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	125048	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN PEARL NURSING FACILITY	45-181 WAIKALUA ROAD KANEOHE, HI 96744

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F 000	INITIAL COMMENTS The Department of Health, Office of Health Care Assurance, conducted a recertification survey on March 22, 2024. The facility was found not to be in compliance with 42 CFR §483, Subpart B. Aspen complaint tracking system (ACTS) intake #10807 was investigated and found not in compliance at 483.10 (g)(14) Notification of changes. The highest scope and severity (S/S) = G at F580 Notify of Changes. Survey dates: March 19, 2024, to March 22, 2024. Census: 45 Sample Size: 14	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	F 550		5/3/24

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

Electronically Signed | 04/26/2024

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all 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 observation, interview and record review, the facility failed to maintain the dignity of one of the 14 residents (R) in the sample. The urinary catheter bag for R101 was not covered and visible from the hallway, revealing his medical condition to other residents and visitors to the facility. This deficient practice has the potential to affect all residents in the facility with an indwelling urinary catheter. Findings include: R101 is an 80-year-old resident admitted to the facility on 03/12/24 for short-term rehabilitation and wound care. R101 had an indwelling urinary catheter (flexible tube placed in the body to drain	F 550	This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. Resident #101 no longer resides at the facility. He was discharged home on 4/10/24. Facility residents who have urinary	

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F 550	Continued From page 2 and collect urine from the bladder) to prevent getting the wounds to groin area wet. On 03/19/24 at 08:47 AM, observed R101 lying in bed in his room watching videos on his tablet. R101's bed was positioned closest to the door and is visible from the hallway. The collection bag for his indwelling urinary catheter was hung on the right side of his bed facing the door. There was no cover for the bag. On 03/21/24 at 3:01 PM, an interview was conducted with Licensed Practical Nurse (LPN) 50 just outside of R101's room. Asked LPN50 what was the reason they cover the collection bag for the indwelling urinary catheter. LPN50 responded "The cover for the bag is used to maintain the resident's dignity." LPN50 added. It's supposed to be on the collection bag all the time, even when they get up on their wheelchairs." Review of R101's baseline care plan done. Under the problem "Indwelling Catheter", intervention included but not limited to, "Keep drainage bag below level of bladder. Place in dignity bag."	F 550	catheter bags have the potential to be affected by this alleged practice. Nursing staff were inserviced by the Director of Nursing (DON)/Designee on Residents Rights and Dignity with an emphasis on residents who have urinary catheter bags. Nursing staff will use privacy bags to house urinary catheter bags to maintain the dignity of those residents. DON/Designee will round on units 2x/week to audit for compliance with providing dignity for those residents with urinary catheter bags to ensure they are not exposed. Audits will be done weekly for a minimum of 12 weeks or until the Quality Assurance Performance Improvement (QAPI) committee determines compliance is achieved. The results of these audits will be brought to the QAPI meeting monthly for a minimum of 3 months for review and recommendations.	
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		5/3/24

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mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

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F 580	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the resident's (R)12's physician was notified after an incident that occurred resulted in an injury for one resident sampled. On 02/08/24, R12 reported that during physical therapy he experienced a loud crack and sharp pain to his hip when physical therapist (PT)1 pushed R12's left knee to the resident's chest. R12's physician and his treatment team were not notified of the incident which resulted in a left hip fracture that was delayed in diagnosis and treatment. On 02/26/24, R12 was transferred to a hospital for a surgical repair of the fracture. As a result of this deficient practice, R12 suffered pain, continued to decline and sustained harm. Findings include: Cross reference to F610 Investigation. During an interview with R12 on 03/20/24 at 2:40 PM in his room, he stated he recently had hip surgery. R12 reported during physical therapy during an assisted exercise of his legs, the physical therapist (PT)1 was pushing his legs to his chest. When PT1 extended his left leg on the third push to his chest, he heard a crack and felt a sharp pain. The PT1 then stopped and stated, "All pau (finished) for the day". Conducted a review of R12's electronic health record (EHR) of the incident. Minimum Data Set (MDS) with an assessment reference date (ARD) of 12/22/23, documented in Section C. Cognitive Patterns, R12 scored a 15 out of 15, indicating the resident's cognition is intact.	F 580	The nurse involved with Resident #12's care was inserviced on timely notification of changes and interdisciplinary team communication on 4/2/24. Facility residents who have a change in condition have the potential to be affected by this alleged practice. Nursing staff were inserviced by the DON/Designee on the INTERACT Program with emphasis on timely notification of Change of Condition call protocols and interdisciplinary team communication. DON/Resident Care Managers (RCMs)/Designee will monitor for compliance through record review audits weekly for a minimum of 12 weeks or until the Quality Assurance Performance Improvement (QAPI) committee determines compliance has been achieved. The results of these audits will be brought to the QAPI meeting monthly for a minimum of 3 months for review and recommendations.	

