STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045326	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRAWFORD HEALTHCARE AND REHABILITATION CENTER	2010 MAIN STREET VAN BUREN, AR 72956

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure an indwelling urinary catheter drainage bag was concealed in a privacy bag when in common areas, to promote dignity and maintain privacy for 2 (Residents #69 and #53) of 5 (Residents #69, #53, #27, #64, and #85) sampled residents who had an indwelling urinary catheter. This failed practice had the potential to affect 11 residents who had indwelling urinary catheters, based on a list provided by Director of Nursing (DON) on 3/4/2020 at 8:09 a.m. The findings are: 1. Resident #69 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set with an Assessment Reference Date of 1/30/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status; required extensive assistance to total dependence of one to two plus persons with activities of daily living tasks; and had an indwelling urinary catheter. a. On [DATE] at 11:17 a.m., the resident was lying in bed. The resident's indwelling urinary catheter drainage bag was hanging on the bed frame. There was dark yellow urine visible in the drainage bag from the hallway. There was no privacy bag in use. b. On 3/4/2020 at 9:18 a.m., the Director of Nursing (DON) was asked if the catheter should be in a privacy bag. She stated, Yes. 2. Resident #53 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 1/13/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS); was totally dependent for bed mobility, transfer, toilet use, and personal hygiene, and had in indwelling urinary catheter. a. A physician's orders [REDACTED].Foley cath (catheter) care Q (every) shift . b. The Care Plan documented, .Toilet use . needs assist of 2 staff for toilet use . Incontinent of bowel with change and skin care PRN (as needed) and Foley catheter for bladder with Foley catheter care every shift Catheter . Position catheter bag and tubing below the level of the bladder and away from entrance room door . Place in privacy bag when up in w/c (wheelchair) or gerichair . c. On [DATE] at 3:29 p.m., the resident's indwelling urinary catheter drainage bag was hanging underneath the resident's wheelchair. The catheter drainage bag was not completely covered by the privacy bag, and yellow urine was visible draining into it from the hallway. (The Surveyor took a photograph of the catheter drainage bag at this time.) d. On 3/4/2020 at 10:32 a.m., Licensed Practical Nurse (LPN) #4 was asked, Should a resident's Foley catheter bag be kept completely covered in a privacy bag if it is visible from the resident's door? LPN #4 stated, Yes. e. On 3/4/2020 at 10:38 a.m., the Director of Nursing (DON) was asked, Should a resident's Foley catheter bag be kept completely covered in a privacy bag if it is visible from the resident's door? The DON stated, Yes.
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** Based on observation, record review, and interview, the facility failed to ensure resident grievances voiced by residents to staff in Resident Council were documented, acknowledged, and communicated to Administration, and prompt efforts to resolve grievances were initiated, and a statement as to whether the grievance was confirmed or not confirmed, any corrective actions taken, and the date the written decision was issued was documented to honor residents' rights. This failed practice had the potential to affect all 94 residents, per the Resident Census and Conditions of Residents form dated [DATE]. The findings are: 1. On [DATE] at 9:50 a.m., the Social Service Director was asked, Can you tell me about the Resident Council meetings? She stated, We are trying to get the Council to where we talk about what they want and what they want to have changed. She was asked, During Resident Council, and they voice a concern, what do you do with that? She stated, I take it to the person that needs to address it. She was asked, In the January Resident Council meeting, (Resident #43) and (Resident #14) had voiced concerns to the nurse about health problems and wanting to talk to the doctor and was not seen. Should this have been a grievance? She stated, I think maybe, but I turned over to the person who needed to take care of the situation. She was asked, Has it been charted anywhere, the resolution? She stated, I don't know. 2. On [DATE] at 10:14 a.m., the Director of Nursing was asked, When residents have concerns during Resident Council, what happens? She stated, We address them and take care of them. She was asked, In the January Resident Council, the residents had concerns about supplies being low, or none at all. What did you do? She stated, I went and looked and there were no concerns. She was asked, Was it documented anywhere? She stated, No. She was asked, They (residents) had concerns about running out of medications? She stated, We haven't been out of anything. 3. On [DATE] at 10:35 a.m., the Administrator was asked, When residents have concerns that are voiced in Resident Council, what do you do with those concerns? He stated, We take care of them. He was asked, Are they documented anywhere? He stated, No, we just take care of it.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure written notification of transfer / discharge was provided to the resident and / or resident's representative when residents transferred to the hospital or were discharged to protect resident rights for 4 (Residents #1, #13, #18, and #50) of 8 (Residents #1, #13, #18, #50, #34, #43, #53, and #68) sampled residents who were transferred and / or discharged since November 1, 2019. This failed practice had the potential to affect 24 residents who were transferred or discharged since November 1, 2019, according to a list provided by Nurse Consultant #1 on 3/ . The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD of 12/18/19 documented the resident scored 3 (0-7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS). a. A Discharge Minimum Data Set with an Assessment Reference Date of 12/18/19 documented the resident was discharged to the hospital. b. A Nurses Note dated 12/18/19 documented the resident was admitted to (Hospital) related to behaviors. c. As of 3/3/202 at 9:55 a.m., the clinical record contained no documentation of written notification to the resident or his family regarding the resident's transfer to the hospital emergency room . d. As of 3/3/2020 at 10:00 a.m., the facility was unable to provide documentation related to written notification of the resident / resident representative regarding the transfer to the hospital. 2. Resident #13 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 12/19/19 documented the resident scored 5 (0-7 indicates severely

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

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F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) impaired) on a BIMS. a. A Discharge with Return Anticipated MDS with an ARD of [DATE] documented the resident was discharged to the hospital on [DATE]. b. A Nurses Note dated [DATE] documented the resident was admitted to (Hospital) for cough and congestion. c. An Entry MDS with an ARD of 11/12/19 documented the resident was readmitted on [DATE]. d. As of 3/3/202 at 9:55 a.m., the clinical record contained no documentation of written notification to the resident or his family regarding the resident's transfer to the hospital emergency room . e. As of 3/3/2020 at 10:00 a.m., the facility was unable to provide documentation related to written notification of the resident / resident representative regarding the transfer to the hospital. 3. Resident #18 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 12/9/19 documented the resident scored 9 (8-12 indicates moderately impaired) on a BIMS. a. A Progress Note dated 11/5/19 documented the resident was admitted to the hospital on [DATE] related to [MEDICAL CONDITION]. b. A Discharge Return Anticipated MDS with an ARD of 11/5/19 documented the resident was discharged to the hospital on [DATE]. c. A Reentry MDS with an ARD of 11/9/19 documented the resident was readmitted . d. A Nurses Note dated 11/15/19 documented the resident was admitted to the hospital on [DATE] related to Urinary Tract Infection. e. A Discharge with Return Anticipated MDS with an ARD of 11/15/19 documented the resident was discharged to the hospital on [DATE]. f. A Nurses Note dated 11/21/19 documented the resident was readmitted on [DATE]. g. A Nurses Note dated 2/10/20 documented the resident was admitted to the hospital on [DATE] related to Hematuria. h. On 3/4/2020 at 1:05 p.m., Nurse Consultant #2 was asked, Do you have transfer notices for the list we provided you? She stated, We only have one transfer notice for the facility. We are not sure what happened, but we can't find any of the other ones. 4. Resident #50 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 1/13/2020 documented the resident scored 14 (13-15 indicates cognitively intact) on a BIMS. a. A facility list provided by the Nurse Consultant on 3/4/202 documented Resident #50 was sent the emergency roiagnom on [DATE] for falls and [DIAGNOSES REDACTED] evaluation. b. As of 3/3/202 at 9:55 a.m., the clinical record contained no documentation of written notification to the resident or his family regarding the resident's transfer to the hospital emergency room . c. As of 3/3/2020 at 10:00 a.m., the facility was unable to provide documentation related to written notification of the resident / resident representative regarding the transfer to the hospital. 5. On 3/4/2020 at 2:36 p.m., Nurse Consultant #2 stated the facility was unable to locate any written notification of the transfer of residents to the emergency room for all except one resident.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure the resident and / or the resident's representative was notified in writing of the facility's bed hold policy at the time of a resident's transfer to the hospital and / or discharge to ensure residents were informed of the policy and any potential bed hold charges for 4 (Residents #1, #13, #18, and #50) of 7 (Residents #1, 13, #18, #50, #34, #43, and #68) sampled residents who were transferred and / or discharged since November 1, 2019. This failed practice had the potential to affect 24 residents who were transferred or discharged since November 1, 2019, according to a list provided by Nurse Consultant #1 on 3/ . The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD of 12/18/19 documented the resident scored 3 (0-7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS). a. A Discharge Minimum Data Set with an Assessment Reference Date of 12/18/19 documented the resident was discharged to the hospital. b. A Nurses Note dated 12/18/19 documented the resident was admitted to (Hospital) related to behaviors. c. As of 3/3/202 at 9:55 a.m., the clinical record contained no documentation of written notification to the resident or family regarding the facility bed hold policy. d. As of 3/3/2020 at 10:00 a.m., the facility was unable to provide documentation related to written notification of the resident / resident representative regarding the facility bed hold policy. 