STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125019	A. BUILDING _____ B. WING _____	08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARE CENTER OF HONOLULU	1900 BACHELOT STREET HONOLULU, HI 96817

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 08/08/2022 to 08/12/2022. The facility was not in compliance with 42 CFR 483 Subpart B. Four facility-reported incidents (ACTS #HI9654, #HI9642, #HI9601, and #HI9457) were investigated and not substantiated. Survey dates: 08/08/2022 to 08/12/2022 Census: 155 Sample size: 31	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		9/24/22

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

Electronically Signed | 09/19/2022

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews, and facility policy review, the facility failed to conceal the urine collection bag for a resident's indwelling urinary catheter to maintain dignity for 1 (Resident #8) of 1 sampled resident reviewed for urinary catheter management. Findings included: Review of a facility policy titled, "Dignity," revised 02/2021, revealed, "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation 1. Residents are treated with dignity and respect at all times." Review of an "Admission Record" revealed	F 550	Resident #8 catheter bag was covered on 8/8/22. Follow-up visit by DON with resident on 9/2/22 found catheter bag was covered and resident had no concerns. Residents residing in the facility with catheters have the potential to be affected. Observation audits were done on 9/2/22 with no additional residents identified. DON/Designee re-educated CNAs, Licensed Nurses and other staff members starting 8/18/22, and on an ongoing basis, regarding the importance of maintaining residents' dignity by concealing the urine collection bag of residents with indwelling catheters.	

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F 550	Continued From page 2 Resident #8 had diagnoses including acute respiratory failure with hypoxia (failure of the respiratory system to maintain adequate levels of oxygen in the blood), quadriplegia (paralysis of all four limbs), and encounter for fitting and adjustment of urinary device. Review of a quarterly Minimum Data Set (MDS), dated 05/10/2022, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. According to the MDS, the resident was totally dependent on two or more people for bed mobility, dressing, and toilet use. The MDS also indicated the resident had an indwelling catheter and was always incontinent of bowel. Additionally, the MDS indicated the resident received tracheostomy care and suctioning while a resident. Review of an "Order Summary Report" revealed Resident #8 had a physician's order dated 05/01/2022 for a 16 French urinary catheter due to a diagnosis of neurogenic bladder. Review of a "Care Plan," dated as initiated on 08/08/2022, revealed Resident #8 had an indwelling urinary catheter. Interventions included to keep the catheter bag and tubing positioned below the level of the bladder and keep the drainage bag covered. On 08/08/2022 at 10:14 AM, Resident #8 was observed lying in bed, with a urinary catheter drainage bag hanging from the bedframe without a privacy cover in place. The catheter bag contained urine and was visible from the hallway outside the resident's room.	F 550	DON/Designee will conduct dignity focused observation audits of 6 residents on various units weekly to verify that urine collection bags are covered x 4 weeks, then 3 residents weekly x 4 weeks. In addition, observation of dignity bags is included on the facility's Leadership Rounds Tool to verify ongoing compliance. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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F 550	Continued From page 3 During an observation and interview on 08/08/2022 at 10:21 AM, Registered Nurse (RN) #5 revealed Resident #8's catheter bag should be in a privacy bag and considered it a dignity issue that it was visible from the resident's doorway. She revealed the Certified Nursing Assistants (CNAs) and nurses were responsible for ensuring catheter bags were covered. During an observation and interview on 08/08/2022 at 10:27 AM, CNA #3 acknowledged that Resident #8's catheter bag was visible to others from the resident's doorway. She indicated she would get a cover and place it on the catheter bag, because this was a dignity issue. She indicated CNAs were responsible for ensuring catheter bags were covered. During an interview on 08/10/2022 at 10:01 AM, the Director of Nursing (DON) revealed she expected catheter bags to be maintained in a privacy bag to promote residents' dignity. She indicated she considered it a dignity issue for the catheter bag to not be covered. She stated the CNAs and nurses were responsible for ensuring catheter bags were maintained with privacy covers. During an interview on 08/11/2022 at 10:14 AM, the Administrator revealed she expected catheter bags to be covered for a resident's privacy and dignity. She indicated she considered it a dignity issue for a catheter bag to be visible from the hallway without a cover. She indicated the direct care staff were responsible for ensuring catheter bags were covered to promote residents' dignity.	F 550		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		9/24/22