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Reviewed progress notes of R12's reported incident:

-02/02/24 at 8:50 PM, Nurse Practitioner (NP) in facility with new order to obtain x-ray of the left knee and left hip. Order carried out.

-02/06/24 at 8:54 PM, NP in facility with new orders. Referral to orthopedic surgeon for further eval for osteo arthritis (OA) to left (L) hip and L knee (Send copies of recent x-rays). Start Tramadol (pain medication) 50 milligrams (mg) every night (QHS) for right (R) knee pain. Orders carried out.

-02/07/24 at 08:10 AM, Received and reviewed progress note from NP facility visit on 02/2/24, seen for knee pain. See scanned note for details.

-02/08/24 02:02 AM, Nurses notes. Resident complained of (c/o) 10/10 sharp pain to left knee whenever he moves it. Resident states he hurt it while he was in PT. Resident mention that the guy was pushing it down and lifting his knee against his chest and resident heard a loud crack noise. No sign of swelling or redness to area. Resident unable to fully make his left knee straight. Administered as needed (PRN) tramadol and hot pack. P: continue plan of care.

Review of R12's progress notes after reporting the incident to registered nurse (RN)99.

-02/12/24 02:43 AM, resident awake when entering room to care for another resident, resident voiced he was in pain to the right lower extremity (RLE). The resident was asked to rate it and voiced 5/10. Resident was given the option

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of PRN Tylenol or PRN tramadol; residents request was PRN tramadol. Given 0244.

-02/13/2024 at 4:12 PM, NP in facility with new orders. Apply a small amount of Voltaren to L hip and L knee and reposition. Offer heat packs PRN. Orders carried out.

-02/14/24 at 1:45 PM, Received and reviewed progress note from NP facility visit on 2/6/24, seen for follow up on pain. See scanned note for details.

-02/15/24 at 13:59, medical doctor (MD) in facility. Reviewed x-ray on 2/3/24, see scanned note for details.

-02/19/24 at 2:32 PM, ...Resident states that he is unable to move left knee since two nights ago. Residents had complaints of pain to L knee...

-02/20/24 at 5:11 PM, NP in facility with new orders to repeat X-ray of L hip and L knee for Diagnosis (Dx). Pain. Orders carried out. Imaging to be here late this evening.

-02/20/24 at 8:20 PM, Received X-ray results: L knee unchanged. L hip: New acute avulsion fracture involving the lesser trochanter, along the attachment of the iliopsoas tendon. Called physician, awaiting call back. Notified director of nursing (DON).

- 02/23/24 at 9:48 PM, Resident continue to have left hip pain 10/10, noted left leg unable to move ...New order to send resident to ... (acute hospital) ...for evaluation. Acute lack of sensation to left lower extremities (LLE); diminished sensation to RLE ...Resident left facility at 9:40

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PM"

-02/24/24 02:27AM, Called Emergency department for an update on resident. Resident was admitted for Hip fracture. DON and resident clinic manager (RCM) notified.

Review of provider notes documented:

- 02/13/24, NP1 documented, He presented in stable condition but noted to still have pain to his left knee and hip at rest and with movement. He notes pain cream was effective to left knee but had not tried to hip. Reported tramadol was effective during night to both led hip and knee pain. Was still able to reposition left leg but limited ROM (range of motion). Noted PT was held due to (d/t) pain. Requested for trial of pain cream to hip and encouraged him to request for PRN tramadol during day if needed since only scheduled QHS. Discussed if pain did not improve will repeat imaging.

- 02/20/24, NP1 documented,
-"Since x-ray on 2/3, he initially reported pain improved with tramadol, pain cream, and repositioning of left side. Prior ortho referral was still pending.
- Today registered nurse (RN) reported he was not able to move his left leg. During the visit, he noted he was also unable to tolerate turning side to side with certified nurse aide (CNA). During the exam, he was not able to move or straighten his leg and noted to have more tenderness to his left hip and surrounding area. No warmth, edema, erythema noted. Still had lack of sensation below the knee, which he stated having in the past but intact sensations proximal from knee. Skin remained warm to touch along with extremity,

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given pain progressed, he agreed to repeat x-ray."