2. Resident #13 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 12/19/19 documented the resident scored 5 (0-7 indicates severely impaired) on a BIMS. a. A Discharge with Return Anticipated MDS with an ARD of [DATE] documented the resident was discharged to the hospital on [DATE]. b. A Nurses Note dated [DATE] documented the resident was admitted to (Hospital) for cough and congestion. c. An Entry MDS with an ARD of 11/12/19 documented the resident was readmitted on [DATE]. d. As of 3/3/202 at 9:55 a.m., the clinical record contained no documentation of written notification to the resident or family regarding the facility bed hold policy. e. As of 3/3/2020 at 10:00 a.m., the facility was unable to provide documentation related to written notification of the resident / resident representative regarding the facility bed hold policy. 3. Resident #18 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 12/9/19 documented the resident scored 9 (8-12 indicates moderately impaired) on a BIMS. a. A Progress Note dated 11/5/19 documented the resident was admitted to the hospital on [DATE] related to [MEDICAL CONDITION]. b. A Discharge Return Anticipated MDS with an ARD of 11/5/19 documented the resident was discharged to the hospital on [DATE]. c. A Reentry MDS with an ARD of 11/9/19 documented the resident was readmitted . d. A Nurses Note dated 11/15/19 documented the resident was admitted to the hospital on [DATE] related to Urinary Tract Infection. e. A Discharge with Return Anticipated MDS with an ARD of 11/15/19 documented the resident was discharged to the hospital on [DATE]. f. A Nurses Note dated 11/21/19 documented the resident was readmitted on [DATE]. g. A Nurses Note dated 2/10/20 documented the resident was admitted to the hospital on [DATE] related to Hematuria. h. As of 3/3/202 at 9:55 a.m., the clinical record contained no documentation of written notification to the resident or family regarding the facility bed hold policy. i. As of 3/3/2020 at 10:00 a.m., the facility was unable to provide documentation related to written notification of the resident / resident representative regarding the facility bed hold policy. 4. Resident #50 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 1/13/2020 documented the resident scored 14 (13-15 indicates cognitively intact) on a BIMS. a. A facility list provided by the Nurse Consultant on 3/4/202 documented Resident #50 was sent the emergency roiagnom on [DATE] for falls and [DIAGNOSES REDACTED] evaluation. b. As of 3/3/202 at 9:55 a.m., the clinical record contained no documentation of written notification to the resident or his family regarding the facility bed hold policy. c. As of 3/3/2020 at 10:00 a.m., the facility was unable to provide documentation related to written notification to the residents / resident representatives regarding the facility bed hold policy. 5. On 3/4/2020 at 2:36 p.m., Nurse Consultant #2 stated the facility was unable to locate any written notification of the facility bed hold policy for the residents who were transferred / discharged to the emergency room for all except one resident.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure specific fall prevention interventions to be utilized to minimize the potential for further falls or injuries for 1 (Resident #68) of 7 (Residents #87, #34, #48, #50, #68, #88, and #92) sampled residents who had falls in the last 4 months. This failed practice had the potential to affect 23 residents who had falls in the last 4 months, according to a list provided by the Director of Nursing on 3/4/2020. The findings are: 1. Resident #68 was admitted on [DATE] and had [DIAGNOSES REDACTED]. The Medicare 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/31/2020 documented the resident scored 8 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (MDS); required extensive assistance with bed mobility, transfer, locomotion on and off the unit, dressing, toilet use, and personal hygiene; had no falls prior to admission; and had no falls since admission. a. A Progress Incident Note dated 2/29/2020 documented, .11:40 (11:40 a.m.) . CNA (Certified Nursing Assistant) found resident in the floor next to bed laying on her stomach. CNA called out for help. This nurse went to assess resident and found resident laying prone in the floor next to bed. Assisted resident to a sitting position and observed a laceration to the bridge of the nose. CNA and nurse assisted resident into wheelchair. This nurse attempted to get the bleeding under control with no success. This nurse asked resident what had happened, and resident stated, 'I fell asleep in my chair and fell .' RN (Registered Nurse) on call and physician notified. Received order to send resident to ER (emergency room) for evaluation and treatment. (Name) significant other notified. BP (Blood Pressure) 130/79 . P (Pulse) 119 . R (Respirations) 20 . Temp (Temperature) 96.4 ax (Axillary) . Sp02 (Oxygen Saturation) 95% on room air . b. A facility Incident and Accident (I&A) Report dated 2/29/2020 documented, .Incident Description

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Resident found in floor by CNA with blood in the floor and resident had a laceration to the bridge of her nose Resident Description . Resident stated , 'I fell asleep in my chair and fell .' . Immediate Action Taken . Assisted resident into wheelchair, gave tissue to collect blood . Resident Taken to Hospital? N (No) . Physician, Family and POA (Power of Attorney) notified . c. On [DATE] at 11:00 a.m., the resident was sitting in her wheelchair in her room watching television. The resident had stitches over the bridge of her nose, and both of her eyes were bruised / blackened. (The Surveyor took a photograph of the resident's eyes and nose at this time.) d. On [DATE] at 11:04 a.m., the resident was sitting in her wheelchair dosing off and was leaning forward in her wheelchair. (The Surveyor took a photograph of the resident in her wheelchair at this time.) e. As of 3/3/2020 at 5:58 p.m., the Care Plan contained no documentation related to falls or falls with major injury. f. On 3/4/2020 at 10:38 a.m., the Director of Nursing (DON) was asked, If a resident has a fall with a major injury, should there be an intervention put in place to avoid future falls and injury? She stated, Yes. She was asked, Should an intervention be on the resident's Care Plan? She stated, Yes. She was asked, How do you determine the root cause of the fall / injury and come up with interventions to avoid future falls? She stated, I look at everything. I look at the room, diagnoses, wheelchair, medications, something physical, the time of day, labs (laboratory results). I just look at everything physiological. g. On 3/4/2020 at 10:52 a.m., the MDS Coordinator was asked, If a resident has a fall with a major injury, should there be an intervention put in place to avoid future falls and injury? She stated, Yes. She was asked, Should an intervention be on the resident's Care Plan? She stated, Yes.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Plan of Care was revised after a fall to include interventions that were initiated to minimize the potential for further falls or injuries for 1 (Resident #87) of 7 (Residents #87, #34, #48, #50, #68, #88, and #92) sampled residents who had falls in the last 4 months. This failed practice had the potential to affect 23 residents who had falls in the last 4 months, according to a list provided by the Director of Nursing on 3/4/2020. The findings are: 1. Resident #87 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] documented the resident scored 7 (0-7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS); required extensive assistance with bed mobility, dressing, and personal hygiene; required supervision with transfer, locomotion on and off the unit, eating, and toilet use; and had one fall with injury since admission. a. A Progress Note dated [DATE] documented, . Notified by CNA (Certified Nursing Assistant) resident on the floor in her bathroom. Noted resident laying on right side against door frame slouched forward with knees bent under her in front of toilet. Assisted up to bed. ROM (Range of Motion) intact bilat (bilateral) upper and lower extremities. PERRLA {pupils equal, round, and reactive to light, accommodation). No bruising, skin tears, or any injuries noted at this time. Resident denied any pain at this time. Resident stated she tried to get up from the toilet and her legs were weak and she fell . V/S (vital signs) . T (temperature) 101 AX (axillary) . BP (blood pressure) 128/55 . P (pulse) 129 . R (respirations) 24 . SPO2 (oxygen saturation) 96%. On call RN (Registered Nurse) supervisor notified, Doctor, and (Name) . New orders rec'd (received) and noted for 30-minute checks. Neuro (neurological) checks initiated and STAT (immediate) orders for CBC (complete blood count), CMP (complete metabolic panel), UA (urinalysis) With Reflex Culture .FLU (Influenza) Swab and 2 view chest x-ray. PRN (as needed) Tylenol given for elevated temp (temperature). Labs, chest x-ray ordered and collected . b. A facility Incident and Accident (I&A) report dated [DATE] documented, .Incident Description Notified by CNA (Certified Nursing Assistant) resident on the floor in her bathroom. Noted resident laying on right side against door frame slouched forward with knees bent under her in front of toilet. Assisted up to bed. ROM (Range of Motion) intact bilat (bilateral) upper and lower extremities. PERRLA (pupils equal, round, and reactive to light, accommodation). No bruising, skin tears, or any injuries noted at this time. Resident denied any pain at this time. Resident Description . Resident stated she tried to get up from the toilet and her legs were weak and she fell . Immediate Action Taken On call RN (Registered Nurse) Supervisor notified, Doctor, and (Name) Family Member. New orders rec'd (received) and noted for 30-minute checks. Neuro (neurological) checks initiated and STAT (immediate) orders for CBC (complete blood count), CMP (complete metabolic panel), UA (urinalysis) with Reflux Culture, Flu (Influenza) swab and 2 view chest X-ray. PRN (as needed) Tylenol given for elevated temp (temperature) . Resident taken to Hospital? N (No) . c. As of 3/3/2020 at 1:25 p.m., the resident's Care Plan contained no documentation related to an intervention for the fall that occurred on [DATE]. d. On 3/4/2020 at 10:38 a.m., the Director of Nursing (DON) was asked, If a resident has falls documented on their Care Plan, should the Care Plan be revised for a new fall intervention? She stated, Yes. e. On 3/4/2020 at 10:38 a.m., the MDS Coordinator was asked, If a resident has falls documented on their Care Plan, should the Care Plan be revised for a new fall intervention? She stated, Yes.