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F 657	Continued From page 4 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to revise the comprehensive care plan to address an increased need for assistance during meals for 1 (Resident #104) of 2 sampled residents reviewed for nutrition. Findings included:	F 657	Resident #104 care plan has been updated to address the increased need for assistance during meals. Residents residing in the facility requiring assistance during meals have the potential to be affected. Observation audits of residents during meals will be completed and those identified will have	

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F 657	Continued From page 5 Review of a facility policy titled, "Care Plans, Comprehensive Person-Centered," revised March 2022, revealed, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." The policy also indicated the comprehensive, person-centered care plan, "b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being including" and "reflects currently recognized standards of practice for problem areas and conditions." Additionally, the policy indicated, "12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition." A review of Resident #104's "Admission Record" revealed the resident had diagnoses of hemiplegia (paralysis on one side of the body) affecting the left nondominant side, dysphagia (difficulty swallowing) following cerebral infarction, and encephalopathy (a disease that affects brain function or structure and causes an altered mental state or confusion). Review of a quarterly Minimum Data Set (MDS), dated 04/21/2022, revealed Resident #104 scored 14 on a Brief Interview for Mental Status (BIMS), which indicated the resident was cognitively intact. The MDS indicated the resident required only set-up assistance to eat independently. Review of a significant change MDS, dated 07/13/2022, revealed Resident #104 scored 10	F 657	their care plan updated as indicated. DON/Designee re-educated Licensed Nurses on 8/25/22, and on an ongoing basis, regarding the care plan process and importance of updating residents plan of care. DON/Designee re-educated interdisciplinary team on 9/2/22, on an ongoing basis, on process of updating care plans. In addition, residents who may require assistance during meals will be discussed in Morning Clinical Meeting and interventions will be created as needed. DON/Designee will conduct random audits to include residents on each unit weekly x 8 weeks to verify that care plans have been revised to address recent/current changes in residents feeding assistance need if indicated. In addition, checking if resident needs additional assistance was added to the facility s Leadership Rounds Tool to verify ongoing compliance. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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F 657	Continued From page 6	F 657		

on a BIMS, which indicated moderate cognitive impairment. The MDS indicated the resident required extensive assistance of one person with eating, which represented a decline in the resident's eating ability had occurred since the previous MDS.

Review of a "Care Plan," dated as last reviewed 05/09/2022, revealed the following focus areas for Resident #104:
- A focus area dated as revised 11/12/2021 indicated Resident #104 had limited physical mobility due to a stroke and weakness.
- A focus area dated as revised 11/12/2021 revealed Resident #104 had a cerebrovascular accident (CVA - a stroke) affecting the left non-dominant side, resulting in hemiplegia. Interventions included to monitor/document the resident's ability to chew and swallow and if the resident presented with problems, to obtain an order for speech therapy to evaluate and treat.
- A focus area dated as revised 11/12/2021 revealed Resident #104 had a swallowing problem due to dysphagia secondary to a CVA.
- A focus area dated as revised 04/25/2022 indicated Resident #104 had a nutritional problem related to diet restrictions. Interventions included to monitor/document/report as needed any signs and symptoms of dysphagia.
The "Care Plan" was not revised to address the resident's need for extensive assistance with eating, as identified on the significant change MDS dated 07/13/2022.

Observation on 08/08/2022 at 12:52 PM in Resident #104's room revealed the resident was in bed attempting to eat lunch. No staff member was present to assist the resident. The resident picked up the fork, scooped up a small amount of

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F 657	Continued From page 7	F 657		

corn, and brought the fork to his/her mouth, but the resident's hand was visibly shaking, and the resident was struggling to keep the food on the fork. Resident #104 stated, "My [family member] usually feeds me."

During an interview on 08/10/2022 at 8:46 AM, Certified Nursing Assistant (CNA) #4 revealed Resident #104 did require assistance with every meal and that Resident #104's family member usually came to the facility to assist the resident with eating. If the family did not come in, staff would assist. CNA #4 added that if a resident required any additional assistance, this would be indicated on the KARDEX.

During an interview on 08/10/2022 at 12:10 PM, Resident #104's family member confirmed he/she came to the facility to assist the resident with most meals.

