findings included: Review of the Admission Record revealed Resident #3 had diagnoses including diabetes mellitus type 2, vascular dementia without behavioral disturbance, benign prostatic hyperplasia (condition where urine flow is blocked due to enlargement of the prostate), and retention of urine. Review of an annual Minimum Data Set (MDS), dated 03/24/2022, revealed Resident #3 scored 15 on a Brief Interview for Mental Status (BIMS), indicating intact memory and cognition. The resident required extensive assistance with bed mobility, transfer, toilet use and personal hygiene. Per the MDS, the resident had an indwelling catheter. Review of a care plan dated 07/14/2021 revealed Resident #3 had an alteration in elimination resulting in the need for a catheter. The interventions included: a. A 20 French (Fr) catheter with 10 milliliter (ml) bulb. Change every 4 weeks. b. Diagnosis for need: urinary retention. c. Observe and report any signs or symptoms of an infection and or complications such as pain, odor, fever, confusion, nausea/vomiting, cloudy, bloody urine due to catheter. 1. Review of the resident's Progress Note dated 01/15/2022 at 1:21 PM revealed a health status note that indicated the resident's urinary catheter was changed.	F 690		

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F 690	Continued From page 8	F 690		

The Progress Note dated 02/14/2022 at 2:11 PM recorded a health status note which indicated the resident returned from a urology appointment, during which his indwelling urinary catheter was changed.

Review of a physician's order dated 03/02/2022 revealed the resident was to have a 20 French catheter with a 10 cubic centimeter (cc) bulb with directions to change the catheter every 4 weeks and as needed (PRN). The order also indicated a leg bag could be used during waking hours and washed out every day.

Review of a physician's order dated 03/03/2022 revealed a urinalysis with reflux and culture was to be performed.

Review of a physician's order dated 03/04/2022 revealed the resident ordered to receive Cipro tablets (an antibiotic) 500 milligrams (mg) by mouth twice a day from 03/04/2022 through 03/11/2022.

Review of Resident #3's March 2022 Treatment Administration Record (TAR) revealed the resident's urinary catheter was changed on 03/01/2022 and 03/04/2022.

Review of the April 2022 TAR revealed the catheter was scheduled to be changed on 04/01/2022 and 04/29/2022; however, there was no documentation that staff changed the catheter on 04/29/2022.

Review of the May 2022 TAR revealed the resident's urinary catheter was changed on the 05/27/2022.

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	165220	A. BUILDING _____ B. WING _____	07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 690	Continued From page 9	F 690		

Review of the June 2022 TAR revealed the resident's urinary catheter as scheduled to be changed on 06/03/2022; however, there was no documentation that staff changed the catheter on that date.

The physician's order dated 06/03/2022 indicated the resident was to have a 20 French catheter with 10 cc bulb, which was to be changed every four weeks. The order indicated a leg bag could be used with the catheter during waking hours.

Review of the July 2022 TAR revealed the resident's urinary catheter as scheduled to be changed on 07/01/2022; however, there was no documentation that staff changed the catheter on that date.

During an interview on 07/08/2022 at 4:09 PM, the Director of Nursing (DON) stated the resident's indwelling urinary catheter had not been changed during the months of June and July 2022, as ordered by the physician. The DON reported a nurse had left for the day prior to completing the task. The DON stated her expectation was for the nurse to stay until all assigned tasks were completed.

2. Review of a physician's order, dated 06/03/2022, revealed Resident #3 was to have a 20 French catheter with a 10 cubic centimeter (cc) bulb to be changed every four weeks. The order indicated a leg bag could be used with the catheter during waking hours.

Review of Progress Notes dated 07/05/2022 at 10:04 AM revealed a health status note that indicated the nurse had notified the urology department where the resident was seen for the

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F 690	Continued From page 10	F 690		

catheter and urology needs in the past. The clinic nurse at the urology office suggested to try flushing the catheter with normal saline and then 'if still cont [continues] to have blood in it to follow what the PCP [Primary Care Physician] had given for orders.'

The Progress Note dated 07/05/2022 at 3:55 PM documented the nurse flushed the resident's catheter with 60 cc normal saline due to blood in the leg bag and the nurse recorded a good return of yellow urine. There were no further signs of blood in the urine that shift. The note indicated the nurse spoke with the resident's power of attorney (POA) and reported the bloody urine and the interventions taken.

During a telephone interview on 07/07/2022 at 4:10 PM, the resident's PCP reported she was aware of the blood in the resident's urinary catheter drainage bag. The PCP stated she ordered a catheter change and urine sample for urinalysis but had not received the results of the urinalysis. She did not indicate she was aware of the irrigation of the catheter.