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, the facility failed to ensure multiple plug extension cords were not used as a substitute for fixed wiring of electrical outlets in 1 (Resident #43) of 27 rooms on the 200 Hall, to prevent the possible ignition of overloaded electrical outlets and failed to ensure extension cords were not placed on the 200 Hall Residents' floor approximately 1 to 3 foot from the head of the bed to create a possible trip hazard. This failed practice had the potential to affect all 94 residents who resided in the facility, according to the Midnight Census Report provided by the Director of Nursing on [DATE] at 11:12 a.m. The facility also failed to ensure interventions were developed and implemented to prevent further potential falls and minimize the risk for fall related injuries for 1 (Resident #68) of 7 (Residents #68, #43, #88, #34, #50, #92, and #87) sampled residents who had falls in the past 3 months. This failed practice had the potential to affect 23 residents who had falls in the past 3 months, according to a list provided by the Director of Nursing on [DATE]. The findings are: 1. Resident #43 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/6/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview of Mental Status (BIMS); required extensive two plus person assistance with bed mobility, toilet use, and personal hygiene; was totally dependent on two person assistance with transfer; and had functional limitation in range of motion on both sides of lower extremities. a. Resident #43's Care Plan with a revised date of 9/25/19 documented, . Potential to fall associated with mobility issues . Identify and apply safety measures / factors that increase potential for injury to help decrease falls / injuries . Maintain physical environment to help ensure safety this review period . Promote safety and help prevent falls this review period . Will receive minimal / no injuries from falls this review period . Needs a safe environment with . even floors free from spills and / or clutter . adequate, glare-free light . a working and reachable call light . the bed in low position at night . handrails on walls . personal items within reach . b. On [DATE] at 9:21 a.m., Resident #43's room, located on the 200 Hall, had a 3 electrical outlet household extension cord plugged into a wall electrical outlet. There were two electrical plug-ins in the extension cord. c. On [DATE] at 9:21 a.m., Resident #43's room located on the 200 Hall contained a multi-three electrical outlet extension cord that had a nebulizer, a [MEDICAL CONDITION] machine, and oxygen concentrator plugged into it with the middle plug in point protruding inch from the outlet. There were 3 electrical cords plugged into the extension cord, and the extension cord was lying on the floor on the left side of the resident's head of the bed. The cords were extending approximately 3 feet from the wall and the middle plug-in was not securely plugged into the extension cord. d. On 3/4/2020 at 3:10 p.m., the Director of Nursing (DON) was asked to provide the facilities policy on the use of extension cords and multiple outlet cords in resident rooms. As of 3/4/2020 at 4:00 p.m., the Maintenance Supervisor was not available, and no facility policy regarding extension cords was located by the Director of Nursing (DON). 2. Resident #68 was admitted on [DATE] with [DIAGNOSES REDACTED]. The Medicare 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/31/2020 documented the resident scored 8 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (MDS); required extensive two plus person assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene; had no falls prior to admission; and had no falls since admission. a. A

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) Progress Note dated 2/29/2020 at 11:40 a.m. documented, .CNA (Certified Nursing Assistant) found resident in the floor next to bed laying on her stomach. CNA called out for help. This nurse went to assess resident and found resident laying prone in the floor next to bed. Assisted resident to a sitting position and observed a laceration to the bridge of the nose. CNA and nurse assisted resident into wheelchair. This nurse attempted to get the bleeding under control with no success. This nurse asked resident what had happened, and resident stated, 'I fell asleep in my chair and fell .' RN (Registered Nurse) on call and physician notified. Received order to send resident to ER (emergency room) for evaluation and treatment. (Name), significant other notified. BP (Blood Pressure) 130/79 . P (Pulse) 119 . R (Respirations) 20 . Temp (Temperature) 96.4 ax (axillary) . Sp02 (oxygen saturation) 95% on room air . b. A facility Incident and Accident (I&A) Report dated 2/29/2020 documented, .Incident Description . Resident found in floor by CNA (Certified Nursing Assistant) with blood in the floor and resident had a laceration to the bridge of her nose . Resident Description . Resident stated, 'I fell asleep in my chair and fell .' . Immediate Action Taken . Assisted resident into wheelchair, gave tissue to collect blood . Resident Taken to Hospital? N (No) . Physician, Family and POA (Power of Attorney) notified . c. On [DATE] at 11:00 a.m., the resident was sitting in her wheelchair in her room watching television. The resident had stitches over the bridge of her nose, and both of the resident's eyes were bruised / blackened. (The Surveyor took a photograph of the resident's nose and eyes at this time.) d. On [DATE] at 11:24 a.m., the resident was dosing off and leaning forward in her wheelchair. (The Surveyor took a photograph of the resident in her wheelchair at this time.) e. As of 3/3/2020 at 5:58 p.m., the resident's Care Plan contained no documentation related to falls or falls with major injury. f. On 3/4/2020 at 10:32 a.m., Licensed Practical Nurse (LPN) #4 was asked, If a resident has a fall with a major injury, should there be an intervention put in place to avoid future falls and injury? He stated, Yes. g. On 3/4/2020 at 10:38 a.m., the Director of Nursing (DON) was asked, If a resident has a fall with a major injury, should there be an intervention put in place to avoid future falls and injury? She stated, Yes. She was asked, How do you determine the root cause of the fall / injury and come up with interventions to avoid future falls? She stated, I look at everything. I look at the room, diagnosis, wheelchair, medications, something physical, the time of day, labs. I just look at everything physiological. h. On 3/4/2020 at 10:52 a.m., the MDS Coordinator was asked, If a resident has a fall with a major injury, should there be an intervention put in place to avoid future falls and injury? She stated, Yes.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to use appropriate hygiene practices when providing incontinent care in accordance with infection control standards of practice to prevent possible urinary tract infections; and failed to ensure the indwelling urinary catheter tubing was secured to avoid possible trauma or injury to the urinary meatus or bladder by accidently pulling on the tubing when the resident turns / moves and during positioning or incontinent care for 1 (Resident #64) of 5 (Residents #64, #27, #53, #69, and #85) sampled residents who had physician's orders [REDACTED]. This failed practice had the potential to affect 11 residents who had physician's orders [REDACTED]. Resident #64 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/27/2020 documented the resident scored 13 (13-15 indicates cognitively intact) on a Brief Interview of Mental Status Score; required extensive assistance of 2 persons for bed mobility, transfers, dressing, toileting, and personal hygiene; and was always incontinent of bowel. a. A physician's orders [REDACTED].Foley cath (catheter) 18F (French) / 30 cc (cubic centimeters) . change monthly starting 1/20/19 for Obstructive and Reflex [MEDICAL CONDITION] . b. On [DATE] at 3:47 p.m., Certified Nursing Assistant (CNA) #2 and CNA #3 provided pericare for the resident with catheter care. There was no device in place to secure the catheter tubing to prevent potential pulling and