| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 025025 | A. BUILDING _____ B. WING _____ | 05/15/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **PRESTIGE CARE & REHAB CENTER OF ANCHORAGE** | **9100 CENTENNIAL DRIVE ANCHORAGE, AK 99504** |

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 0689<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to implement interventions to reduce known hazards and risks from falls for 1 resident (#2) out 5 sampled residents. This failed practice placed the resident at risk for injury from a fall. Findings: Review of the clinical record on 5/12-13/20 revealed Resident #2 had [DIAGNOSES REDACTED]. The Resident was hospitalized during the investigation. MDS/Assessments Review of the Resident's quarterly Minimum Data Set (MDS- a federally mandated nursing assessment) assessment, completed 4/3/20, revealed the Resident scored 3 out of 15 in the BIMS (Brief Interview for Mental Status), which indicated the Resident's cognitive skills may have been severely impaired. The Resident was assessed as needing extensive assistance with transfers and did not ambulate. Further review revealed the Resident had 2 or more falls since the previous assessment and injury (except major)-skin tears, abrasions, lacerations, superficial bruises, hematoma, sprains, or any fall related injury that caused the resident to complain of pain. Review of the Resident's Falls Risk Assessment, dated 4/18/20, revealed a score of 75 (>45=high risk). Falls Review of a nurse's note, dated 4/2/20 at 11:40 pm, revealed While counting the med-cart narcotics with the off going nurse. The off going nurse and I heard a loud thump. When I the oncoming nurse looked up the resident was observed lying on (his/her) back with a large laceration noted to (his/her) right brow area. The facility's intervention was to initiate a chest strap for use which was to be evaluated by nursing and physical therapy . Review of a nurse's note, dated 4/8/20 at 5:15 am, revealed the Resident was on the floor in front of (his/her) wheelchair holding .eyeglasses. The Resident replied 'yes' when asked if he was trying to pick up something from the floor. The facility's planned intervention included placing the Resident on alert charting and to continue with the previous fall preventions. Review of a nurse's note dated 4/17/20 at 9:28 am, revealed Resident found by LN (licensed nurse) scooting on (his/her) bottom towards the door of the room .When asked what happened resident said 'I get up'. LN asked if resident crawled out of bed and resident said 'Yah'. The facility's planned intervention was to continue with previous fall preventions. Review of a nurse's note, dated 4/24/20 at 1:45 am, revealed Resident fell from wheelchair in resident dining area while entertaining self in activity, occurred after given bolus feeding. Witnessed by (Certified Nursing Assistant) CNA support staff. Resident unbuckled seatbelt it appears and fell forward from wheelchair. Left side of cheek and orbital (eye socket) bruised and affected. The facility's planned intervention was to continue the plan of care, offer diverting activities when awake and continue the fall precautions in place and practice. Review of a nurse's note on 4/25/20 at 12:00 pm revealed At around 12:00 Resident took off (his/her) seatbelt from (his/her) wheelchair and found (him/her) in a left lying position in (his/her) room. The CNA had just toileted (him/her) to minutes prior to the incident. (He/she) sustained a t shaped laceration to upper (eye) lid .Stated 'fell down, I'm okay'. Review of a nurse's note on 5/3/20 at 4:00 am, CNA stated that res (Resident #2) had fallen et (and) ran over to resident, resident was lying face down in front of w/c, in front of another residents room. Res nose was dripping blood, res was non-responsive et upper body was twitching. 911 was called, paramedics transported to ER (emergency room ) at ANMC (Alaska Native Medical Center). Res had been anxious all evening yelling at staff leaning forward from w/c, also attempting to get out of bed on his own. Review of a Health State Note, Completed by occupational therapy on 4/21/20 revealed Discussion during UR (utilization review) meeting relevant to (Resident #2) regarding appropriateness and style of pelvic support/seat belt. Recommendation for a push button style seat belt for independence of pt (patient) release. There was no assessment of the risk and benefits of the seat belt and why it was the best device for Resident #2. Review of the comprehensive care plan, revised 4/7/20, revealed the following: Focus: Resident is at high risk for falls (related to) comorbidities, physical limitations, cognitive impairment, poor safety awareness, impulsiveness, & history of falls Goal: The resident will not retain serious injury through the review date. Target date 7/13/20 Interventions/Tasks: Fall Prevention: Keep (at) arms reach (with) active activities initiated 5/22/19 Anticipate and meet the resident's needs initiated 7/8/19 Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all request for assistance. Initiated 7/8/19 Ensure the Resident is wearing appropriate footwear when