STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145771	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review the facility failed to provide a resident with their electric wheelchair for one of 35 residents (R118) reviewed for accommodation of needs in the sample of 35. This failure resulted in R118 having difficulty moving throughout the facility. The findings include: R118's Minimum Data Set, dated dated dated [DATE] shows, Cognitive Patterns: Memory, R118 can recall current season, location of own room, staff names and faces, and knows she is in a nursing home. Functional Status: Transfer Extensive assistance of two plus persons. Locomotion on and off the unit, independent with setup help only. Active. Diagnoses: [REDACTED]. R118's Care Plan revised March 10, 2020 shows, R118 has limited physical mobility related to contractures present, stroke, weakness but does meet criteria for motorized wheelchair as she has sufficient cognitive and physical abilities to safely operate the motorized wheelchair. On 03/09/20 at 10:31 AM, R118 was sitting in her room in a wheel chair with left and right leg rests attached to the wheel chair. When asked about the care R118 has received in the facility, R118 indicated that she would like to use her electric wheel chair and is unsure why she is not allowed to use it. On 03/11/20 at 8:27AM, R118 was asked why she wanted to use her electric wheel chair instead of the manual wheel chair. R118 gave an annoyed expression. R118 then pointed at the hand rail and her legs as she shook her head. On 03/10/2020 at 9:57 AM, V21 CNA-Certified Nursing Assistant said, R118's electric wheel chair is broken. I am not sure how long it has been broken, but around two weeks. I do not know what is wrong with it, it doesn't work. On 03/10/20 at 10:43 AM, V22 Restorative Nurse said, R118's electric wheel chair was repaired October 16, 2019. A power module and the joy stick was replaced. She was also given a new battery charger. R118 was reassessed to ensure she could control the wheel chair around other people. The assessment has residents going around cones and showing they can use the mirrors when going around corners. R118 passed her evaluation. R118's Power Wheelchairs Evaluation form dated October 18, 2019 shows, R118 acknowledged the facility's Memo on Power Wheelchairs. R118 acknowledged the facility's Rules of the Hallway. R118's Power Wheelchair Driver Test dated October 18, 2019 shows, R118 was able to perform all required techniques and pass a multiple choice quiz called, Rules of the Hallway. The test and quiz was administered by V23 Occupational Therapist.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide incontinence care for four of five dependent residents (R88, R158, R9, R44) reviewed for incontinence care in the sample of 35. The findings include: R88's Face Sheet shows R88 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R88's Minimum Data Set ((MDS) dated [DATE] shows R88 is moderately cognitively impaired, requires extensive assistance with two staff members for transferring and toilet use. On 3/10/2020 at 8:15 AM, R88 was observed in bed asleep on his back. V17 CNA (Certified Nursing Assistant) stated that R88 was a shower but V17 was going to get the people that required less assistance up first and save R88 for last because he gets up with a mechanical lift and requires two staff members. R88 was observed still in bed unchanged and on his back at 9:39 AM, 10:23 AM, and at 10:58 AM, V17 and V7 CNA prepared to perform incontinence care to R88. R88 had creases on his backside and his incontinence brief was saturated from front to back with dark urine. There also was a small amount of soft stool in the incontinence brief. V17 stated that R88 is a heavy wetter. R88's Care Plan shows, R88 has an activities of daily living self care performance deficit related to incontinence .R88 has bladder incontinence related to activity intolerance, confusion, dementia, impaired mobility, inability to communicate needs, cognitive loss, and absence of balance. Clean peri area with each incontinence episode. R158's Minimum Data Set assessment dated [DATE] shows that R158's cognition is severely impaired, requires extensive assistance for toileting and is frequently incontinent of urine and stool. R158's care plan revised on 2/11/20 shows, staff will assist (R158) with toileting at: Upon waking, between 9A (AM) and 10A, between 1P and 2P On 3/09/20 at 10:16 AM, R158 was in his room and stood up from the wheelchair and transferred himself into bed. V10 (Licensed Practical Nurse) was in the room and watched him transfer. R158 had a large wet area on the back buttock area of his pants. R158 stated, I need new pants. V10 went to R158's closet and looked for a pair of pants and could not find any. V10 stated, It looks like you don't have any, I will have to tell laundry and left the room. R158 was laying in bed on his left side with the wet spot on his pants visible. On 03/09/20 at 10:18 AM, V8 (Registered Nurse) walked into R158's room and then left. R158's pants were still visibly wet. On 3/09/20 at 11:13 AM, V12 (CNA) brought R158 to the bathroom to be toileted. R158's incontinence brief was saturated and his pants