trauma to the urinary meatus or bladder. The resident's catheter tubing and collection bag was left on the bed frame and was not moved to other side of the bed when the resident was turned to the left side for care. The catheter tubing with cloudy yellow urine in the drainage bag was pulled taut between the resident's legs, between her knees and feet. c. On [DATE] at 3:50 p.m. the resident was asked if she felt the tubing pulling when the staff turned her. She stated, Yes, it pulled. She was asked if she felt uncomfortable when the tubing felt like it was pulling. She stated, Yes, a little bit. d. On [DATE] at 4:00 p.m., CNAs #2 and #3 were asked if the catheter tubing should have had a device to secure it to the resident's thigh so it would not pull or be accidentally pulled out. They stated, Yes, but some residents don't like to use them and refuse them. e. On [DATE] at 4:11 p.m., the resident was asked if she had been offered or had used a device to secure the catheter tubing from moving and pulling. The resident stated, No. f. On [DATE] at 4:15 p.m., CNAs #2 and #3 were asked if the catheter tubing should have been secured with a leg strap or stat lock. Both CNAs #2 and #3 stated, Yes, it should have been there. CNAs #2 and #3 were asked if the catheter drainage collection bag should have been moved to ensure the tubing didn't pull when she (the resident) was turned. They stated, Yes, it should have been moved to the other side of the bed so as not to pull. g. On [DATE] at 4:19 p.m., CNAs #2 and #3 were asked when hand sanitizer or handwashing should be used when providing incontinent care. CNA #3 stated, We wash after we change soiled gloves. No hand sanitizer was observed by the surveyor to be used by the CNAs except with the initial glove change. h. [DATE] at 4:29 p.m., the Director of Nursing (DON) was asked what her expectations were for incontinent care and the use of hand sanitizer and handwashing during glove changes and if gloves are visibly soiled, and regarding the use of a stat lock or securing catheter tubing and moving the catheter collection bag when rolling the resident when the resident is turned so the tubing does not pull. The DON stated, I expect the catheter collection bag to be moved to the other side of the bed and secured to the resident so as not to pull or accidently come out. I expect when gloves are removed, hand sanitizer or hand washing is done before continuing care. i. The facility policy titled Catheter Care provided by the DON on [DATE] at 4:39 p.m. documented, .Purpose . To prevent infection and to reduce irritation . Procedure . 5. Cleanse area well at catheter insertion site, taking care not to pull on catheter or advance further into the urethra .
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure an enteral feeding container was labeled with an identifying name, date, and time of initiation of the delivery bag to prevent possible pathogen growth and cross contamination for 1 (Resident #27) of 3 (Residents #27, #53, and #21) sampled residents who had physician's orders [REDACTED]. Resident #27 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set Assessment with an Assessment Reference Date of 12/23/19 had a Staff Assessment for Mental Status score of 3 (3 indicates severe impairment); was totally dependent and needed assistance of one to two plus persons for all activities of daily living tasks; had a feeding tube; received 51% or more of total calories per tube feeding; and received 501 cubic centimeters per day or more of fluid intake per tube feeding. a. The resident's physician's orders [REDACTED].Enteral Feed order every shift Enteral Nutrition via Pump Fibersource HN (High Nitrogen) at 70 ml (milliliters) / hr (hour) for 24 hours . continuous water flush at 55 ml/hr via kangaroo pump every shift . b. On [DATE] at 11:35 a.m., Resident 27's enteral nutrition bag was hanging from the infusion pump at the bedside. There was no identifying name, substance identification contained in the bag, or date and time documented on the bag. The water flush bag was also hanging on the infusion pump, approximately seventy-five percent full of fluid, and contained no identifying name, substance identification, date or time. c. On 3/4/2020 at 9:18 a.m., the Director of Nursing (DON) was asked if the enteral feeding bag should be labeled and dated. The DON stated, Yes. The DON was asked if the water flush bag should be labeled and dated. The DON stated, Yes. d. A facility policy titled Enteral Feeding Pump-Guidelines For Use provided by the DON on 3/5/2020 at 9:48 a.m. documented, .Documentation . Date, time (or shift) . Reason for the feeding pump . Type and amount of formula administered . Amount of water flushed . Rate of Administration . Signature and title .
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure an oxygen flow rate was set at the physician ordered amount for 2 (Residents #69 and #294) sampled residents, oxygen tubing was properly stored when not in

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	045326	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRAWFORD HEALTHCARE AND REHABILITATION CENTER	2010 MAIN STREET VAN BUREN, AR 72956

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) use for 4 (Residents #68, #43, #87, and #294) sampled residents who received oxygen therapy, and 1 (Resident #43) sampled resident who received bi-level positive airway pressure (Bi-Pap) therapy; tubing and humidification bottle were properly dated when initiated to ensure tubing was changed out at the frequency specified on the plan of care for 4 (Residents #43, #68, #87, and #294) sampled residents; and only licensed personnel adjusted the oxygen flow rate to prevent potential complications for 1 (Resident #69) of 12 (Residents #69, #27, #77, #73, #83, #43, #64, #295, #2, #87, #30, and #294) sampled residents who received oxygen and/or Bi-Pap therapy. This failed practice had the potential to affect 18 residents who received oxygen therapy, and 1 resident who received bi-level positive airway pressure (Bi-Pap) therapy, based on a list provided by the Director of Nursing (DON) on 3/4/2020 at 8:09 a.m. The findings are: 1. Resident #69 had [DIAGNOSES REDACTED]. A Significant Change Minimum Data Set with an Assessment Reference Date of 1/30/2020 documented the resident scored 3 (3 indicates severe impairment) on a Staff Assessment for Mental Status; required extensive two-plus person assistance for bed mobility, dressing, toilet use, and personal hygiene; was totally dependent on two-plus person assistance with transfer; had shortness of breath with exertion, when sitting at rest, and when lying flat; and received oxygen therapy. a. A physician's orders [REDACTED].O2 (oxygen) (at) 3 L/MIN (liters per minute) via N/C (nasal cannula) continuous every shift related to heart failure . b. On [DATE] at 11:20 a.m., Resident 69's oxygen flow rate was set at 2 liters per minute and was delivered by nasal cannula. c. On 3/4/2020 at 9:00 a.m., the resident was in a gerichair being escorted to the Day Room by Certified Nursing Assistant (CNA) #1. The resident's oxygen flow rate was set at 3 liters per minute and was delivered from a portable oxygen canister secured to the back of the chair. d. On 3/4/2020 at 9:05 a.m., CNA #1 was asked who changed the oxygen tubing from the concentrator to the portable oxygen canister on the back of the chair. She stated, I did. CNA #1 was asked, Who set the oxygen flow rate? CNA #1 stated, I did. e. On 3/4/2020 at 9:18 a.m., the Director of Nursing (DON) was asked if any aide is allowed to set the oxygen flow rate or change oxygen tubing from the concentrator to the portable tanks. The DON stated, No, the aides are not allowed to touch the oxygen at all because it's like a medication. The DON was asked if the flow rate should match what the physician's orders [REDACTED]. f. A facility policy titled Oxygen Administration provided by the DON on [DATE] at 2:18 p.m. documented, .Oxygen shall be administered to resident only by a capable person trained in the administration and use . 