During an interview on 08/11/2022 at 9:49 AM, CNA #5 revealed she checked the KARDEX to find out what assistance residents needed.

During an interview on 08/11/2022 at 9:52 AM, Registered Nurse (RN) #8 revealed nurses looked at the care plans and the CNAs looked at the KARDEX to find out what assistance residents required.

Review of the KARDEX sheet for Resident #108 on 08/11/2022 revealed the section for Eating/Nutrition did not address the resident's need for extensive assistance with eating.

During an interview on 08/11/2022 at 12:47 PM, the Director of Nursing (DON) confirmed Resident #104 needed extensive assistance with

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F 657	Continued From page 8 eating and stated this should be care planned. During an interview on 08/11/2022 at 1:22 PM, the Administrator stated Resident #104's eating assistance should be care planned and she was not sure why this was not added to the current care plan.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure care and services were provided in accordance with physician's orders and accepted standards of practice for two sampled residents (Resident #105 and Resident #137). Specifically, the facility: - failed to conduct and document thorough assessments of a non-pressure related wound to enable healing progress to be tracked or deterioration to be promptly identified for 1 (Resident #105) of 1 sampled resident reviewed for non-pressure related skin conditions. - failed to ensure physician's orders for laboratory (lab) services were consistently followed to allow the physician to titrate anticoagulant (blood thinner) medication dosages for 1 (Resident	F 684	Resident #105 skin assessment and documentation was completed on 8/15/22. Wound round was also completed with the provider on 8/24/22 with new orders. DON monitored resident #137 labs with no additional concerns and no negative impact noted, resident was discharged from the facility on 8/14/22 due to other comorbidities and returned under hospice services. Residents with non-pressure related wounds may be at risk and will be audited to verify that assessment and measurement(s) were documented, MD orders are current, and care planned. Residents receiving coumadin/warfarin	9/24/22

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F 684	Continued From page 9 #137) of 1 sampled resident reviewed for lab monitoring of anticoagulant therapy. Findings included: 1. Review of a facility policy titled, "Wound Care," revised October 2010, revealed, "The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e. [meaning], wound bed color, size, drainage, etc. [et cetera]) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data." Review of an "Admission Record" revealed Resident #105 had diagnoses that included leprosy and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting right dominant side. Review of a quarterly Minimum Data Set (MDS), dated 07/14/2022, indicated Resident #105 scored 14 on a Brief Interview for Mental Status (BIMS), indicating the resident was cognitively intact. Per the MDS, the resident had no ulcers or other skin problems and received application of nonsurgical dressings other than to feet and received application of ointments/medications other than to feet.	F 684	may be at risk and an audit will be conducted to verify that labs were done per MD orders. Revisions and education will be done as indicated. DON/Designee re-educated Licensed Nurses on 8/25/22, and on an ongoing basis, regarding the importance of providing and documenting care and services per MD orders and accepted standards of practice for wounds and labs. Non-pressure related wounds will be reviewed at the Skin and Nutrition Meeting to track healing progress or promptly identify deterioration as needed. New PT/INR orders will be reviewed in the morning clinical meeting to verify that MD orders were followed to allow the physician to titrate medication dosages as needed. Wound Nurse/Designee will conduct audits of 6 residents with non-pressure related wounds per week for 4 weeks, then 4 per week for 4 weeks to verify that assessments and thorough documentation was completed. DON/Designee will audit residents with PT/INR lab orders weekly x 8 weeks to verify that it was followed, and concerns were addressed timely. DON/Wound Nurse/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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Review of an "Order Summary Report" revealed Resident #105 had a physician's order dated 03/27/2022 for halobetasol propionate cream 0.05% to be applied to the right knee topically every day and evening shift for open areas. The directions were to cleanse with normal saline, cover with a non-adherent dressing, and wrap with kerlix (rolled gauze).

Review of "Care Plan," dated 04/14/2022, revealed the resident had potential/actual impairment of skin integrity. The care plan did not specify the location or type of skin impairment involved. Interventions included avoiding scratching, following the facility's protocols for treatment of injury, and conducting a systematic skin inspection every shift.

Review of "Skin Observation Tools," dated 05/01/2022 and 05/08/2022, revealed Resident #105 had right knee lesions that persisted. The top lesion was intact with no discharge and the lower part of the lesion had scant drainage from the old dressing.