were wet. V12 said that she has not checked or changed him since she came in at 6:30 AM since he was already up when she got to work. R9's Minimum Data Set assessment dated [DATE] shows that his cognition is severely impaired, requires extensive assistance with toileting and is always incontinent of urine and stool. R9's current care plan shows, Toilet use: (R9) is incontinent, wears briefs and is dependent on staff assist to complete peri/incontinence care. Staff will assist (R9) with toileting upon waking, before and after meals . On 3/09/20 at 10:46 AM, V12 and V13 (CNAs) provided incontinence care to R9. V12 and V13 removed R9's incontinence brief and the brief was saturated with urine and a small amount of stool. The bottom of R9's shirt was wet. On 3/09/20 at 10:46 AM, V12 said that she is R9's CNA and she last changed him around 7:00 AM. On 3/10/20 at 2:20 PM, V16 (CNA) said that incontinent residents should be checked and changed every 2 hours or as needed. V16 said that if clothes are wet, they should be cleaned up right away. On 3/10/20 at 2:11 PM R44 stated, Yesterday or the day before I was in my chair all day and no one came to assist me. On 3/11/20 at 09:55AM V32 (RN- House Supervisor) stated, I was relieving the switchboard. {R44's}daughter called and said she needed to speak to me immediately. She told me her mother had been covered with BM (bowel movment) all day. She was very angry and then hung up on me. I called the nurse and had the CNA go in and clean her up. When I went down there {R44} was sitting up in bed and she was clean and didn't offer any complaints. I reported this to the V1 (Administrator) and I obtained statements from the the CNA. CNA said she was incontinent of BM so she cleaned her up. It was approximately 15 minutes from time V26 called me to the time I got there. I never saw V26 at all. She left before I got to the room. On 3/11/20 at 1:10 PM - V1 stated, The CNA that cleaned her up said she had dried poop up the back of her legs. I haven't had a chance to fully investigate everything since you guys came in on Monday. On 3/11/20 at 2:01PM, V25-CNA stated, I saw {R44} after dinner. I had seen her before dinner sitting in the TV room but she wasn't my resident at that time. We started with 6 CNAs then we had 5 then one went home and we only had 4. I was told to go help in the main dining room for dinner. Then the nurse came and told me that {V26} was upset that {R44} hadn't been cleaned up all day. I said, Who's {R44}?, because she wasn't my patient until the assignment changed after dinner. I talked to the other girl that cleaned her up so

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

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) this is just hearsay but she said she had dried poop on her almost up her back. She said it didn't just happen and she had to have been like that all day. She said it was really bad and it was stuck to her. She said the other shift must not have taken her to the bathroom at all. On 3/11/20 at 10:51AM V26 (R44's daughter) showed surveyor a picture she took of the resident's adult brief on Sunday after she voiced a concern to the staff that her mom had not been changed all day. The brief was saturated with urine, dark in color, and and falling apart. The picture also showed dry stool on the back of R44's legs. R44's Minimum Data Set assessment dated [DATE] shows that R44 scored a 10 (Mild cognitive impairment) on her BIMS (Basic Interview for Mental Status). This same document shows that R44 requires extensive assist from 1-2 staff for toileting and personal hygiene. R44's care plan dated 1/12/2020 states, {R44} uses disposable briefs. Change PRN and Incontinent: check as required for incontinence. R44's electronic medical record dated 3/8/20 at 5:30PM written by V32 states, I answered a phone call from someone who identified herself as {R44's} daughter. She yelled into the phone angrily that she wanted to see the charge nurse immediately. I told her that I was unable to come immediately due to other immediate duties, but I asked her to share her concern and explained that I would be able to see her when the employee I was relieving returned. She stated that her mother had been covered in BM all day. I assured her that I would immediately get in contact with her nurse and CNA, investigate the matter, and ensure that her mother was clean and comfortable. The phone was then disconnected. Approximately 15 minutes later, after talking to {R44's} nurse, I went down to {R44's} room. {V26} was no longer there, however {R44} was sitting up in her bed , eating. She verbalized no complaints and appeared clean and comfortable. I asked her nurse to assess her skin on her peri area and to alert me if there were any issues. An undated statement written by V33{CNA} reads, I {CNA's name} put {R44} to bed and seen dry poop on her. No skin issues. The facility's Perineal Hygiene Policy revised on 3/23/18 shows, Perineal care is completed as part of the personal care provided for residents. The frequency of perineal care is based on the resident's individualized need .Review care plan and/or communicate with nurse supervisor it identify individualized resident needs and/or preferences .