During an interview on 07/08/2022 at 11:43 AM, Staff A, Licensed Practical Nurse (LPN), stated she was helping the floor nurse on 07/05/2022, and the resident reportedly had blood in the catheter tubing and bag. The other nurse working that day had already called the PCP and received an order to change the catheter. Staff A stated Staff G, Registered Nurse (RN) had gone to the Director of Nursing (DON) regarding the order and the concern of further bleeding due to the resident being on blood thinners. The DON instructed Staff G to call the urologist the resident had seen in the past. Staff G called the urology

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F 690	Continued From page 11 office and spoke with the triage nurse, who recommended flushing the catheter. The triage nurse had instructed the facility nurses that if the flushing did not clear the blood, to follow what the PCP had ordered. As of 07/08/2022, the physician's orders in the resident's electronic medical record included the order to obtain a urinalysis, but there was no physician's order to irrigate/flush the resident's catheter. On 07/08/2022 at 12:54 PM, the DON reported the order for irrigating the catheter should have been entered into the electronic medical record. The DON stated the nurse had received the verbal order but had not entered the order to prompt the physician to sign it. During an interview on 07/08/2022 at 12:57 PM, the DON stated Staff G contacted the resident's PCP and was told to go ahead and flush the catheter, and if the bleeding continued, to obtain the urinalysis. At 4:14 PM, the DON stated the order to flush the catheter was a verbal order, but the nurse did not chart it. The DON indicated the orders should have been addressed in the progress notes and the TAR, and the order itself should have been faxed to the physician for signature. On 07/08/2022 at 4:48 PM, the Administrator was interviewed and stated she expected staff to follow the physician's orders.	F 690		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 12 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

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	165220	A. BUILDING _____ B. WING _____	07/08/2022

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AZRIA HEALTH PRAIRIE RIDGE	608 PRAIRIE STREET MEDIAPOLIS, IA 52637

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F 842	Continued From page 13 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on facility policy review, clinical record review, and interviews, the facility failed to ensure medical records, specifically Hospice communication notes, were complete for one (Resident #9) of one sampled resident who received Hospice services. The facility identified a census of 36 current residents. Findings included: Review of the facility policy titled Azria Hospice Program, dated 07/2017, revealed, that in general, it is the responsibility of the facility to	F 842		

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F 842	Continued From page 14	F 842		

meet the resident's personal care and nursing needs in coordination with the Hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. These responsibilities include the following: d. Communicating with the Hospice provider (and documenting such communication) to ensure that the needs of the resident were addressed and met 24 hours per day.

Review of Resident #9's Admission Record revealed the resident had diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side.

Review of a significant change of condition Minimum Data Set assessment, dated 04/20/2022, revealed the resident scored 14 on a Brief Interview for Mental Status, which indicated the resident was cognitively intact.

Review of the resident's Care Plan, dated 06/05/2022, revealed the resident received Hospice care from a contracted hospice provider. The Care Plan indicated the facility would work effectively with the Hospice team to ensure all the resident's needs were met.

A review of the facility's contract dated 04/01/2022, with the contracted Hospice provider for Resident #9, did not reveal any specific details about the form of communication between the facility and Hospice provider.

Review of the Hospice Communication Notes from April 2022 through June 2022 from the Hospice provider, revealed Hospice staff members visited the facility to provide services to Resident #9 on 04/04/2022, 04/12/2022,

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F 842	Continued From page 15 04/15/2022, 04/19/2022, 04/26/2022, 05/09/2022, 05/12/2022, 05/17/2022, 05/19/2022, 05/24/2022, 05/26/2022, 05/31/2022, 06/02/2022, 06/09/2022, 06/13/2022, and 06/27/2022. Review of the resident's Progress Notes, dated from April 2022 through June 2022, revealed no documentation of Hospice staff members visiting the facility to provide services to Resident #9 on any of the above dates. During an interview on 07/07/2022 at 11:17 AM, Staff A, Licensed Practical Nurse (LPN) stated the communication with Hospice was verbal. Staff A indicated Hospice maintained progress notes in their system and the facility's progress notes were maintained in the facility's system. During an interview on 07/07/2022 at 11:21 AM, Staff F, Hospice Case Manager Registered Nurse, stated that all communication with the facility was done verbally. Staff F would let the nurse working with Resident #9 know that Hospice staff members were in the facility and would then tell the same nurse once the visit was completed. Staff F added there was a notebook in the room for communication, but this was intended primarily for family. During an interview on 07/07/2022 at 2:30 PM, Staff B, Registered Nurse, stated that Hospice staff members communicated with facility staff verbally and that the Hospice provider did not leave anything for the facility. Staff B indicated that the communication notebook in the room could be used but there was no clinical documentation in it; it was mainly for family. During an interview on 07/08/2022 at 11:23 AM,	F 842		

