STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205100	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRESQUE ISLE REHAB AND NURSING CENTER	162 ACADEMY ST PRESQUE ISLE, ME 04769

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure that a physician order [REDACTED].#1, #3). Findings: 1. A review of Resident #1's medical record and physician orders [REDACTED]. On 5/26/20 at 1800 (6:00 p.m.), documentation indicates that Resident #1 received 2 mls of [MEDICATION NAME] which would be equal to 20 mgs instead of the 2 mgs as ordered. The Surveyor confirmed this finding in an interview on 6/1/20 at 3:20 p.m. with the Director of Nursing. 2. Resident #1's clinical record contained a written physician order, dated 5/26/20 at 6:30 p.m., directing staff to obtain vital signs every 30 minutes and to include respiratory status. The clinical record, which included review of the electronic and paper versions of the record, and the nurse's report sheet lack evidence this was completed. On 6/2/20 at 1:37 p.m., during an interview with surveyors, the Director of Nursing reviewed the clinical record (paper and electronic) and the nurse's report sheet and was unable to find evidence of vital signs and respiratory status monitoring that should have been obtained on 5/26/20 after 6:30 p.m. On 6/3/20, during an interview with a surveyor, Licensed Practical Nurse (LPN) #2 stated she took the order and brought it to the nurse's station that Resident #1 was at and did not take any vital signs. 3. Resident #1's clinical record contained a written physician order, dated 5/26/20, directing staff to administer [MEDICATION NAME] solution (10 mg/ml) 2 mg every 1 hour as needed and [MEDICATION NAME] solution (2 mg/ml), 1 mg every 1 hour as needed. Both the physician orders [REDACTED]. 4. Resident #3's clinical record contained a written physician order, dated 5/5/20, directing staff to administer [MEDICATION NAME][MEDICATION NAME] mg/ml Intramuscular (IM) injection every 2 weeks. The physician order [REDACTED]. On 6/2/20 at 1:37 p.m., during an interview with the Director of Nursing and the Administrator, the surveyors confirmed these findings.
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure 1 of 4 sampled residents receiving [MEDICATION NAME] was free of a significant medication error (#1). Finding: On 5/29/20 the Division of Licensing and Certification was notified of a medication error that occurred on 5/26/20 at approximately 1800 (6:00 p.m.). During record review, the surveyor noted that Resident #1 had an order dated 5/26/20 for [MEDICATION NAME] solution (10 milligrams (mg)/milliliters(ml)) 2 mg every 1 hour as needed (PRN) for end of life pain and dyspnea. The medication [MEDICATION NAME] is in the form of a liquid and the dosage is as follows: 10 mg in 1 ml, requiring that Resident #1 be administered 0.2 ml to equal 2 mg. Review of the facility incident report and investigation indicated that on 5/26/20 at 1800 (6:00 p.m.) Resident #1 received 2 ml of the medication [MEDICATION NAME] equaling 20 mg in error. Resident #1's Narcotic bound book page #144 indicates that Resident #1 received 2 mls of [MEDICATION NAME] which would be equal to 20 mgs instead of the 2 mgs as ordered. On 6/3/20 at 1132 a.m., during an interview with a surveyor, Licensed Practical Nurse #2 stated that she checked the order 3 times prior to giving the [MEDICATION NAME] to Resident #1 to make sure the dose was correct and to her knowledge, her calculations for the dose was correct; She did not realize she made an error until she signed the Narcotic bound book. She immediately notified the Director of Nursing then called the on-call Physician and received orders to hold Resident #1's [MEDICATION NAME] until physical signs of pain are seen and to check Resident #1's vital signs every 30 minutes including respiratory status. During this interview, the surveyor confirmed the above finding.
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 observations and interviews the facility failed to follow professional standards of practice with the usage of Personal Protective Equipment (PPE) and to provide a sanitary environment to help prevent the transmission of disease and infection related to hand hygiene and proper use of PPE on 2 of 2 days of survey (6/1/20 and 6/2/20) Findings: 1. On 6/1/20 at 2:05 p.m. a surveyor observed a Certified Nursing Assistant (CNA) #2 enter room [ROOM NUMBER] which is dedicated as a precaution room for a new admit who was on their 14-day quarantine. CNA #2 had on a mask, she put on a pair of goggles and then a pair of gloves, she knocked on the door and walked in with residents' permission and was asking some questions regarding the resident's preferences. When CNA #2 was done with task she exited the room removed her gloves, came out into the hall and removed her dirty goggles with her ungloved hands, she then put on a clean pair of gloves, cleaned the outer edges of the shared goggles using a germicidal wipe and placed the goggles lens down on the top of the cart for the next person to use. She then sanitized her hands. During an interview with the surveyor regarding the use of PPE the CNA stated she should have cleaned the goggles completely and not just the edges, especially where several staff use the same goggles. 2. On 6/1/20 at 2:10 p.m. a surveyor observed CNA #1 exit room [ROOM NUMBER] which is dedicated as a precaution room for a new admission (resident) who was on their 14-day quarantine. CNA #1 had no gloves on, exited the room, removed her goggles. She used a germicidal wipe to clean the edges of the goggles and placed them lens down on top of the isolation cart. CNA #1 then walked across the hall into room [ROOM NUMBER], picked up both residents' drinking cups and walked back out into hallway. CNA was not observed to have washed her hands. She was holding the cups and the surveyor asked when she had washed her hands, the CNA stated right now. The charge nurse was with the surveyor and the CNA was asked where she washed her hands and the CNA then said I should have washed my hands when I left room [ROOM NUMBER] (precaution room). She stated she couldn't use the sanitizer due to an open cut on the inside of her finger. She stated had she not been stopped, she would have walked down to the kitchenette with the 2 cups filled them with ice and water and brought them back to the residents in room [ROOM NUMBER] (who are not on precautions). The surveyor confirmed this finding with the Charge Nurse at the time of the observation and stated she would be providing more education for staff on hand hygiene. 3. On 6/1/20 at 2:20 p.m. the surveyor observed a kitchen staff member coming down the hall with a cart of supplies. She had her face mask on but was not on correctly, she had her mouth covered but her nose was not covered by her mask. She stated to Surveyor that I should have it on covering my mouth and nose and they tell me all the time to put it on correctly. 4. On 6/1/20 at 2:35 p.m. the surveyor observed CNA #3 coming out of a precaution room, room [ROOM NUMBER]. which is dedicated as a precaution room for a new admission (resident) who was on their 14-day quarantine. She was wearing a face mask, goggles and pair of gloves. With the dirty goggles and gloves she was observed walking over to the ice water cart. With the dirty gloves she placed cups in a bin on the second shelf and with the same dirty gloves she reached into a bin with clean cups and lids (approximately 5) she then took the ice scoop that was sitting in a container of ice and filled the cup with ice and went back into room [ROOM NUMBER]. CNA #3 was then observed coming to the door of room [ROOM NUMBER] she removed her gloves came out in hall put on a clean pair of gloves removed her goggles and using a germicidal wipe she cleaned the edges of the goggles removed her gloves and used sanitizer on her hands. She then pushed the cart to the next room which was room [ROOM NUMBER] (also a