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide wound care to multiple wounds including a stage three pressure ulcer for one of four residents (R94) reviewed for pressure ulcers in the sample of 35. The findings include: On 03/09/20 at 1:00PM, R94 was lying in bed on his back. On 03/10/20 at 1:30PM, V34 LPN-Licensed Practical Nurse provided wound care to R94. R94 did not have a dressing to the right axillary wound. The right axillary had diffuse redness with three 1 centimeter areas that tunneled into the axilla. The top axilla tunnel had a thick yellow/white drainage. No dressing was present on the wound. R94's coccyx area had a five centimeter by three centimeter open area. The bed of the wound was granulation tissue. There was tunneling that extended past the wound borders under the skin. No dressing was present on the wound. On R94's left groin area there was a five centimeter by three centimeter open area. Granulation tissue was present in the wound. No dressing was covering the wound. On R94's right groin there was a five centimeter by two centimeter open area that tunneled under two intact skin areas that bridged across the wound. No dressing was covering the wound. On 03/09/20 at 1:00PM, R94 said, I am in constant pain from my wounds. On 03/10/20 at 1:45PM, V21 CNA-Certified Nursing Assistant said, there has not been any dressings on R94's wound all day. On 03/10/20 at 1:46PM, V34 LPN-Licensed Practical Nurse said, R94 has daily dressing changes. Dressings are applied to the wounds to protect them and keep them clean. R94's Wound-Weekly Observation Tool dated 03/06/2020 shows, Coccyx, stage three pressure ulcer. R94's physician's orders [REDACTED]. 2) Apply anti-fungal barrier cream and alginate (dressing) to right axilla. 3) Apply anti-fungal barrier cream to peri-wound of coccyx cover with alginate (dressing) and abdominal dressing change daily. 4) Apply [MEDICATION NAME] moistened gauze to bilateral groin wounds and cover with abdominal dressing. 5) Change all dressings as needed if soiled wet or too much drainage. R94's Care Plan Revised Initiated 01/17/2020 shows, chronic wounds will not worsen or improve and remain free from infection by/through review date. Intervention: Administer treatments as ordered and monitor for effectiveness.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to use a gait belt to provide a safe transfer and failed to implement fall interventions for 5 of 8 residents (R36, R47, R51, R75 and R158) reviewed for safety in the sample of 35. R51's Minimum Data Set assessment dated [DATE] shows that she requires extensive assistance of two people for transfers. R51's current care plan shows, Transfer: (R51) requires extensive assist to complete transfers from 1-2 staff member. On 3/09/20 at 10:26 AM, R51 was transferred from her bed to the wheelchair by V12 and V13, Certified Nursing Assistants (CNAs). V12 and V13 sat R51 on the side of the bed and lifted her by putting their arms under R51's armpits and lifted her to the chair. On 3/10/10 at 2:17 PM, V16 (CNA) said that all residents that are assisted with a transfer either one or two person assist, the staff should always use a gaitbelt for the resident's safety and so you don't hurt them. The facility's Gait Belts Policy revied on 3/13/12 shows, Gait belts will be used for weight bearing residents who require hands on assist for transfers. R158's Minimum Data Set assessment dated [DATE] shows that his congnition is impaired and he is not steady with surface to surface transfers. R158's Fall Risk Evaluation dated 3/10/20 shows that he is at risk for falls. R158's fall incident report dated 2/29/20 shows that he had a fall at the facility. R158's current fall care plan shows, (R158) has a bed and chair electronic alarm. Ensure the device is in place and functional. On 3/09/20 at 11:13 AM, V12 and V13 (CNAs) were in R158's room caring for the room mate. R158 transferred himself from the bed to the wheelchair. No alarms went off when R158 transferred. On 3/09/20 at 11:18 AM, V12 tranferred R158 to the toilet. R158 had a wheelchair alarm on his wheelchair but the wheelchair alarm did not sound when R158 stood from the chair. On 3/10/20 at 2:17 PM, V16 (CNA) said that R158 self transfers often and fall interventions in place for him would be a wheelchair alarm and bed alarm. V16 said that if a staff member witness an alarm not going off, they should immediately fix the issue right away. On 03/09/20 at 10:54 AM, R36 was in bed. A bed alarm was hanging on the bed rail. The alarm was not connected to the sensor pad on the bed. The end of the sensor pad cord was sitting on the floor. On 