| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **045222** | A. BUILDING _____ B. WING _____ | **03/13/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **WOODRUFF COUNTY HEALTH CENTER** | **139 WEST HIGHWAY 64 MCCRORY, AR 72101** |

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 0584<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation and interview the facility failed to ensure the environment was maintained and in good condition as evidenced by failure to ensure the clean linen cart cover on the secure unit was free from rips, tears, and fraying; and failed to ensure fall mats were free from tears, rips, fraying, and were maintained and in good condition for 2 (Residents #40 and #68) sampled residents who were care planned for fall mats. The findings are: 1. On 03/09/2020 at 11:31 AM, the clean linen cart cover on the secure unit was torn, ripped, and frayed. 2. Resident #68 had [DIAGNOSES REDACTED]. The Significant Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/6/19 documented the resident was severely impaired in cognition for daily decision making according to a Brief Interview for Mental Status (BIMS); and was totally dependent on 2 staff for most all activities of daily living (ADL's). a. On 03/09/2020 at 2:11 PM, Resident #68 was lying in bed. The fall mat on the floor was torn, ripped, and frayed. 3. Resident #40 had [DIAGNOSES REDACTED]. The Incomplete Quarterly MDS with an ARD of 2/11/2020 documented the resident was severely impaired for daily decision making. a. The Care Plan dated 9/6/2018 documented, .Resident is at risk for falls due to extremity weakness and unsteady gait .Fall mat at bedside . b. The Care Plan dated of 7/25/19 documented the resident requires physical assist of 1 person for transfers. c. On 03/09/2020 at 2:20 PM, Resident #40 was lying in bed. The fall mat on the floor was torn, ripped, and frayed. 4. On 03/12/2020 at 2:57 PM, Licensed Practical Nurse (LPN) #2 was asked, Should residents fall mats be torn, ripped, and frayed? LPN #2 stated, No. LPN #2 was asked, Would this be considered, in need of repair or replacement? LPN #2 stated, Yes. 5. On 03/12/2020 at 3:01 PM, Certified Nursing Assistant (CNA) #2 was asked, Should the clean linen cart covers be torn, ripped, and frayed? CNA #2 stated, Not really. CNA #2 was asked, Would this be considered, in need of repair or replacement? CNA #2 stated, Yes. 6. On 03/12/2020 at 3:10 PM, the Administrator was asked, Should the clean linen cart covers be torn, ripped, and frayed? The Administrator stated, No. The Administrator was asked, Would this be considered, in need of repair or replacement? The Administrator stated, Yes. |
| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **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 observation record review, and interview the facility to ensure the residents were free of potential accident hazards as possible, as evidenced by failure to ensure call lights system was securely attached to the wall, razors, razor blades, smokeless tobacco (snuff) fresheners, and [MEDICATION NAME] skin protectant was out of reach for 3 (Resident (R) #39, #68, and #299) sampled residents. The findings are: 1. On 03/09/2020 at 11:32 AM and 03/10/2020 at 9:47 AM, the call light system connected to the wall in Resident room [ROOM NUMBER] was torn from the wall exposing the wires and a hole in the wall. a. On 03/12/2020 at 9:05 AM, Certified Nursing Assistant (CNA) #3 was asked, Should the cover to the call light be open and exposing wires? CNA #3 stated, No. CNA #3 was asked, Could this be a potential hazard? CNA #3 stated, Yes. b. On 03/12/2020 at 3:01 PM, CNA #2 was asked, Should the cover to the call light be open and exposing wires? CNA #2 stated, No. CNA #2 was asked, Could this be a potential hazard. CNA #2 stated, Yes. c. On 03/12/2020 at 3:10 PM, the Administrator was asked, Should the cover to the call light be open and exposing wires? The Administrator stated, No. The Administrator was asked, Could this be a potential hazard? The Administrator stated, Yes. 2. Resident #39 had a [DIAGNOSES REDACTED]. a. On 03/09/2020 at 11:21 AM, a razor and razor blade was on Resident #39's night stand on the Secure Unit that were not contained and out in the open. b. The Care Plan dated 11/29/19 documented, .Resident has a memory/recall problem related to mental status associated with [DIAGNOSES REDACTED]. c. On 03/11/2020 at 2:48 PM, LPN #1 was asked, are residents supposed to have razors and razor blades out in the open in their rooms? LPN #1 stated, No. LPN #1 was asked, Would this be considered a hazard? LPN #1 stated, Yes. d. On 03/12/2020 at 9:05 AM, CNA #3 was asked, Should razors and razor blades be left out in the open in residents rooms? CNA #3 stated, No. CNA #3 was asked, Would this be a potential for hazard? CNA #3 stated, Yes. 3. Resident #68 had [DIAGNOSES REDACTED]. The Significant MDS with an ARD of 12/6/19 documented the resident was severely impaired in cognition for daily decision making according to a Brief Interview for Mental Status (BIMS); and was totally dependent on 2 staff for most all activities of daily living (ADL's). a. On 03/09/2020 at 2:06 PM, Resident #68 was lying in bed. There were 3 air fresheners in Resident #68's room and a container of skin protectant was on R #68's dresser that stated, in case of accidental ingestion, contact a physician or Poison Control Center right away. b. On 03/11/2020 at 2:48 PM, LPN #1 was asked, Are residents supposed to have air fresheners and skin protectant out in the open in their rooms. LPN #1 stated, No. LPN #1 was asked, Would this be considered a hazard? LPN #1 stated, Yes. c. On 03/11/2020 at 3:00 PM, the Director of Nursing (DON) was asked, Should air fresheners and jars of skin protectant be left out in the open residents' rooms? The DON did not answer the question. 