Review of "Skin Observation Tools," dated 05/14/2022, 05/21/2022, and 05/28/2022 indicated Resident #105 had existing wounds to the right knee and right lower leg. The notes on the forms dated 05/21/2022 and 05/28/2022 indicated the wounds looked like swollen blisters. No measurements were documented on any of the forms.

Review of "Skin Observation Tools," dated 06/04/2022, 06/12/2022, 06/19/2022, 06/26/2022, 07/03/2022, 07/10/2022, 07/17/2022, 07/24/2022, 07/31/2022, and 08/07/2022, indicated Resident #105 had existing wounds to the right knee and

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right lower leg. All the forms dated from 06/04/2022 through 08/07/2022 indicated the wounds appeared flat. No measurements were documented on any of the forms.

During an observation on 08/08/2022 at 3:06 PM, Resident #105 had an area to the right knee where an alteration was visible in the resident's skin. There was also a bandage on the inner aspect of the knee.

During an observation on 08/09/2022 at 10:52 AM, Resident #105 had a bandage to the right inner knee.

During an interview on 08/09/2022 at 11:02 AM, Licensed Practical Nurse (LPN) #1 stated the wound on Resident #105's knee was an old leprosy wound. LPN #1 stated the nurses applied a cream twice per day. LPN #1 stated the wound was sometimes flat and other times, it was bumpy with drainage. LPN #1 stated the wound was the same since she started on the unit last year.

During an interview on 08/10/2022 at 11:11 AM, Wound Care Nurse #1 stated she did not deal with the non-pressure related wounds.

During an interview on 08/10/2022 at 12:05 PM, LPN #1 stated that after a wound treatment was completed, it was marked on the Treatment Administration Record (TAR). LPN #1 stated if she noticed anything unusual or new about the wound, she would document. LPN #1 stated documentation was on the weekly skin assessment.

During an interview on 08/10/2022 at 12:09 PM,

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Unit Manager (UM) #1 stated the nurses used the weekly skin observation tool and every time the treatment was rendered, they looked at the wound and compared.

During an observation on 08/10/2022 at 1:30 PM, Treatment Nurse #1 prepared a treatment for the resident's knee. She stated she was going to perform the wound treatment for Resident #105. Treatment Nurse #1 applied normal saline to a gauze pad and cleaned the wound. Treatment Nurse #1 stated she had already removed the bandage from the previous treatment. Treatment Nurse #1 stated she applied a non-adherent bandage because the gauze was saturated when it was removed. When asked what the treatment order consisted of, Treatment Nurse #1 stated she had come to the room to do a skin assessment, and there was not a current order for treatment that she was aware of, but she covered the wound, because the physician would not want it uncovered. When asked if the halobetasol propionate cream was discontinued, Treatment Nurse #1 stated she did not know. Treatment Nurse #1 went on to say that the halobetasol propionate cream was started two years ago, and she was not sure of the effectiveness of the treatment.

Review of a "Skin and Wound Evaluation," dated 08/10/2022, revealed a wound to Resident #105's right shin was described as an abscess that measured 2.4 centimeters (cm) by 3.5 cm and was warm to touch. Per the evaluation, the wound had light, serosanguineous drainage (thin, watery drainage with a pink or red hue) present.

During an interview on 08/10/2022 at 1:08 PM, Registered Nurse (RN) #1 stated the resident

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received a wound treatment twice per day and that the wound on the resident's knee been in the same condition for a long time. RN #1 stated sometimes the wound opened, sometimes it was closed, sometimes it was flat, and sometimes there was discharge.

During an interview on 08/10/2022 at 2:03 PM, Treatment Nurse #1 stated the reason she had looked at the wound on Resident #105 was because the orders had been in place for so long, she was looking to see if it needed a different form of treatment. Treatment Nurse #1 stated the skin alteration looked like an abscess. She stated the wound was closed but there was a spot that "oozes a little" when touched.

During an interview on 08/10/2022 at 2:38 PM, UM #1 stated she was not sure if the doctor had seen the wound. UM #1 stated Resident #105's wound was sometimes opened and sometimes closed. UM #1 stated the doctor should have been notified if the wound got bigger, reopened, or if there was drainage.