03/09/20 at 10:56 AM, V5 (Certified Nursing Assistant) confirmed R36's bed alarm was not connected to the sensor pad. R36's fall care plan showed R36 was at risk for falls. Under interventions list the use of a bed alarm and, Ensure the device is in place and functional. On 03/09/20 at 09:55 AM, R47 was in bed. R47's fall mat was on the other side of the room. Half of the fall mat was leaning up against the wall and the other half was on the floor. On 03/11/20 at 08:57 AM, V7 (Certified Nursing Assistant) said when a resident is in bed the fall mat should be positioned next to the bed. R47's fall care plan showed R47 was at risk for falls. Under interventions list the use of a fall mat. On 03/09/20 at 03:10 PM, R75 was sitting on the side of the bed. R75's bed alarm was sounding. R75 made several attempts to stand. The resident would raise up and fall back to a seated position. No staff was responding to the bed alarm. R75 stated, I have to go to the bathroom. R75 then stood to her feet. R75 made an attempt to take a step but a blanket was wrapped around her right foot hindering her movement. R75 became unstable and reached out and grabbed onto the state surveyor and stabilized herself. R75's Fall Incident report dated 11/02/2019 at 9:05PM, shows, R75 was sitting on the floor by the end of the bed. Pressure alarm was on the bed but did not go off during the event. R75's Fall Incident Report dated 11/06/2019 at 12:15AM, shows, Resident on her knees in front of the toilet. Batteries to alarm needed changing. R75's Care Plan created 10/11/2019 shows, R75 has electronic alarms on bed and wheel chair. Ensure the devices are in place and functional. The facility's Fall and Fall Risk Management Policy revised on 2/5/18 shows,Factors contributing to falls should be investigated and documented at the time of the fall with interventions determined to be appropriate initiated and care planned.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to offer a therapeutic diet to a resident with failure to thrive for 1 of 4 residents (R88) reviewed for nutrition in the sample of 35. The findings include: R88's face sheet shows R88 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R88's Minimum Data Set ((MDS) dated [DATE] shows, R88 requires extensive assistance with two staff members to transfer and requires supervision and one staff

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) assistance for eating. On 3/10/2020 R88 was observed in bed at 8:15 AM, 9:39 AM, 10:14 AM, 10:23 AM, and 10:58 AM in bed on his back with no breakfast in front of him. At 10:29 AM, R88 said he hasn't gotten breakfast yet and was hungry. At 10:58 AM, V17 CNA (Certified Nursing Assistant) said that R88 had not gotten breakfast. V17 proceeded to shower R88 and said she will bring him to the dining room for lunch. R88 was brought to lunch at 11:52 AM. R88 's Care Plan shows, R88 requires 1 on 1 assist with meals and is on a general pureed diet with nectar thickened liquids .R88 has a potential nutritional problem related to receiving mechanically altered food and fluids. Provide and serve diet as ordered. R88's Physician order [REDACTED]. The facility's Monitoring of Nutrition and Fluid Intake policy revised on 1/28/03 shows, The dietary department will provided the physician ordered diet. Nursing staff will provide the required assistance to prepare the meal for self feeding or will feed the resident as needed. Residents will be encouraged to consume as much of the meal as they are willing to ingest. The nursing staff will continue to make every reasonable effort to assist the resident in meeting his nutrition/hydration needs.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure [MEDICAL CONDITION] medications ordered as needed (PRN) had a duration/end date for 6 of 6 residents (R184, R159, R129, R75, and R72) reviewed for unnecessary medications in the sample of 35. The findings include: On 3/10/20 at 10:50 AM, V6 (Pharmacist) said PRN [MEDICAL CONDITION] medications should have a duration/end date. R184's physician's orders [REDACTED]. R159's physician's orders [REDACTED]. R129's physician's orders [REDACTED]. The anti-psychotic medication did not have a fourteen day stop date. physician's orders [REDACTED]. The anti-psychotic medication did not have a fourteen day stop date. R75's Medication Record Dated 02/02/2020 through 02/29/2020 shows [MEDICATION NAME] two milligrams give 0.25 milliliters every four hours as needed ordered on [DATE]. The [MEDICATION NAME] order did not contain a stop date. [MEDICATION NAME] was administered twice to R75 on February 5, 2020. R75's Note to Attending