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F 842	Continued From page 16 Staff C, Licensed Practical Nurse, stated that all information from Hospice was communicated with the nurse on duty during the visit. Staff C indicated that this information should get put in a progress note by this same nurse. There was a notebook in the room for communication, but this was mainly for family. During a joint interview on 07/08/2022 at 4:49 PM, the Administrator (ADM) and Director of Nursing (DON) revealed they expected the Hospice provider to communicate all information to the facility. They both agreed that communicating this verbally was not sufficient, as things could get lost in translation or forgotten. They added that the Hospice provider should be writing their notes and leaving them with the facility.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		

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F 880	Continued From page 17 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 18 §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 facility policy review, clinical record review, observation, and staff interviews, the facility failed to sanitize the glucometer per manufacturer's recommendations for two of two residents observed during glucose monitoring. (#16 and #33). The facility identified a census of 36 current residents. Findings include: Review of the facility's policy titled Cleaning & [and] Disinfection of Nursing Equipment, dated 06/01/2018, revealed under General Information that Equipment and surfaces are cleansed and disinfected with an EPA [Environmental Protection Agency]-registered and approved disinfectant according to a specified frequency/schedule. III. Procedures Nursing responsibility includes cleaning and disinfecting equipment between patient uses: b. Use of approved disinfection products per manufacturers' guidelines in between resident use. 3. Glucometers: a. Glucometers are cleansed between resident uses (by nursing) if taken to the bedside or when contaminated/soiled. The glucometer is cleaned with approved wipes according to the manufacturer's recommendations c. Glucometer cleaning is accomplished by Nursing Service personnel as assigned.	F 880		

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F 880	Continued From page 19	F 880		

Review of the manufacturer's recommendations from the user's guide for the glucometer in use by the facility revealed the glucometer should be cleaned and disinfected between each patient. The approved products for cleaning and disinfecting the glucometer were Dispatch, Medline Micro-Kill, Clorox Healthcare Bleach Germicidal and Disinfectant Wipes, Medline Micro-Kill Bleach, and germicidal bleach wipes.

A review of Resident #33's Admission Record revealed the facility admitted the resident on 08/25/2020, with a diagnosis of type 2 diabetes mellitus.

Review of the resident's Order Summary Report, dated July 2022, revealed a physician's order for the resident's blood sugar level to be evaluated prior to meals.

A review of the care plan, initiated on 09/14/2020, revealed the resident had an increased risk for an alteration in her blood sugar level, an elevation in her blood sugar level, and/or a decreased blood sugar level related to diabetes mellitus. The care plan included an intervention instructing the facility staff members to measure the resident's blood sugar as the physician ordered.

During an observation of the morning medication administration pass on 07/07/2022 at 11:33 AM, Resident #33 sat in her room in a wheelchair. Staff G, Registered Nurse (RN) removed a glucometer, which was labeled "east," from the top drawer of the medication cart. Staff G pierced Resident #33's finger with a lancet to obtain a blood sample and placed a drop of blood on the test strip that she had inserted into the

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F 880	Continued From page 20	F 880		

glucometer. Staff G did not clean the glucometer prior to obtaining and placing the blood sample to the test strip to obtain the resident's blood glucose level.

2. A review of Resident #16's Admission Record revealed the facility admitted the resident on 06/26/2018 with diagnosis of type 2 diabetes mellitus.

The resident's Order Summary Report, from July 2022, documented a physician's order for the resident's blood sugar to be evaluated prior to meals.

The resident's care plan, initiated on 06/22/2022, indicated the facility had identified the resident was at an increased risk for alteration in their blood sugar levels. The care interventions included instructions that facility staff members need to evaluate the resident's blood sugar level prior to serving her meals, at bedtime, and on an as-needed basis.

During an observation on 07/07/2022 at 12:05 PM, Staff G gathered the supplies needed to test the resident's blood sugar level. Staff G entered the resident's room, cleaned the glucometer with an alcohol swab and proceeded to obtain the resident's blood sample.