-02/23/24, NP1 documented, "Today during his visit, he noted since he was last seen, he lost sensation to his left upper leg and knee as well as right upper leg. Of note, had loss of sensation below knee which was his baseline. The pain to L-leg described as sharp but still unable to move but noted Tramadol; was slightly effective. During exam, he was noted to also loss sensation to his left hip and surrounding area upon palpation, which he had pain to on Tuesday..."

Review of x-ray results taken on 02/03/24 documented " ...No obvious displaced or impacted fracture noted at this time .... No evidence of osteomyelitis ..." A second x-ray taken on 02/20/24 documented "There is an avulsion fracture of the lesser trochanter, new from prior ..." An avulsion fracture occurs when an injury causes a ligament or tendon to break off (avulse) a piece of a bone that's attached to it and usually happens as the result of a traumatic injury or explosive movement. Indicating an incident with force needed to have happened for this type of injury to occur.

On 03/20/24 at 2:55 PM, conducted a confidential interview with direct care staff (DCS). Inquired regarding R12's level of function prior to sustaining a left hip fracture. DCS1 and DCS2 confirmed prior to physical therapy, R12 was able to move his lower extremities, but was unable to bear weight. Both DCS confirmed R12 informed them that during a physical therapy session, there was a loud pop, then sharp pain, then over the next couple of days the resident's pain increased and his movement decreased to the point R12

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decided he shouldn't do physical therapy, related to the pain. Inquired with both staff about R12's cognition and if the resident is a reliable source of information. DCS1 and DCS2 confirmed R12 is a reliable source of information, and the resident is alert and oriented to person, place, time, and situation.

On 03/21/24 at 3:45 PM, conducted an interview with the DON, resident care manager (RCM)1 and RCM2 regarding the facility's investigation of R12's hip fracture. Reviewed the facility's investigation which was submitted to the state agency (SA). Informed the DON, RCM1, and RCM2 about the progress note written on 02/08/24 by RN99 during which R12 informed the staff of an incident during physical therapy regarding the resident hearing a loud crack and felt a sharp pain. Inquired if the facility was aware of the situation. DON, RCM1, and RCM2 reviewed R12's EHR, the facility's morning meeting huddle information and all other additional documents then confirmed the facility was not aware of R12's report of the incident to RN99 and it was not investigated as a potential source of R12's left hip fracture. RCM1 and RCM2 both confirmed R12 is a reliable source of information.

On 03/22/24 at 08:54 AM, conducted an interview and concurrent record review with NP1. Inquired if NP had been informed that R12's verbalized incident during a physical therapy session, where PT1 assisted the resident with range of motion and the resident heard a loud crack and experienced a sharp pain. NP1 confirmed she was not notified of the incident. Reviewed R12's progress notes and inquired if she had been informed of the incident would the course of

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F 580	Continued From page 10 treatment have been different. NP1 confirmed, the course of treatment would have been different, an x-ray would have been done on 02/08/24 to ensure there was no injury to the resident. The identification of an injury would have ended all future physical therapy sessions, and the resident would have been sent out to an acute setting for further treatment. NP1 confirmed R12's treatment was delayed 12 days. NP1 stated she was in close communication with R12's physician and confirmed they both were not informed of R12's report of the incident. Review of the facility's policy and procedure, change in a Resident Condition of Status, revision date 05/19/23, documented " ...The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): 1. accident or incident involving the resident; b. discovery of injuries of an unknown source..."	F 580		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 610		5/3/24