Physician/Prescriber by V6 Pharmacist dated 10/22/2019 shows, Please consider the following Pharmacist recommendations in assessing the Resident's drug regimen and in accordance to the CFR 483.45(c) F756 Drug Regimen Review. The prescriber and/or nursing staff should respond appropriately. Recommendations marked URGENT should be resolved by midnight the next calendar day, copied to MDS Coordinator, and filed in the Resident chart appropriately. R75 currently has the following pertinent as needed medication order. [MEDICATION NAME] 0.5mg every four hours as needed. State and Federal Guidelines have been updated and include 14 day limits on as needed [MEDICAL CONDITION]: The 14 day limitation may be extended beyond 14 days (excluding antipsychotics) if the attending physician or prescriber documents the following upon initiation of the as needed [MEDICAL CONDITION] order: 1 Believe it is appropriate to extend the order-and- 2. Documents clinical rational for the extension -and- 3. Provides specific duration of use. Please consider the following at this time: discontinue as needed [MEDICATION NAME] or add stop date: [MEDICATION NAME] 0.5mg every four hours as needed times 90 days. Rationale: End of life care, no adverse events noted, benefit outweighs risk. Physician/Prescriber Response was left blank. Neither the prescriber nor facility responded to the Pharmacist recommendations. R72's physician's orders [REDACTED]. The pharmacist recommendation dated 1/14/20 states: {R72} currently has the following pertinent PRN (As needed) medication order: [MEDICATION NAME] 0.5mg- 2mg every 2 hours PRN. States and Federal Guidelines have been updated and include 14 day limits on PRN [MEDICAL CONDITION]. This form also shows a statement written by R72's physician that reads, Has psychiatric illness, on hospice care. The facility policy entitled [MEDICAL CONDITION] Medication dated 3/10/15 states, The facility will make every effort to comply with State and Federal regulations related to the use of psychopharmacological medications in the long term care facility to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits. R72's care plan does not address her use of [MEDICATION NAME] for anxiety. R74's physician's orders [REDACTED]. The pharmacist recommendation dated 11/30/19 states: {R74} currently has the following pertinent PRN (As needed) medication order: [MEDICATION NAME] 0.25mg every 6 hours PRN. State and Federal Guidelines have been updated and include 14 day limits on PRN [MEDICAL CONDITION]. There is no response from the physician documented on this form. The psychiatric physician's progress note dated 1/2/20 states, PRN [MEDICATION NAME] used often and effective per charting. On 3/10/20 at 9:22AM, V8 (RN- Unit manager) stated that he is responsible for the [MEDICAL CONDITION] medications in the facility. V8 stated that he is unable to review the medications in real time but he tries to review them on a regular basis. V8 stated that he looks at the PRN medications and whether or not the resident is using them. V8 did not address the need for stop dates for PRN [MEDICAL CONDITION] medications.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to report an outbreak of the [MEDICAL CONDITION] in the facility to the local health department. The facility failed to ensure staff dispose of personal protective equipment in the designated trash receptacle prior to exiting an isolation room, and failed to ensure staff remove their gloves and wash their hands to prevent cross contamination. The facility also failed to follow the Centers for Disease Control and Prevention guidelines related to cohorting residents when a known communicable disease is present. This applies to all 188 residents in the facility. The findings include: On 3/11/20 at 8:14 AM V2 (Director of Nursing) and V3(Assistant Director of Nursing) stated, Our first resident tested positive for Influenza A on 3/4/20 and the second one tested positive on 3/8/20. We called the County Health Department after the first one and they sent us the State Department recommendations and the surveillance tools because ours were from 2015. We reported to the State Department on 3/9/20 but we did not report the second case to the County. We spoke to the County before the second resident tested positive. We still have just 2 residents confirmed with [MEDICAL CONDITION]. The outbreak started on 3/8/20. On 3/11/20 at 1:02 PM V2 stated,The County Health Department told us to call him back if there was an outbreak but I haven't done that. I haven't had a chance to do it yet. The undated facility policy entitled Infection Control Plan 2020 