During an interview on 07/07/2022 at 12:16 PM, the Director of Nursing (DON) indicated she expected the nursing staff to clean the glucometer before each use with bleach wipes. She provided the facility's policy related to cleaning glucometers and the user's guide for the specific brand of glucometer the facility used. The DON provided a copy of the label taken from the

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F 880	Continued From page 21 container of bleach wipes; the label indicated the solution as approved for cleaning the glucometer. During an interview on 07/08/2022 at 4:50 PM, the Administrator stated she expected the facility nurses to follow what the facility had taught them related to cleaning the glucometer. She also stated the facility would re-educate the nurses regarding infection control measures.	F 880		

Tag # 689 Accidents Hazards/Supervision /Devices

1. Immediate action(s) taken for the resident(s) found to have been affected include:

Resident #29 wrist fracture resolved without complications prior to survey, no further assessment required. Care plan and Kardex reviewed post incident and updated for resident specifics related to upright positioning during bed pan usage, and not pulling / using resident hands during positioning and transferring.

2. Identification of other residents having the potential to be affected was accomplished by:

Facility reviewed all residents for current bed pan usage. There are 8 residents who frequently use the bed pan. Care Plans and Kardexes have been reviewed and updated as indicated.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:

Facility reviewed Azria Safe Lifting and Movement of Residents on 7/12/2022. Nursing staff were educated on the Azria Safe Lifting and Movement of Residents and a bed pan positioning competency was completed with nursing staff to include contracted staff. Competency will be completed on new hire, annually and PRN with nursing staff and applicable contracted staff.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:

DON/Designee will conduct Random observational bed pan positioning audits 3xs weekly x 4 weeks, then weekly x 4 weeks. DON/Designee will bring these audits to QAPI for review.

Corrective action completion date: 7-12-22.

Tag # 690 Bowel/ Bladder Incontinence Catheter UTI – Cath orders

1. Immediate action(s) taken for the resident(s) found to have been affected include:

Resident # 3s catheter was changed and orders further clarified to continue cath changes every 4 weeks on Fridays on 7/8/2022. Resident is scheduled to see an urologist on 8/4/22.

2. Identification of other residents having the potential to be affected was accomplished by:

Facility identified 1 other residents with a catheter- all associated catheter orders were reviewed and updated as indicated by nursing management.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:

Licensed nurses were educated on routine catheter associated orders, order transcription, and following physician orders by nursing leadership post survey.

4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON/Designee will complete an audit of resident(s) catheter orders weekly x 8 weeks, to include transcription of new orders and following physician orders as prescribed. DON/Destinee will bring the audits the audits to QAPI for review.

Corrective action completion date: 8-3-22.

Tag # F842- Resident Records

1. Immediate action(s) taken for the resident(s) found to have been affected include:

Resident #9's applicable hospice information was gathered and placed in a binder. Resident # 9 expired on 7/13/22.

2. Identification of other residents having the potential to be affected was accomplished by:

Currently facility has 1 additional hospice resident. Applicable hospice communication notes were obtained for this resident on and placed in an individually labeled binder at the nurse's station.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:

Administrator has verbally communicated and followed up with written documentation with current Hospice companies the need for documentation to be on site for all hospice patients and will continue to provide this education with newly established hospice contracts. Applicable IDT members and licensed nurses were educated by Administrator/Designee on Azria Hospice Program Policy and the binders located at the nurses' station.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:

Administrator/Designee will audit all Hospice Binders to ensure applicable documentation is present 2xs weekly for 4 weeks, then weekly x 4 weeks. Administrator/designee will take these audits to QAPI for review.

Corrective action completion date: 8-3-22.

Tag # F880 Infection Prevention & Control

1. Immediate action(s) taken for the resident(s) found to have been affected include:

There were no adverse occurrences associated with glucometer cleaning practices for residents # 33 or #16. Licensed nurses were educated and competencied during the survey on glucometer policy and practice, initiated 7/7/222.

2. Identification of other residents having the potential to be affected was accomplished by:

Facility identified 7 residents who receive accuchecks. No adverse occurrences associated with glucometer cleaning for these residents noted. Licensed nurses were educated and competencied on Azria Glucometer policy and practice by nursing leadership starting 7/7 /22.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:

Licensed nurses were educated and competencied on Azria Glucometer policy and practice by nursing leadership starting 7/7 /22. The Azria Glucometer Competency will be added to new hire orientation, completed and annually, and PRN.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:

DON/Designee will conduct observational audits of glucometer cleaning 3xs weekly for 4 weeks, then weekly x 4 weeks. DON/Designee will take the audits to QAPI for review.

Corrective action completion date: 8-3-2022.