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F 610	Continued From page 11 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure an injury of unknown origin was thoroughly investigated for one resident sampled. On 02/25/24, the facility submitted a completed event report for resident (R)12 who sustained a left hip fracture, origin of the injury was not known. The investigation report did not include documentation of R12's incident during physical therapy that was reported to nursing staff. Interview of staff responsible for completing the investigation confirmed the facility was unaware of the resident's report and the incident during PT could have potentially been the source of R12's injury. The investigation was initiated by the facility after becoming aware of R12's left hip fracture. As a result of this deficient practice, the Resident experienced a delay in the diagnosis and treatment of a left hip fracture. Findings include: Cross reference F580- notification of physician. Conducted a review of R12's electronic health record (EHR). Initial x-ray results take on 02/03/24 documented " .... No obvious displaced or impacted fracture noted at this time .... No evidence of osteomyelitis ..." A second x-ray taken on 02/20/24 documented "There is an avulsion fracture of the lesser trochanter, new from prior ..."An avulsion fracture	F 610	Office of Healthcare Assurance (OHCA) report submitted on 2/25/24 for Resident #12 resubmitted with addendum indicating probable cause related to therapy session as stated by the resident. Facility residents with incidents that require a report to the Office of Healthcare Assurance (OHCA) have the potential to be affected by this alleged practice. Administrator/Nurse management/Social Services (SS) were inserviced by the Vice President (VP) of Clinical Quality on how to properly investigate a reportable incident on 4/25/24. Administrator/Designee will audit final reports to the State Agency (OHCA) to ensure Nurse management/SS has done a thorough investigation. Audits to be done weekly for a minimum of 12 weeks (if report filed) or until the Quality Assurance Performance Improvement (QAPI) committee determines compliance is achieved. The results of these audits will be brought to the QAPI meeting monthly for a minimum of 3 months for review and recommendations.	

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F 610	Continued From page 12 occurs when an injury causes a ligament or tendon to break off (avulse) a piece of a bone that's attached to it and usually happens as the result of a traumatic injury or explosive movement. Indicating an incident with force needed to have happened for this type of injury to occur. On 03/21/24 at 3:45 PM, conducted an interview with the director of nursing (DON), resident care manager (RCM)1 and RCM2 regarding the facility's investigation of R12's hip fracture. Reviewed the facility's investigation which was submitted to the state agency (SA). Informed the DON, RCM1, and RCM2 about the progress note written on 02/08/24 by RN99 during which R12 informed the staff of an incident during physical therapy regarding the resident hearing a loud crack and felt a sharp pain. Inquired if the facility was aware of the situation. DON, RCM1, and RCM2 reviewed R12's EHR, the facility's morning meeting huddle information and all other additional documents then confirmed the facility was not aware of R12's report of the incident to RN99 and it was not investigated as a potential source of R12's left hip fracture. RCM1 and RCM2 both confirmed R12 is a reliable source of information.	F 610		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services 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		5/3/24

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F 755	Continued From page 13 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 observation, interview, and review of the facility's policy and procedure, the facility failed to ensure the controlled drug records were reconciled between shifts. The deficient practice potentially places the facility at risk for the diversion of controlled medications. Findings include: On 03/21/24 at 09:08 AM, while conducting medication administration observations with registered nurse (RN)19, staff proceeded to initial the controlled medication reconciliation count	F 755	Nurse involved was counseled on proper narcotic medication reconciliation on 4/2/24. Facility residents who receive narcotics have the potential to be affected by this alleged practice. Licensed nurses were inserviced by the DON/Designee on the proper shift change process of Narcotic Medication Reconciliation.	

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F 755	Continued From page 14 sheet, for the off-going (11 PM- 7 AM) shift and the on-coming (3 PM-11 PM) shift. Inquired with RN19 what the facility's procedure is for verifying the count of the controlled medications between shifts is. RN19 stated the off-going shift and the on-coming shift nurses do the count together and sign the sheet once the count is completed and correct. RN19 stated, "I probably shouldn't have done this in front of you", then confirmed he/she did not sign the controlled medication reconciliation sheet in the presence of the off-going nurse and pre-signed the form for the on-coming shift and by doing so there is an opportunity for an error in the reconciliation of the controlled medication(s). While conducting an interview with the director of nursing (DON) on 03/21/23 at 3:45 PM, informed the DON of observation of RN19 not signing the controlled medication reconciliation in the presence of the off-going or on-coming shift. DON confirmed for the facility to ensure all controlled drug counts are in order and accurate, staff is required to reconcile the controlled medication between shifts, and the nurses should be signing (initialing) the reconciliation sheet in the presence of each other right after the count is confirmed. Review of the facility's policy and procedure, 7.4 Controlled Substances (01/23), "7. At each shift change, a physical inventory of controlled medications, as defined by state regulation, is conducted by two licensed clinicians and is documented on an audit record."	F 755	DON/Designee will monitor narcotic medication reconciliation at change of shift 3x/week to ensure nurses are following proper protocol for a minimum of 12 weeks or until the Quality Assurance Performance Improvement (QAPI) committee determines compliance is achieved. The results of these audits will be brought to the QAPI meeting monthly for a minimum of 3 months for review and recommendations.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		5/3/24