states, Information about infections are reported both internally and to public health agencies. This will allow the ability to take action to reduce those risks and decrease infection rates. The CMS 672: Resident Census and Conditions Report dated 3/9/20 shows that 188 residents currently reside in the facility. On 3/10/2020 at 10:58 AM, V7 Certified Nursing Assistant (CNA) unsecured the front of R88's incontinence brief and pushed the front of the incontinence brief down in between R88's legs. V7 removed her soiled gloves and placed them in the left pocket of her scrubs. V7 removed clean gloves from the right pocket of her scrubs and performed incontinence care to R88's back side. R88 had stool in his incontinence brief and it was saturated with urine. V7 had stool on her gloves. V7 removed her gloves and placed them in the left pocket of her scrubs. R88 was taken to the shower by V7 and V17 CNA. R88 still had stool on his buttocks after his shower. V7 and V17 transferred R88 back into bed. V17 cleansed the stool from R88's buttocks and retrieved cream out of R88's drawer, touched the clean depends, touched R88's bed rail, R88's body, R88's bed, applied cream to R88's buttocks, touched R88's clean socks, pants, and mechanical lift sling without changing her gloves or washing her hands. R27's laboratory results dated [DATE] shows R27 is positive for influenza A. R27 is on isolation and visitors and staff wear gowns, gloves, and masks. On 3/9/2020 at 1:22 PM, V8 Unit Manager and V20 CNA transferred R27 from the chair to her bed using a mechanical lift. R27 had a cough. V8 walked out of R27's room with the gown and mask on. V8 did not removed his gown or mask and did not wash his hands prior to leaving R27's room. V8 removed his gown and walked to the hallway trash receptacle and put the gown in it. V8 did not change his mask. V8 went to place glasses onto R152's face and was less than a foot away from her face with the same mask he had on from R27's room. R27's laboratory results dated [DATE] shows R27 is positive for influenza A. R27 is on isolation and visitors and staff wear gowns, gloves, and masks. R154 is R27's roommate and does not have influenza A. R154 was observed in her room and using the restroom. R154 was not on

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) treatment for [REDACTED]. The facility's Census Report dated 3/8/20 shows that R144 and R104 are in house in the same room. R144's laboratory test for influenza dated 3/4/20 shows that she is positive for influenza A. R144's March Medication Administration Record [REDACTED]. R144's MAR indicated [REDACTED]. R104's March MAR indicated [REDACTED]. On 3/09/20 at 12:44 PM, R144 and R104's room had an isolation cart next to the entrance of the room and a sign on the door that said to see the nurse before entering. There were no linen or trash receptacles in the room. R144 was laying in bed and coughing. At 1:10 PM, R104 self propelled herself into the room and went to the other side of the room to look to see if R144 was in bed. V14 (Housekeeping) was in the room and said, Don't get too close, she is not feeling well. While V14 was cleaning R144 and R104's room, she was cleaning both side of the room with disinfectant wipes at the same time. V14 went to her housekeeping cart that was in the hallway outside of R144 and R104's room. With her gloves and gown still on, moved the gown to the side and reached into her pocket and retrieved the keys to her cart out of her pocket. V14 did this three times without removing her gloves and gown. On 3/10/20 at 9:38 AM, R144 and R104's room no longer had an isolation cart outside of the door or a sign on the door directed to see the nurse. V15 (CNA) was providing incontinence care to R144. V15 was wearing only gloves and a mask. R144 was continually coughing throughout the care. V15 said that she thinks that she is still on isolation but the facility took the cart away and she does not know why. At 3:45 PM, the room still had no isolation cart or sign on the door. On 3/11/20 at 9:04 AM, R144 and R104's room had an isolation cart outside of the door and a sign on the door that said to see the nurse before entering. There were no isolation linen or trash receptacles in the room. On 3/09/20 at 9:30 AM, V8 (Registered Nurse-unit coordinator) said that they have two cases of influenza. The residents were immediately put on isolation and everyone was treated with [MEDICATION NAME]. On 3/11/20 at 9:04 AM, V8 said that R144 is on droplet precautions isolation. Staff should be wearing gloves, gown and mask when they go into the room. V8 said that yesterday (3/10/20) R144 was