2. Resident #43 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/6/2020 documented a Brief Interview for Mental Status (BIMS) score of 15 (a score of 13 to 15 indicated cognitively intact); was totally dependent on two-plus persons for transfers and bathing, required extensive assistance of two persons for bed mobility, dressing, toilet use, and personal hygiene; had shortness of breath with exertion, when sitting at rest, and when lying flat; and received oxygen therapy. a. A physician's orders [REDACTED].[MEDICATION NAME] Nebulization Solution (2.5 MG/3ML) (milligram per milliliter) 0.083% 3 ml (milliliters) inhale orally via nebulizer every 8 hours as needed for wheezing related to Chronic [MEDICAL CONDITION] With [MEDICAL CONDITION] . Rinse nebulizer mouth piece after each administration . Lay on paper towel . allow to air dry before placing back in bag . b. A physician's orders [REDACTED].Oxygen at 3 to 4 l/m (liters per minute) via nasal cannula every shift . c. A physician's orders [REDACTED].[MEDICAL CONDITION] (Bi-Level Positive Airway Pressure) at HS (bedtime) and PRN (as needed) . settings 20/6 as needed for SOB (shortness of breath) . d. On 2/27/2020 Resident #43 was diagnosed with [REDACTED]. e. A physician's orders [REDACTED].Clean oxygen machine, nebulizer, and [MEDICAL CONDITION] and filters . change out tubing and water . date everything once a week on Tuesday nights . Clean [MEDICAL CONDITION] hose and mouth / nasal piece with hot soapy water rinse and replace with unit and cover with clean plastic bag and seal . To be done weekly every night shift every Tuesday . Monitor and document O2% (oxygen) and liters of O2 in use q (every) shift related to Chronic [MEDICAL CONDITION] with [MEDICAL CONDITION] . f. On [DATE] at 11:52 a.m., 3 bath basins were sitting on the bedside table with first (closest to bed) basin with a Sierra nebulizer machine with tubing / medication cup open to air lying to the side and on top of the machine. The middle bath basin contained a [MEDICAL CONDITION] machine, with its mask and tubing open to air. The third bath basin had oxygen tubing and masks placed in it, open to air. A zipper type plastic bag was available beside the oxygen tubing but was not being used to protect the oxygen tubing, masks, and respiratory equipment from possible contaminates in the room or being in contact with pathogens to prevent a possible resident infection. g. On [DATE] at 11:55 a.m., the oxygen concentrator attached humidifier beside the resident's bed had connected oxygen tubing that was not dated. h. On 3/3/2020 at 8:53 a.m., the Director of Nursing (DON) was asked how the respiratory tubing, masks, and equipment are stored to prevent contamination and infection. The DON stated, They should be cleansed if needed, and placed in a plastic bag. They should not be left out in the open in basins to avoid contamination. The DON was asked about placing a date on the oxygen. She stated, They are supposed to write a date on it when it was changed on the oxygen tubing or humidifier. 3. Resident #68 had [DIAGNOSES REDACTED]. The Medicare 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/31/2020 documented the resident scored 8 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (MDS); required extensive two-plus person assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene; required supervision while eating; had shortness of breath with exertion; and received oxygen therapy. a. The physician's orders [REDACTED].O2 (oxygen) (at) 2L (liters) via NC (nasal cannula) Clean oxygen machine and filter . change out tubing and water, date everything once a week every night shift every Mon (Monday) . b. The Care Plan documented, .Oxygen as ordered . c. On [DATE] at 11:00 a.m., the resident was sitting in a wheelchair in the room watching television. The resident had an oxygen concentrator present in the room that was turned off. The oxygen tubing and humidification bottle were dated [DATE]. There was no storage bag present. (The Surveyor took a photograph of the oxygen concentrator, tubing, and humidification bottle at this time. 4. Resident #87 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] documented the resident scored 7 (0-8 indicates severely impaired) on a Brief Interview for Mental Status (BIMS); required extensive assistance with bed mobility, dressing, and personal hygiene; required supervision with transfer, eating, and toilet use; had shortness of breath with exertion; and did not receive oxygen therapy. a. The physician's orders [REDACTED].O2 (at) 2 to 4 L/M (liters per minute) via NC (nasal cannula) PRN (as needed) for Shortness of breath Clean oxygen and nebulizer machine and filters . Change out tubing and water, date everything, once a week b. The residents Care Plan documented, .Oxygen as ordered . c. On [DATE] at 11:08 a.m., the resident was in the room sitting in a recliner with eyes closed. An oxygen concentrator was present in the room and running at 2.5 to 3.0 liters per minute (LPM). (The Surveyor took a photograph of the oxygen concentrator at this time.) The oxygen tubing and humidification bottle were not dated and there was no storage bag present. (The Surveyor took a photograph of the oxygen humidification bottle at this time.) The oxygen tubing was under the resident's bed blanket. (The Surveyor took a photograph of the oxygen tubing at this time.) An oxygen tank was sitting at the foot of the resident's bed. The oxygen tubing connected to the oxygen tank was not dated and no storage bag was present. The oxygen tubing was draped over the oxygen tank with the nasal cannula portion lying on the floor. (The Surveyor took a photograph of the oxygen tubing and nasal cannula at this time.) 5. Resident #294 had [DIAGNOSES REDACTED]. The 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/25/2020 documented the resident scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS); required supervision with bed mobility and transfer; required limited one person assistance with personal hygiene; had shortness of breath with exertion, when sitting at rest, and when lying flat; and received oxygen therapy. a. The physician's orders [REDACTED]. clean oxygen and nebulizer machine and filters . change out tubing and water, date everything, once a week every night shift every Sun (Sunday) . b. The residents Care Plan documented, .Oxygen as ordered . c. On [DATE] at 1:31 p.m., the resident was in the room lying in bed. The resident had an oxygen concentrator in the room and the flow rate was set on 5 to 6 liters of oxygen per minute via nasal cannula. The oxygen tubing and humidification bottle were not dated and there was no storage bag present. (The Surveyor took a photograph of the oxygen tubing and humidification bottle at this time.) d. On 3/4/2020 at 10:32 a.m., Licensesd Practical Nurse (LPN) #4 was asked, Should physician's orders [REDACTED].? He stated, Yes. He was asked, How often should oxygen tubing, humidification bottle, and storage bags be changed? He stated, We change them weekly. He was asked, Should oxygen tubing, humidification bottle, and storage bags be dated? He stated, Yes. e. On 3/4/2020 at 10:38 a.m., the Director of Nursing (DON) was asked, Should physician's orders [REDACTED].? She stated, Yes. She was asked, How often should oxygen tubing, humidification bottle, and storage bags be changed? She stated, Weekly. She was asked, Should oxygen tubing, humidification bottle, and storage bags be dated? She stated, Yes. f. The facility policy titled Oxygen Administration provided by the Director of Nursing on 3/4/2020 documented, .Policy . Oxygen shall only be administered by Physician order [REDACTED]. When oxygen is not in use, the tubing and cannula are to be coiled and

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) placed in a plastic bag . Procedure . 1. Check Physician order [REDACTED]. 7. Care and Use of Prefilled Disposable Humidifiers . a. Prefilled disposable humidifiers may be changed per facility policy i. Label humidifier with date, time opened, and your initials . Change humidifier and tubing weekly on 11-7 shift per facility policy 8. Care and Use of Reusable Humidifiers . g. Label humidifier with date, time opened and your initials . Change humidifier and tubing weekly on 11-7 shift per facility policy .