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F 761	Continued From page 15 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to label medications in accordance with acceptable professional standards. Proper labeling of medications is necessary for safe administration practices and to decrease the risk of medication errors. This deficient practice has the potential to affect all the residents in the facility. Findings include: On 03/20/24 at 08:03 AM, observed Licensed	F 761	Resident #252's inhaler was discarded, and a new inhaler was ordered. Nurses involved were inserviced on proper labeling of medications that require open and discard dates on 3/20/24. Facility residents who use inhalers have the potential to be affected by this alleged practice. Licensed Nurses were inserviced on medications with shortened expiration	

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F 761	Continued From page 16 Practical Nurse (LPN)23 during the morning medication pass. While LPN23 was preparing the medications for Resident (R)252, observed the box for the inhaler (device used to deliver medicine into the lungs) with no open and discard dates. On 03/20/24 at 09:41 AM during a concurrent interview with LPN23 and inspection of the medication cart for the Ilima wing, LPN23 confirmed that the inhaler for R252 was supposed to be labeled with the open and discard dates. Review of the facility policy titled "Medication Storage" stated, ". . . 10. Medications, . . . need to be labeled when opened. It [sic] using a label tag that requires open and discard dates, these should be filled in appropriately. . ."	F 761	dates and properly labeling those medications with an open and discard date at time of first use. Resident Care Managers (RCMs)/Designee will audit medication carts 3x/week for inhalers with shortened expiration dates to ensure proper labeling in place for a minimum of 12 weeks or until the Quality Assurance Performance Improvement (QAPI) committee determines compliance is achieved. The results of these audits will be brought to the QAPI meeting monthly for a minimum of 3 months for review and recommendations.	
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	F 880		5/3/24

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F 880	Continued From page 17	F 880		

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:
(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.

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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 observation, interview and record review, the facility failed to implement the facility's infection prevention and control measures. The facility did not ensure the staff were wearing applicable personal protective equipment (PPE) when providing care to a resident on enhanced barrier precautions (EBP). This deficient practice placed all the residents at risk for the potential spread of infections and communicable diseases. Findings include: On 03/19/24 at 08:11 AM, observed a sign by the entrance of Resident (R)101's room that stated he was on EBP and to check with the nurse before entering the room. Asked Licensed Practical Nurse (LPN)23 if a gown was needed prior to entering the room. LPN23 said a gown is only needed when providing high contact care like bathing, dressing, transferring to wheelchair, wound dressing change or catheter care. LPN23 added that a gown is not needed if staff are going in just to talk to the resident, giving oral medications or serving meals. When asked why R101 was on EBP, LPN23 said it was because he had an indwelling urinary catheter and open wounds to groin area.	F 880	Certified Nursing Assistant (C.N.A.) involved was inserviced on Enhanced Barrier Precautions (EBP) Signage and use of proper personal protective equipment (PPE) when emptying a urinary catheter bag on 3/23/24. Facility residents on Enhanced Barrier Precautions have the potential to be affected by this alleged practice. Nursing staff were inserviced by the Infection Control Preventionist (ICP)/Designee on Enhanced Barrier Precautions and proper use of PPE when providing High Resident Care Activities. ICP/Designee will round on units 3x/week to ensure enhanced barrier precautions are being followed when providing high resident care activities to specified residents. Audits will be done for a minimum of 12 weeks or until the Quality Assurance Performance Improvement (QAPI) committee determines compliance is achieved. The results of these audits will be brought to the QAPI meeting monthly for a minimum of 3 months for	

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F 880	Continued From page 19 0n 03/19/24 at 08:37 AM, observed Certified Nurses' Aide (CNA)53 emptying R101's urinary catheter collection bag. CNA53 was not wearing a gown. On 03/21/24 at 09:02 AM, an interview was conducted with the Infection Preventionist (IP) in her office. IP confirmed that CNA53 was supposed to be wearing a gown when she was emptying R101's urinary catheter collection bag. Review of facility policy titled "Transmission Based Precautions" under "Enhanced Barrier Precautions" stated, ". . . Used to reduce transmission of multidrug resistant organisms (MDROs) to staff hands and clothing during resident care activities . . . Apply to any resident/guest with wounds, indwelling medical devices (central line, urinary catheter, feeding tube, tracheostomy) . . . Staff will wear gown and gloves during high contact resident care activities . . ."	F 880	review and recommendations.	