ambulating or mobilizing in w/c. initiated 7/8/19 Fall Prevention: Appropriate shoes/socks when out of bed. initiated 5/22/19 Fall Prevention: Bathroom light on at NOC (night) for nightlight. Initiated 5/22/19 Fall Prevention: Fall mat at bedside when in bed. Initiated 5/22/19 Fall Prevention: Keep call light in reach, remind to use. Initiated 5/22/19 Fall Prevention: Keep wheelchair in reach when in bed/bathroom. Initiated 5/22/19 Fall Prevention: PT (physical therapy) evaluate for seatbelt due to poor trunk control to help with sliding out of wheelchair. Resident must be able to unbuckle seatbelt (themselves). Initiated 4/8/20 Revised 5/12/20 Fall Prevention: Seat belt due to poor trunk control to help with sliding out of wheelchair. Resident is able to unbuckle seatbelt (themselves). Initiated 5/12/20 Interviews During an interview on 5/12/20 at 9:30 am LN #1 stated Resident #2 was currently in the hospital. The LN stated the Resident would undo his/her seat belt and fall forward out of the wheelchair. LN #1 stated Resident #2 had a UTI (urinary tract infection) at the time of the fall and had been having some behaviors. The LN stated when he/she acted like that they try to make sure someone is on the Resident. During an interview on 5/13/20 at 2:00 pm the Administrator and the Director of Nursing stated the Resident was impulsive and would lean out of the wheelchair to pick up items off the floor. The Resident was able to unbuckle the seatbelt, so the seatbelt did not prevent the Resident from falling out of the chair. The Administrator stated that the Resident was unable to stand or walk. The Administrator stated the Resident's care plan had not been revised since 4/8/20 (until the 5/12/20 entry), even though the Resident continued to fall. The Administrator stated they had been thinking about getting a helmet so the Resident would not injure his/her face when falling from the wheelchair. . |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on observation, interview and policy review, the facility failed to ensure: 1) hand hygiene was performed during medication administration for 2 residents (#s 6 and 7); 2) hand hygiene was performed by staff when entering and exiting 1 resident's isolation rooms (#8); 3) reusable equipment was sanitized after use for 1 resident (#5); and 4) disposable equipment used for gastric tube feedings was changed and stored in a clean manner for 1 resident (#5). These failed practices had the potential to affect all residents, based on a census of 85 residents, at risk from the spread of infection and/or COVID-19. Findings: Hand Hygiene During on observation on 5/12/20 at 8:42 am, Licensed Nurse (LN) #2 was observed to pass a medicine cup and cup of water to Resident #6, take the cups back for disposal started typing on the nursing charting keyboard without [MEDICATION NAME] hand hygiene. During a second observation on 5/12/20 at 9:08 am, LN #2 prepared medication and cup of water from the community drinking station. The Nurse was not wearing gloves and did not hand sanitize prior to giving medication to Resident #7. During an interview on 5/12/20 at 12:31 pm, LN #3 stated that due to |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 1)<br>increased precautions to prevention contagion infection, Nurses were educated to increase observation and ensure that staff were hand sanitizing between each resident interaction and in/out of rooms. During an interview on 5/12/20 at 1:50 pm, Certified Nurse Aide (CNA) #1 stated there were increased precautions to prevent infections included [REDACTED]. Isolation Unit Spruce unit was designated as the quarantine (temporary isolation) unit for new admits and readmitted residents. During an observation on 5/13/20 at 10:00 am revealed signs posted outside some resident rooms on the Spruce units that read, Wash hands before/after entering rooms. During an interview on 5/13/20 at 10:05 am, LN #4 stated that infection control protocol was droplet precaution on the Spruce unit that included wearing protective glasses, mask, and gloves for residents on isolation. The LN further stated that there was a book on the unit that outlined infection control procedures for COVID-19 that was available as a reference for unit staff. During on observation on 5/13/20 at 10:08 am, CNA #2 exited Resident #8's isolation room, fill a beverage cup from the unit hydration station and return to the Resident's room. He/she did not use the hand sanitizer or hand wash during the process. Shortly after, CNA #2 retrieved a vase, took it into the Resident room, exited the room with flowers in the vase and set them in the common area. He/she did not use the hand sanitizer or wash hands when exiting the room. During an interview on 5/13/20 at 10:25 am, when asked what about the protocol and training for the isolation residents, CNA #3 stated staff were to wear protective glasses and use hand sanitizer when coming in or out of the room. When providing cares, staff were to wash hands for 20 seconds. During an observation on 5/13/20 at 10:45 am, CNA #2 was observed collecting clean linens and supplies from around the unit, then went into a resident