off of isolation but was then put back on until the doctor assessed her. On 3/11/20 at 8:14 AM, V2 (DON) and V3 (ADON) said that the best case scenario for isolation residents is in a room by themselves. If there is no rooms available, we would try and keep the same organisms together. V2 and V3 said, We could have put the two residents together. V2 and V3 said that they are not sure why R27 and R144 who are both positive for influenza were not put together. V2 and V3 said that R27 and R144's roommates were treated with [MEDICATION NAME] and the directive was to treat everyone on the dementia unit. V2 and V3 said that an isolation room is set up with a cart outside of the room that has gloves, masks and gowns in it. When a staff member goes into the room of a droplet isolation, they should put on a mask, gloves and gown. The room should have a container set up for garbage and linen. The personal protective equipment (PPE) should be removed and discarded while still in the room and the staff should wash their hands before leaving. V2 and V3 said you wouldn't want to walk out into the hallway with your PPE on, that could be contaminated and you wouldn't want to spread the infection. On 3/11/20 at 9:42 AM, V11 (Housekeeping Supervisor) said that if a staff member is cleaning an isolation room, they should bring all supplies that are needed with them so they do not have to go out of the room with their PPE on. The facility's Personal Protective Equipment-Using Glove Policy dated 2020 shows, Remove gloves before removing the mask and gown and discard them into the designated waste receptacle inside the room. The facility's Isolation Precautions Policy revised on 5/14/18 shows, Facility staff will apply transmission based precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with infectious agents which require, as determined by the CDC, additional controls to effectively prevent transmission. On 3/09/20 at 11:21 AM, V12 (CNA) toileted R158. V12 cleaned R158's buttocks and front perineal area. With the same gloves on, V12 put R158's incontinence brief and pants on, moved the wheelchair by touching the wheelchair armrest and straightened R158's shirt. On 03/11/20 at 8:56 AM, V12 said that staff should remove their gloves and wash their hands after providing toileting assistance and before touching other objects in the room to prevent to spread of infection. The facility's Personal Protective Equipment-Using Gloves Policy dated 2020 shows, Purpose: to guide the use of gloves to prevent to spread of infection .
F 0883 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to offer both the 23-valent pneumococcal [MEDICATION NAME] vaccine (PPSV23) and the 13-valent pneumococcal conjugate vaccine (PCV13) to all residents. This applies to all 188 residents in the facility. The findings include: On 3/11/20 at 8:14 AM V2(Director of Nursing) and V3 (Assistant Director of Nursing) stated, The consent for the pneumonia vaccine is done with admission. I think the consent says Prevnar 13 but I'm not sure which one we give. I print out the log from the electronic medical record. It shows who has had it and who hasn't. Review of the pneumonia vaccine for 5 residents shows the following: R104 received PCV13 on 2/24/05 prior to admission and was never offered the PPSV23. R104 is not on the facility pneumonia vaccine log. R144 refused the pneumonia vaccine R94's Immunization Questionnaire shows that he received a pneumonia vaccine in July 2013 (no documentation of which one) However R94 is not on the facility log. R30 refused the pneumonia vaccine R173's Immunization Questionnaire shows that she received a pneumonia vaccine in October 2017(no documentation of which one) However R173 is not on the facility log. On 3/11/20 at 12:33 PM V3 stated, When we don't know what they have had we get a doctor's order and then give whichever one the doctor tells us to give. The facility Immunization Report shows that the facility provided the pneumonia vaccine to 9 residents. 6 are documented as [MEDICATION NAME] 23, 2 are documented as [MEDICATION NAME] Dose 1 and 1 is documented as Pneumococcal Conjugate Vaccine (PCV13). The facility policy entitled Influenza and Pneumococcal Vaccine and Precautions dated 3/3/15 states, Individual doses of the pneumococcal [MEDICATION NAME] vaccine will be ordered from the pharmacy as needed. The facility Immunization Questionnaire states, I have been provided with the information about Pneumococcal Disease and Pneumococcal [MEDICATION NAME] Vaccine. The CMS 672: Resident Census and Conditions Report dated 3/9/20 shows that 188 residents currently reside in the facility.