During an interview on 08/10/2022 at 3:04 PM, Wound Care Nurse #1 stated that Resident #105's wound appeared to be very old. Wound Care Nurse #1 stated she spoke to the doctor and had Resident #105 added to wound rounds for the following week. Wound Care Nurse #1 stated the wound was an abscess, and Treatment Nurse #1 had told her it felt a little warm. Wound Care Nurse #1 stated the doctor would probably want the wound cultured.

During an interview on 08/11/2022 at 9:58 AM, the Director of Nursing (DON) stated nurses should have documented in a "Progress Note,"

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even for non-pressure related skin conditions. The DON stated Resident #105's wound fluctuated; it improved and then got worse. The DON stated the nurses should have documented whether the wound was improving, the same, or getting worse, as well as described and measured it. The DON stated Resident #105's wound should have been discussed with the wound team.

During an interview on 08/11/2022 at 12:45 PM, the Administrator stated she was told Resident #105 had a wound treatment for a while, and the Medical Director was notified for further guidance. The Administrator stated the nurses should have documented the size and drainage of the wound to show if it was progressing or getting worse.

During an interview on 08/11/2022 at 2:38 PM, Wound Care Nurse #1 stated she had followed up with the wound care provider and they were researching, because the doctor was relating the wound to leprosy that went as far back as 2001. The doctor told Wound Care Nurse #1 not to change the treatment, because they were still researching, and they were going to reach out to specialists to find out if the current order was the correct treatment. The doctor told Wound Care Nurse #1 they would see Resident #105 on wound rounds the following week.

2. Review of a facility policy titled, "Anticoagulation-Clinical Protocol," revised November 2018, revealed, "The physician should adjust the anticoagulant dose or stop, taper, or change medications that interact with the anticoagulant, and/or monitor the PT/INR [prothrombin time/international normalized ratio - a lab test to monitor blood clotting in individuals

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on anticoagulant therapy] very closely while the individual is receiving warfarin [an anticoagulant medication], to ensure that the PT/INR stabilizes within a therapeutic range."

Review of an "Admission Record" revealed the facility admitted Resident #137 on 07/21/2022 with diagnoses that included paroxysmal atrial fibrillation and long-term use of anticoagulants.

Review of an admission Minimum Data Set (MDS), dated 07/24/2022, revealed Resident #137 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment, indicating moderate cognitive impairment.

Review of an "Order Summary Report" revealed Resident #137 had a physician's order dated 07/24/2022 for a PT/INR every Wednesday and Sunday evening/night for warfarin maintenance. The most recent warfarin order was dated 08/01/2022 and indicated the resident was to receive warfarin sodium 1.5 milligram by mouth once daily for anticoagulation.

Review of a "Progress Note," dated 07/28/2022 revealed the PT/INR specimen sent to the lab had no label and the lab was unable to process it. The physician was informed and ordered the PT/INR to be repeated on 07/29/2022.

Review of a "Lab Results Report," dated 07/28/2022, revealed the PT/INR lab was not processed because the specimen was received unlabeled and was stored at the wrong temperature.

Review of a "Lab Results Report," dated 07/29/2022, revealed Resident #137's INR was

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5.8, which was significantly higher than the listed therapeutic ranges of 2.0 to 3.5.

Review of a "Progress Note," dated 08/04/2022, revealed the PT/INR was not processed because the specimen was placed in the wrong specimen container. The physician was informed and ordered the PT/INR to be drawn again on 08/05/2022.

Review of a "Lab Results Report," dated 08/04/2022, revealed lab was canceled because the appropriate specimen type for testing was not received. The report indicated the specimen was not drawn by lab personnel.

During an interview on 08/11/2022 at 9:41 AM, Registered Nurse (RN) #3 stated Resident #137 had orders for a PT/INR to be drawn every Wednesday and Sunday. RN #3 stated there was a PT/INR drawn on August 4, but there was a problem with the specimen, so it was redrawn.

During an interview on 08/11/2022 at 10:44 AM, Unit Manager #2 stated the facility had a company that drew lab specimens but if needed, the facility nurses would sometimes draw the specimens. Unit Manager #2 stated Resident #137's INR fluctuated a lot and that if it was high, the resident could have spontaneous bruising and if the resident fell, he/she would be at high risk for hemorrhage (uncontrolled bleeding).