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure [MED] stored in the medication cart was labeled, dated, and disposed of in accordance with manufacturer's instructions, state laws, and accepted standards of pharmacy practice for 1 (Resident #2) who had physician's orders [REDACTED].#74, #13, #37, and #43) residents who had physician's orders [REDACTED].#77) who had physician's orders [REDACTED].#73) who had physician's orders [REDACTED]. The findings are: 1. On 3/4/2020 at 1:51 p.m., the West 1 Medication Cart was checked with Licensed Practical Nurse (LPN) #2 with the following results: a. Resident #74 had a medication card containing [MEDICATION NAME] 4 milligrams (mg) one tablet by mouth every 4 hours as needed for nausea / vomiting on the Medication Cart. The medication had an expiration date of [DATE]20. b. Resident #13 had a medication card containing [MEDICATION NAME] 4 mg 1 tablet by mouth every 6 hours as needed for nausea / vomiting on the Medication Cart. The medication had an expiration date of 2/27/20. c. Resident #37 had a medication card containing [MEDICATION NAME] 4 mg 1 tablet by mouth every 4 hours as needed for nausea / vomiting on the Medication Cart. The medication had an expiration date of [DATE]. d. Resident #77 had a medication card containing [MEDICATION NAME] 25 mg tablet by mouth every 6 hours as needed for itching on the Medication Cart. The medication had an expiration date of 2/3/20. e. Resident #2 had 2 Novalog Flex Pens in the Medication Cart. The [MED] flex pen contained no label. The medication was disposed of by Licensed Practical Nurse (LPN) #2 and reordered from the pharmacy. LPN #2 was asked, Should expired medications be on the Medication Cart? She stated, No. 2. On 3/4/2020 at 2:01 p.m., the East 2 Medication Cart was checked with LPN #1 with the following results: a. Resident #73 had a medication card containing [MEDICATION NAME] 25mg capsule 1 capsule by mouth every 8 hours as needed for anxiety on the Medication Cart. The medication had an expiration date of 1/27/20. b. On 3/4/2020 at 2:15 p.m., LPN #1 was asked, Should expired medications be on the Medication Cart? She stated, No. 3. On 3/4/2020 at 2:07 p.m., the Central Medication Cart was checked with LPN #3 with the following results: a. Resident #43 had a medication card containing [MEDICATION NAME] 4 mg 1 tablet by mouth every 6 hours as needed for nausea / vomiting on the Medication Cart. The medication had an expiration date of 11/18/19. b. LPN #3 was asked, Should expired medications be on the Medication Cart? She stated, No. c. On 3/4/2020 at 2:09 p.m., the Director of Nursing was asked, Should expired medications be on the Medication Cart? She stated, No.
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served in accordance with the planned, written menu for 2 of 2 meals observed. This failed practice had the potential to affect all 89 residents who received meals from the kitchen, according to the list provided by Consultant #1 on 3/4/2020. The findings are: 1. On [DATE] at 12:25 p.m., Dietary Employee #1 was asked about the dessert. She stated, We didn't have time for all that. They are getting ice cream today. 2. On [DATE] at 12:25 p.m., the facility menu documented pumpkin pie was the dessert for the lunch meal. 3. On [DATE] at 9:30 a.m., Dietary Employee #3 was preparing the chili for Frito pie for the lunch meal. The quantified recipe for 100 people documented 15 pounds plus 12 ounces of ground beef. The facility used the 15 pounds and 12 ounces per the recipe. The recipe stated 12 and 1/2 ounces of onions. She cut one large onion and put it in the pot. The recipe documented canned diced tomatoes 3 and 3/4 quarts plus 1/2 cup. Dietary Employee #3 used one (1) 6.63-pound stewed tomatoes instead. The next ingredient was canned tomato puree, 3 quarts plus 1/2 cup. Dietary Employee #3 used tomato sauce. The recipe documented chili powder 3/4 cup plus 1 tablespoon. Dietary Employee #3 sprinkled chili powder over the top of the tomatoes and stated, I don't have any idea where our measuring spoons are. The recipe calls for ground cumin 2 tablespoons plus 1 teaspoon. She sprinkled cumin on top. The recipe documented salt 1/4 cup plus 2 and 1/2 teaspoons. She just sprinkled salt and stated, That looks good. The recipe documented black pepper 3/4 teaspoon. She sprinkled black pepper over the top. The recipe documented 1/4 cup of sugar and 3 tablespoons. She used a measuring cup and placed 1/4 cup of sugar in the chili. The recipe documented 14 pounds plus 12 ounces of dark red kidney beans. Dietary Employee #3 added two gallons of dark red kidney beans. Dietary Employee #3 stated, I will tell you right now, it calls for diced tomatoes and I don't have them, and it calls for tomato puree and I have tomato sauce. You work with what you have.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, record review, and interview, the facility failed to ensure dietary staff wore hair restraints to prevent potential contamination of food when preparing or serving food; failed to ensure food items stored in the refrigerator and the freezer were labeled, dated, and sealed when opened, and failed to ensure kitchen equipment was maintained in clean and sanitary condition to minimize the potential for food borne illness for residents who received meals from 1 of 1 kitchen. These failed practices had the potential to affect 89 residents who received meals from the kitchen, as documented on a list provided by the Consultant on 3/4/2020. The findings are: 1. On [DATE] at 10:45 a.m., the sink to the left of the door contained a brown liquid in the bottom of the sink. 2. On [DATE] at 10:48 a.m., Dietary Employee #1 removed the green bean casserole from the oven and was going to start puree the green bean casserole. Dietary Employee #1 was asked, How many pureed diets do you have here? She stated, I'm not sure. We are doing the best we can. She was asked, Are you short-handed? She stated, It's hard to know what to do when we don't have a boss to let us know what our census is. 3. Dietary Employee #1 put on gloves and went to the worktable and put on oven mitts over her gloves. Dietary Employee #1 took off the oven mitts and went to get a #8 scoop from a hanger on the wall. Without changing gloves, she scooped seven #8 scoops of green beans into the Robo coup. Dietary Employee #1 finished the pureed green beans and placed them in a metal container. Dietary Employee #1 took the pan of green bean casserole and placed it on the worktable. She reached over and got a bag of dried onions, opened it, and spread the dried onions with the gloved hands. She was asked, Should you have changed gloves before you spread the onions? She stated, Yes. I am just trying to get it done. 4. On [DATE] at 11:02 a.m., the pureed green beans very a thin consistency. 5. On [DATE] at 11:15 a.m., one 11-pound container of creamy coleslaw was stored on a shelf in the refrigerator. The coleslaw contained no label or date as to when it was opened. a. One 5-pound container of cottage cheese was stored on a shelf in the refrigerator. The cottage cheese contained no date or label that documented when it was opened. b. One 5-pound container of sour cream was stored on a shelf in the refrigerator. The sour cream contained no date or label. 6. On [DATE] at 11:15 a.m., the following observations were made in the freezer: a. One box containing cheese omelets was stored on a shelf in the freezer. The omelet box was open and food in the box was exposed to air. 7. On [DATE] at 11:18 a.m., food crumbs were on the shelves where pans were being stored underneath the Robo coupe. The serving line had eggs scattered across the serving line. (The eggs were not cleaned up before the lunch meal service was started.) There were napkins wadded up and were on the plate warmer next to the clean plates. 8. On [DATE] at 11:20 a.m., Dietary Employee #1 put on gloves and retrieved a pan from the pan rack. The pan was still wet with droplets of water. Dietary Employee #1 shook it out and placed the cooked rolls in the pan. The Registered Nurse (RN) Supervisor stated she needed some coffee cups. Dietary Employee #1 walked over and got a tray of coffee cups and took them to the supervisor. With the same gloves still on, she went back to the task she was working on never changing her gloves. Dietary Employee #1 walked to the sink and put approximately a gallon of water into a

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	045326	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRAWFORD HEALTHCARE AND REHABILITATION CENTER	2010 MAIN STREET VAN BUREN, AR 72956

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

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 6) water pitcher. She walked back to the preparation table, and with the same gloved hands, used her hands to scoop out chicken base put it in the water. She put her fingers in the water to rinse off the chicken base. 9. On [DATE] at 11:30 a.m., Dietary Employee #1 prepared to do the pureed stuffing. She placed seven #8 scoops of stuffing in the Robo coupe and used the chicken base to thin the mixture. The chicken base was added several times the mixture. The pureed mixture of stuffing was a thin consistency. 10. On [DATE] at 11:30 a.m., Dietary Employee #1 filled drink pitchers. She reached to pick up the pitcher with her hands, placing her first two fingers inside of the pitcher, contaminating the top of 5 of 8 drink pitchers. 11. On [DATE] at 11:30 a.m., Dietary Employee #2 was asked, Do you change the way you serve from the weekend to week-days? She stated, On the weekend we do it the RN Supervisor way. She was asked, Does it rush the residents? She stated No. 12. On [DATE] at 11:50 a.m., Dietary Employee #1 was asked, Is that breakfast crumbs still on the steam table? She stated, Yes, we are doing all we can. The egg crumbs were left on the steam table while loading the steam table for the lunch meal. 13. On [DATE] at 12:30 p.m., Dietary Employee #4 came into kitchen and went to the serving line to help serve dinner. Dietary Employee #4 did not have on a hair net at the time she was serving on the line. 14. On [DATE] at 12:30 p.m., the RN Supervisor came to the door of kitchen, walked in, and washed her hands without a hair net. She stepped out of the kitchen, put on a hair net, and came back in the kitchen to get drink carts.