room. He/she was not observed using hand sanitizer when entering the room. During an interview on 5/13/20 at 2:30 pm, the Director of Nursing (DON) stated that she would expect staff to be using hand sanitizer or washing hands with any direct contact between residents such as during medication pass. The DON further stated that infection control and training was for staff to hand sanitize on entering/exiting resident rooms, particularly on the Spruce unit. Review of the facility's policy Standard Precautions, revised 3/20 revealed, Standard Precautions apply to the care of all residents regardless of situations regardless of suspected or confirmed presence of infectious disease. According to the Center for Disease Control (CDC) at accessed on 5/13/20 at www.CDC.gov Hand hygiene should be performed after touching blood, body fluids, secretions, excretions, contaminated items, immediately after removing gloves and between patient contacts. Sanitizing Equipment During an observation on 5/13/20 at 10:12 am, LN #5 pushed a rolling vital sign monitor into Resident #5's room. After sanitizing his/her hands the LN used the manual cuff from the basket attached to the monitor and his/her stethoscope to obtain a blood pressure on the Resident's left arm. After completing the task, LN#5 draped the now unclean stethoscope around his/her neck, rolled up the soiled manual cuff and placed it back in the basket. The LN then rolled the monitor to the common area. Without performing hand hygiene, or cleaning the equipment, LN#5 walked over to the desk and made a phone call. After completing the call, the LN walked over to the medication cart and performed hand hygiene with hand sanitizer. During an interview on 5/13/20 at 10:42 pm, when asked about the sanitizing of equipment after use, LN #5 replied if residents were on isolation, they would have dedicated equipment. During an observation on 5/13/20 at 10:45 am, Certified Nurse Aide (CNA) #4 put the rolling vital sign monitor, still containing the unclean blood pressure cuff, into the clean storage closet. During an observation on 5/13/20 at 11:30 am, LN #5, retrieved the vital sign monitor from the closet and took it into Resident #5's room. After removing his/her personal stethoscope from around his/ her neck and using retrieving the manual cuff from the basket, the LN obtained the Resident's blood pressure a second time. The LN, again placed the soiled stethoscope around his/her neck, placed the used blood pressure cuff in the basket. LN #5 then rolled the monitor to the doorway, stopped to sanitize hands, and returned the monitor to the common area. During an interview on 5/13/20 at 2:30 pm, the Administrator and DON stated should clean reusable medical equipment after each use. Review of the facility policy Standard Precautions, revised 3/20, revealed, Ensure reusable equipment is not used for the care of another resident until it has been cleaned and reprocessed . Disposable Equipment During an observation on 5/13/20 at 10:20, LN #6 entered Resident #5's room to administer medications. The LN stated he/she was going to administer some extra water through the Resident's gastric tube (GT) tube surgically implanted in the stomach for nutrition and fluids) as the Resident's blood pressure was too low. LN #6 donned gloves and picked up a pink basin containing a plastic container with labeled 5/3/20, a large syringe labeled 5/11/20, plastic disposable cups, along with a banana hair comb, sitting on the sink. The LN took the plastic container to the sink and filled it 2/3 full of water. The LN the removed his/her gloves, sanitized hands and left room. The LN returned with a new large syringe and threw away the old one. After donning gloves, LN#6 put the tip of the syringe into the plastic container of water, drew up 60 ml of water and administered it to the Resident through the GT. The LN #6 again put the tip of the syringe into the container, drew up a syringe full of water, and administered a second syringe full of water to the Resident. After completing the task, the LN set the used syringe in the pink basin with the container full of water, next to the hair comb, removed gloves, sanitized hands, and left the room. During the interview on 5/13/20 at 2:30 pm, when asked how often the syringe and the plastic container for GT feedings should be changed, the Administrator and DON responded the syringe should be changed daily and stored in a plastic bag. Both stated there was no policy on changing the plastic containers, as they would expect the nurses to use disposable cups. Review of the facility policy Naso-gastic/[DIAGNOSES REDACTED] or naso-jejunal Feeding Tube revised 3/19 revealed Irrigation syringes will be changed daily and stored in supplied bag when not in use .The syringe and bag will be labeled with the resident's name and date issued. If no bag is supplied a Ziploc bag will be used and changed daily as well. The policy did not mention the use of disposable cups or reusable plastic containers for water administration. Review of audits, completed by facility staff, on March, April, and May 2020 revealed hand hygiene and contact precaution audits. . |