During an interview on 08/11/2022 at 12:28 PM, the Director of Nursing (DON) stated there was an occasion when the facility did not get the results for Resident #137's PT/INR because the wrong tube was used for the specimen. The DON stated it did not happen often, but that it did

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F 684	Continued From page 17 sometimes. The DON stated if a lab was missed, it could have been dangerous for the resident. Further, the DON stated if there was a critical high lab result, the facility would have needed to watch for cuts and bruising. During an interview on 08/11/2022 at 12:58 PM, the Administrator stated she was not aware of the issues with lab draws.	F 684		
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, 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:	F 880		9/24/22

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F 880	Continued From page 18 (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. §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:	F 880		

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F 880	Continued From page 19 Based on observations, record review, interviews, and facility policy review, the facility failed to ensure staff performed hand hygiene/changed gloves prior to performing medication administration via gastrostomy tube (g-tube) for 1 (Resident #113) of 1 sampled resident reviewed for medication administration via g-tube. Findings included: Review of a facility policy titled, "Administering Medication through an Enteral Tube," revised 11/2018, revealed, "The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube." The policy also indicated, "Steps in the Procedure 1. Wash your hands." Review of an "Admission Record" revealed Resident #113 had diagnoses which included gastrostomy status and tracheostomy status. Review of a quarterly Minimum Data Set (MDS), dated 07/22/2022, revealed Resident #113 scored 15 on a Brief Interview for Mental Status (BIMS), which indicated the resident was cognitively intact. Per the MDS, the resident required extensive assistance with bed mobility and was totally dependent on the assistance of one person for eating. The MDS also indicated the resident had a feeding tube through which he/she received 51% or more of the total caloric intake and 501 cubic centimeters (cc) per day of fluid intake. Review of an "Order Summary Report" revealed Resident #113 had a physician's order dated 07/16/2022 for gabapentin 100 milligrams (mg).	F 880	Resident #113 did not develop an infection based on review of medical record and vital signs by DON on 9/2/22. On 8/12/22, Registered Nurse #1 was educated by DON/ADON on proper administration of medication via gastrostomy tube (g-tube). Residents on tube feeding have the potential to be affected. Med pass observation of Licensed Nurses providing medications via g-tube will be completed and newly identified concerns will be addressed. DON/Designee re-educated Licensed Nurses on 8/25/22, and on an ongoing basis, on the importance of performing hand hygiene and changing gloves prior to performing medication administration via g-tube. DON/Designee will conduct med pass observations of 4 residents receiving medications via g-tube weekly for 8 weeks to verify that infection control practices were followed. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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The directions were to give one capsule via g-tube three times daily for neuropathic pain.

Observations on 08/10/2022 at 12:32 PM revealed Registered Nurse (RN) #1 preparing to administer medication to Resident #113 via the resident's g-tube. The RN entered the resident's room and washed his hands, then donned gloves. He then obtained the assistance of a certified nursing assistant (CNA) to reposition the resident in bed. After the resident was repositioned, the RN proceeded to administer medication via the resident's g-tube without first washing his hands/changing gloves.

During an interview on 08/10/2022 at 12:46 PM, the surveyor reviewed the above observation with RN #1. He stated he should have performed hand hygiene and donned clean gloves prior to handling the gastrostomy tubing and supplies to administer the medication.

During an interview on 08/12/2022 at 9:51 AM, Licensed Practical Nurse (LPN) #2 stated a nurse should wash hands and don clean gloves just prior to beginning medication administration via a g-tube.

During an interview on 08/12/2022 at 9:55 AM, RN #7 stated a nurse should wash hands and don clean gloves just prior to beginning medication administration via a g-tube.

During an interview on 08/12/2022 at 7:54 AM, the surveyor informed the Director of Nursing (DON) of the observation of RN #1 administering medications to Resident #113. When asked if she would have expected the RN to perform hand hygiene and change gloves after repositioning the

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F 880	Continued From page 21 resident, prior to handling the g-tube and supplies, she stated, "Of course." During an interview on 08/12/2022 at 7:57 AM, the surveyor informed the Administrator of the observation of RN #1 administering medication to Resident #113. The Administrator stated she would have expected the RN to perform hand hygiene and change gloves after repositioning the resident, prior to handling the g-tube and supplies.	F 880		