F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Dispose of garbage and refuse properly.** Based on observation and interview, the facility failed to ensure trash was properly contained within 1 of 3 dumpsters, to minimize the presence of foul odors and decrease the potential for pest infestation. The failed practice had the potential to affect all 94 residents who resided in the facility, as documented on the Resident Census and Conditions of Residents form dated [DATE]. The findings are: 1. On 3/3/2020 at 9:20 a.m., the dumpster area was checked with the Maintenance Supervisor. The first dumpster had approximately 15 clear gloves lying to the left side of the dumpster, two clear bags with rolled up white bundles that appeared to be an incontinent brief, two white wadded up pieces of paper towels, a clear bag, and two straws. On the right side of the dumpster was 7 clear gloves, a brown bag, and 3 pieces of white paper. 2. On 3/3/2020 at 9:20 a.m., the Maintenance Supervisor was asked, Should there be trash around the dumpster? He stated, No, but it's an on-going problem. 3. On 3/3/2020 at 10:30 a.m., the Administrator was asked, Should trash be accumulated around the dumpster? He stated, No.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure staff changed gloves and washed hands between dirty and clean tasks during the provision of incontinent care to prevent potential cross-contamination that could result in infection for 1 (Resident #64) of 4 (Residents #64, #34, #43, and #50) sampled residents who were dependent for incontinent care; and failed to ensure the urinary catheter tubing was secured to decrease the potential for trauma or injury to the urinary structures during positioning or the provision of incontinent care for 1(Resident #64) of 5 (Residents #27, #53, #64, #69, and #85) sampled residents who had an indwelling urinary catheter, per the list provided by the Director of Nursing on 3/4/20 at 8:09 a.m. This failed practice had the potential to affect 70 residents who were dependent for incontinent care and 11 residents who had indwelling urinary catheters, according to a list provided by the Director of Nursing on 3/4/2020. The facility failed to ensure Intravenous (IV) tubing was properly timed / dated when initiated, the tubing capped when not in use, and the dressing secure to prevent potential cross-contamination and infection for 1 (Resident #294) of 1 sampled resident who had a Peripherally Inserted Central Catheter (PICC line) and required intravenous antibiotics; and failed to ensure an effective method was in place to alert staff and visitors of the need for isolation precautions prior to entering the room and meal trays were served on styrofoam to prevent the potential spread of infection for 1 (Resident #294) of 1 (Resident #294) sampled resident who required isolation precautions. This failed practice had the potential to affect 1 resident who required isolation, according to the list provided by the Director of Nursing on 3/4/2020. The facility also failed to ensure staff changed gloves / washed hands between dirty and clean tasks during and after the provision of [MEDICAL CONDITION] care to prevent potential cross contamination and infection for 1 (Resident #27) of 2 (Residents #27 and #53) sampled residents who had a [MEDICAL CONDITION]. This failed practice had the potential to affect 2 residents who had a [MEDICAL CONDITION], according to a list provided by the Director of Nursing (DON) on 3/4/2020 at 8:11 a.m. The findings are: 1. Resident #64 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/27/2020 documented the resident scored 13 (13-15 indicates cognitively intact) on a Brief Interview of Mental Status; required extensive assistance of 2 persons for bed mobility, transfers, dressing, toilet use, and personal hygiene; was always incontinent of bowel; and had an indwelling urinary catheter. a. A physician's orders [REDACTED].Foley cath (catheter) 18Fr (French) /30 cc (cubic centimeter) . change monthly starting 1/20/19 for Obstructive and Reflex [MEDICAL CONDITION] . b. On [DATE] at 3:47 p.m., Certified Nursing Assistant (CNA) #2 and CNA #3 provided peri care for the resident with catheter care. The resident did not have a leg band or other device in place to secure the catheter tubing. CNA #3 removed Resident #64's soiled incontinent brief. The resident's perineal area was cleansed. CNA #3 changed her gloves and used hand sanitizer only when the resident's soiled incontinent brief was removed. The urinary catheter was cleansed proximal to distal with traction held at the urethra by CNA #3. c. On [DATE] at 3:51 p.m., the CNAs turned the resident to the left side and a small amount of brown fecal matter was visible at the resident's rectum. CNA #3 cleansed the fecal matter and removed her gloves. Without using any sanitizer, she walked into the resident's bathroom and obtained more incontinent supplies. Without washing her hands or using hand sanitizer, CNA #3 returned to the resident and continued incontinent care. d. On [DATE] at 4:05 p.m., CNAs #2 and #3 were asked when hand sanitizer or handwashing should be used when providing incontinent care. They stated, We wash after we change soiled gloves. No hand sanitizer was observed by the surveyor to be used by CNAs #2 and #3 except with the initial glove change, and no handwashing was done when CNA #3 went into the bathroom and obtained supplies. e. On [DATE] at 4:29 p.m., the Director of Nursing (DON) was asked what her expectations were for incontinent care and the use of hand sanitizer and handwashing during glove changes and if gloves are visibly soiled, and regarding use of stat lock or securing the catheter tubing, and moving the catheter collection bag when rolling / turning the resident so the tubing does not pull. The DON stated, I expect the catheter collection bag to be moved to the other side of the bed and secured to the resident so as not to pull or accidently come out. I expect when gloves are removed hand sanitizer or handwashing is done before continuing care. f. The facility policy titled Incontinent Care provided by the DON on 2/3/2020 at 4:39 p.m. documented, .Purpose . To keep skin clean, dry, free of irritation and odor . To prevent infection . Procedure . 10. Change your gloves as needed and wash your hands between glove changes . 20. Remove your gloves and wash your hands before straightening clean linens or providing any other care for the resident . g. The facility policy titled Handwashing and Hand Hygiene Policy provided by the DON on 2/3/2020 documented, .This facility recognizes the importance of handwashing or use of alcohol-based hand rubs in controlling the spread and acquisition of nosocomial infections . The need for hand hygiene depends on the type, intensity, and duration of resident contact or contact with articles considered contaminated . The following are examples of when hand hygiene is indicated . Before and after contact with a resident . 1. basins, soiled linens, waste receptacles . 9. Before and after changing an incontinent resident . 2. Resident #27 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set Assessment with an Assessment Reference Date of 12/23/19 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status; was totally dependent on one to two-plus person assistance for all activities of daily living tasks; required oxygen therapy; and did not have a [MEDICAL CONDITION]. a. On 3/3/2020 at 1:25 p.m., [MEDICAL CONDITION] (trach) care was provided by Licensed Practical Nurse (LPN) #3. She put on sterile gloves. She removed the inner canula of [MEDICAL CONDITION] threw it away. She cleaned the [MEDICAL CONDITION] with peroxide and gauze, and with Normal Saline and gauze. She picked up a drain sponge from the sterile drape area and placed the drain sponge around the [MEDICAL CONDITION]. She checked the resident's pulse oximetry and obtained a reading of 95%. She removed the [MEDICAL CONDITION] and placed the [MEDICAL CONDITION] around the resident's neck and behind his head while still wearing her sterile gloves. She removed the sterile inner cannula from the sterile tray area and inserted the cannula into the resident's trach, still using the same gloved hands. She removed her gloves and sanitized her hands. b. On 3/3/2020 at 2:00 p.m., LPN #3 was asked if anything should have been done differently after touching the things in the room, before putting on gloves, and beginning care. LPN #3 stated, I should have sterilized my hands before I put on the first pair of sterile gloves. LPN #3 was asked if gloves should have been changed and hands sanitized after cleaning and applying the [MEDICAL CONDITION], and before the sterile