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

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) precaution room). She then put on goggles and walked into the room, she didn't see the resident and came out. The resident then came out of the bathroom and 2 CNA's #2 and #3 put gloves and goggles on to help the resident wash their hands and assisted walking him/her back to their chair near the bed. CNA #3 then left the room removing her gloves and goggles, cleaned the edges of the goggles with the germicidal wipes and placed them on the top of the cart. 5. On 6/1/20 at 2:50 p.m. as CNA #3 was going to another room to fill their ice cups, before she could enter another room this surveyor expressed concerns with her previous breach of infection control practices with touching the cart, ice scoop and clean cups with dirty gloves. CNA #3 stated that she knows she should have removed her gloves when leaving room [ROOM NUMBER] and put on a clean pair, she acknowledged that the cart is now considered contaminated and she will take it to kitchen and get a new clean cart with more ice and a clean scoop and cups. Review of the facilities Hand Hygiene Policy and procedure dated 6-13-19 indicated by bullet point #4 that staff are directed to wash their hands before and after entering an isolation precaution setting. 6. On 6/2/20 at 11:13 a.m. a surveyor observed CNA #6 walk into room [ROOM NUMBER] a room which is dedicated as a precaution room for a new admission (resident) who was on their 14-day quarantine. She was observed putting on her PPE (gloves and goggles). She assisted the resident and when she asked the resident if they needed anything else, she placed her gloved hands palms facing the small of her back on her clothing. She then came over to the door removed her gloves washed her hands, she came out in the hall put on a clean pair of gloves removed and cleansed the goggles. She removed her gloves and did not wash or sanitize her hands. She was observed walking into the kitchenette and got the resident a snack. She came back to the precaution cart put on gloves and the goggles and delivered the snack. When she left the room, she removed PPE correctly and sanitized her hands. She was then asked by surveyor if she followed all the correct steps when leaving and entering a precaution room. CNA #6 stated I should have sanitized my hands before going to the kitchenette. 7. On 6/2/20 at 12:10 p.m., during a lunch service observation on Station 1, a surveyor observed CNA #5 enter a resident's room carrying a meal tray. CNA #5 was observed unwrapping food and placing dishes on the resident's tray, moving the bedside table, and touching the arm of the resident's recliner. CNA #5 exited the resident's room and did not wash his/her hands or use hand sanitizer. CNA #5 walked to the meal cart and open and close the doors with soiled hands. CNA #5 then picked up dirty dishes, brought them the kitchen window, and then walked down the hallway and washed his/her hands. On 6/2/20 at 2:00 p.m., during a joint interview with the Administrator and the Director of Nursing, the surveyors confirmed the above findings.