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) inner cannula was picked up and inserted. LPN #3 stated, Yes. c. A facility policy titled [MEDICAL CONDITION] Care provided by the Assistant Director of Nursing on 3/3/2020 at 2:49 p.m. documented, .Procedure .3. Open sterile catheter using aseptic technique . Suction [MEDICAL CONDITION] using sterile technique . 4. Pour hydrogen peroxide or solution in basin . 5. Put gloves on . 6. Unlock inner cannula of [MEDICAL CONDITION], remove . 7. Remove dressing, discard in appropriate type of plastic bag and clean skin around [MEDICAL CONDITION] with applicators and peroxide . Remove all exudate and drainage . Do Not Allow any Solution to Enter Outer [MEDICAL CONDITION] or [MEDICAL CONDITION] Opening . 9. Suction before inserting inner cannula . 10. Insert inner cannula and lock into place . 11. Measure and cut [MEDICAL CONDITION] ties or collar to appropriate size . 13. Have a second person hold the [MEDICAL CONDITION] in place while changing ties or collar, if necessary . 14. Prepare [MEDICAL CONDITION] dressing . and fit around the ties or collar . 16. Remove gloves, discard all disposable equipment . 3. Resident #294 was admitted on [DATE] with a [DIAGNOSES REDACTED]. The Medicare 5- Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/25/2020 documented the resident scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS); required extensive assistance with bed mobility, transfer, and personal hygiene; and required supervision with dressing, eating, and toilet use; received antibiotic medications 6 out of the last 7 days; required isolation precautions; and received intravenous (IV) medications. a. A physician's orders [REDACTED].Insert PICC (peripherally inserted central catheter) line for medication administration . A physician's orders [REDACTED].[MEDICATION NAME] HCl ([MEDICATION NAME]) Solution Use 1 gram intravenously every 18 hours [MEDICAL CONDITIONS] . Midline dressing change with Salvador patch . b. The Care Plan dated 2/26/2020 documented, .Has a PICC line and is at risk for complications related to this . Change dressing as ordered using sterile technique . Keep site clean and dry . c. On [DATE] at 1:31 p.m., the resident was sitting in bed and was on isolation [MEDICAL CONDITION] in lungs (Pneumonia) and blood (Bacteremia). The resident was receiving contact and droplet precautions. There was isolation equipment (personal protective equipment) hanging on the door, but there was no sign indicating what type of isolation the resident was on, or to see the nurse before entering. (The Surveyor took a photograph of the door at this time.) The resident was receiving intravenous (IV) antibiotics. The IV tubing was not connected at this time, had no time or date on tubing, and no cap on the tubing end. (The Surveyor took a photograph of the IV tubing at this time.) The resident was receiving IV antibiotics via a peripherally inserted central catheter (PICC) line. The residents PICC line dressing occlusive was not secure. There were open areas and the dressing had been secured with multiple types of tape. There was no date or initials on the dressing. (The Surveyor took a photograph of the dressing at this time.) The resident had a regular meal tray in his room, and not styrofoam. d. On [DATE] at 11:16 a.m., the resident was asked, When was your PICC line dressing changed last? The resident stated, The dressing was changed a day or so ago and they applied tape right after they did it due to it no sticking. There was no dressing present over the PICC line site. (The Surveyor took a photograph of the PICC line site at this time.) e. On [DATE] at 2:29 p.m., the Director of Nursing (DON) was asked, Should IV tubing be dated, timed and initialed? She stated, Yes. She was asked, If IV tubing is going to be reused, should it be recapped after medication administration? She stated, Yes. She was asked, Should a resident's PICC line dressing be continually reinforced or changed? She stated, It should be changed. She was asked, How often are PICC line dressings changed? She stated, It depends. Seven days with bio patch, and 3 to 4 days without. She was asked, Who changes PICC line dressings? She stated, The LPN or RN, whoever is trained. She was asked, Should a meal tray be removed from the resident's room with regular dishes? She stated, It should not be regular dishes. It should be Styrofoam and just thrown away. f. On 3/4/2020 at 10:32 a.m., Licensed Practical Nurse (LPN) #4 was asked, Should IV tubing be timed, dated, and initialed? He stated, Yes. He was asked, Should IV tubing be capped after medication administration and not in use and connected to the resident? He stated, Yes. He was asked, How often should PICC line dressings be changed? He stated, As per the physician order. He was asked, If a bio patch is ordered, should it be in place? He stated, Yes. If anything is ordered it should be in place. He was asked, Should the dressing be changed if it becomes loose? He stated, Yes. He was asked, Why? He stated, To avoid infection and so the PICC line doesn't move. He was asked, Should there be a sign on the resident's door indicating to see the nurse before entering when a resident is on isolation? He stated, Yes. He was asked, Should a resident on isolation have a stack of meal trays left in their room? He stated, No. He was asked, Should they be served on Styrofoam? He stated, Yes. g. On 3/4/2020 at 10:38 a.m., the DON was asked, Should there be a sign on the resident's door indicating to see the nurse before entering when the resident is on isolation? She stated, It's not a policy of ours. If there is isolation gear on the door, they know. We educate family and it's a dignity issue to do that too. h. A facility policy titled Isolation Precautions provided by the Director of Nursing on 3/4/2020 at 10:52 a.m. documented, .Categories of Isolation Precautions 4. This facility has adopted Standard Precautions on a facility-wide basis in order to comply with CDC (Centers for Disease Control and Prevention) and OSHA (Occupational Safety and Health Administration) recommendations . We continue to post signs and acknowledge other category-specific isolation precautions in order to assure comprehensive and quality care and to alert visitors . Supervision Policy The Charge Nurse of each unit shall be responsible for carrying out all functions of the isolation precautions as directed by the Infection Control Coordinator and the policies and procedures of this facility . This includes supervision of personnel and assurance that all personnel and visitors follow established isolation precautions as well as any special instructions that become necessary . Isolation Procedures . 3. The isolation room is easily identified with an appropriate isolation sign which is posted outside the door by the Infection Control Coordinator or the Nurse Supervisor . Posting of Isolation Signs . 1. When isolation of a resident is ordered, the appropriate isolation sign shall be posted outside the entrance of the resident's room by the Infection Control Coordinator or the Director of Nurses . 2. Our isolation signs have been designed to give information about isolation precautions for the category as well as specific communicable diseases . Each sign is a different color and lists the diseases specific to that particular type of isolation, as well as a brief description of precautions to take . 3. A supply of isolation signs are maintained at each Nurses' Station at all times . Extra isolation signs may be requested from the Infection Control Coordinator or the Director of Nurses. 4. Upon posting of the isolation sign, Bed A or Bed B shall be on the sign . Equipment and Supplies . 1. The Infection Control Coordinator or designee is responsible for obtaining the needed isolation precautions supplies and equipment, overseeing the isolation set-up, posting the appropriate isolation sign outside the resident's room [ROOM NUMBER]. After confirmation of the category of isolation precautions that is needed, the Infection Control Coordinator or designee will post the appropriate isolation sign outside the resident's door and place an isolation cabinet in the corridor The cabinet shall be labeled with the type of isolation precautions and the resident's room number and bed (A or B) . Disposal of Infectious Material . 1. All disposables such as dressings, tissue, dishes, etc. (et cetera) shall be placed in the isolation trash container located in the isolation room . Serving Drinking Water During Isolation . 1. Disposable cups shall be used to serve drinking water to the resident throughout the isolation period . 2. A new disposable cup will be brought to the room daily or as needed . 3. Disposables will be placed in the trash container located in the isolation room . Food Service . 1. Resident's placed in isolation shall be served all meals on disposable trays, dishes, and utensils until isolation procedures are discontinued . 4. All disposable items used to serve the resident's meals and left-over food shall be placed in the isolation trash container located in the room . i. A facility policy titled PICC Line provided by the Director of Nursing on 3/4/2020 at 8:09 a.m. documented, .What is a PICC Line . A peripherally inserted central catheter or PICC line is a soft plastic tube that is inserted into a large vein right above the patient's heart . The PICC line must remain sterile at all times so that they patient does not run the risk of getting an infection . How Often are PICC Line Dressing Changed . PICC lines should be changed at least once per week . If the dressing becomes loose, wet, or dirty, the dressing must be changed more often to prevent infection . PICC line dressings must be inspected on a daily basis . Moist dressings are breeding grounds for infections . Signs of moisture, wetness, or dirt are signs that the dressings need to be changed more often . Loose fitting PICC line dressings can make it possible for dirt and debris to enter the area around the insertion site j. A facility polity titled IV Infection Control Measures provided by the Director of Nursing on 3/4/2020 at 8:09 a.m. documented, .Nosocomial infections . An infection acquired in a health care setting . One third of all Nosocomial infections are caused by some form of IV therapy . Below are measures you should take to decrease the rate of Nosocomial infections . 13. IV tubing and extensions should be changed every twenty-four hours . 14 Labels should also be placed on IV tubing and IV dressings . 15. Peripheral IV caps are to be changed at the same time the IV is restarted (q (every) 72 hours) . 20 . Put a cap on all catheters .