4. Resident #299 had a [DIAGNOSES REDACTED]. The Incomplete Admission MDS with an ARD of 1/15/2020 documented the resident was severely impaired in cognitive skills for daily decision making. a. The Care Plan dated of [DATE] documented the resident required assistance of staff with all activity of daily living (ADL's). b. The Care Plan dated 1/20/2020 documented, .Resident has a severe memory loss and confusion due to Dementia and [MEDICAL CONDITION] with late onset . Ensure resident's areas are free of hazards . c. On 03/09/2020 at 12:27 PM, the resident was in her room in her wheelchair. There were two cans of snuff smokeless tobacco on top of R #299's walker tabletop. d. On 03/10/2020 at 9:06 AM, Resident #299 was sitting in recliner in her room. R #299 had snuff (brown substance) in mouth. A snuff can was on the nightstand next to R #299's recliner. A snuff can was on R #299's rolling walker tray. A snuff can was on the nightstand next to the bed. Resident #299 was asked, Do you like dipping snuff? R #299 stated, Yeah. I have since I was 3 years old. I'm 95 now. The smokeless tobacco was not stored in manner where others couldn't access it. e. On 03/11/2020 at 2:52 PM, LPN #3 was asked, Did you know R #299 dips snuff? LPN #3 stated, I didn't know she had any in there. But I knew she dipped it. She's supposed to keep it in the medication room. LPN #3 was asked, Would that be a potential for hazard if a cognitively impaired resident were to obtain the snuff? LPN #3 stated, Yes. f. On 03/11/2020 at 3:00 PM, the Administrator was asked, Are residents allowed to have snuff in their rooms? The Administrator stated, There shouldn't be a problem if they dip in their room. They can have it. The Administrator was asked, Has an assessment been done for the snuff to be left in the room? The Administrator stated, No formal assessment for dipping. But we have a smoking assessment. The Administrator was asked, If a resident uses snuff, should that be care planned? The Administrator replied, Yes. 5. A Smoking Policy dated [DATE] documented, .This facility may check periodically to determine if residents have any smoking articles .lighters, matches, e-cigarettes or vapor units, etc. which are in violation of our smoking policy . 6. A facility in-service form titled dated [DATE]20 |

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 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>documented, .Air freshener and mouthwash aren't allowed in resident rooms, anything that states, keep out of the reach of small children is not allowed in resident's rooms. This is a safety issue . 7. A document titled Items Not Allowed in the Resident's Room in the Admission Packet documented, .Items not allowed in the resident's room .No medication allowed .These can be stored in the medicine room . 8. A policy titled Safety and Supervision of Residents documented, .Safety and Supervision of Residents .Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .Resident supervision is a core component of the systems approach to safety . |
| F 0695<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide safe and appropriate respiratory care for a resident when needed.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation record review, and interview the facility failed to ensure a nasal cannula tubing, nebulizer masks, and tubing was stored in a bag or other closed container when not in use to prevent potential contamination or infection for 2 (Resident (R) #34 and #40) sampled residents who had physician orders [REDACTED]. The findings are: 1. Resident #34 had a [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/1/19<br>documented the resident was cognitively intact for daily decision making skills; and required limited physical assist of 1 person for personal hygiene. a. A physician's orders [REDACTED].oxygen 2 liters per minute as needed for shortness of breath . b. A physician order [REDACTED].[MEDICATION NAME] sulfate solution for nebulization, 2.5 mg (milligrams)/3 ml (milliliters) (0.083% (percent)) amount 1 inhalation .every 4 hours for shortness of breath . c. The Medication Administration Record [REDACTED]. d. On 03/09/2020 at 2:26 PM, Resident #34 was sitting up in his wheelchair in his room. The oxygen concentrator was on and running. The nasal cannula was on the floor and was not dated. A nebulizer mask was in the top drawer of the nightstand and was not dated or bagged. The nebulizer mask was on the nebulizer machine on top of the nightstand and was not dated. It had a full chamber with clear liquid in it, and was not contained. Resident #34 was asked, Do you use oxygen all the time? Resident # 34 stated, Yes. Resident #34 was asked, Do you receive updraft/breathing treatments? R #34 stated, Yes. R #34 was asked, Do you give the treatments to yourself? Resident #34 stated, Yes. Resident #34 was asked, How often do you take the breathing treatments? Resident #34 stated, Every 4 hours and sometimes sooner than that if I have a hard time breathing. e. On 03/10/2020 at 9:19 AM, Resident #34 was sitting on his bed. The oxygen nasal cannula as on the floor. The nebulizer masks were not labeled and not contained. The nebulizer mask was placed on the nebulizer machine and had a clear liquid in it. f. On 03/10/2020 at :49 AM, the nebulizer mask dated 3/5/2020 was saying on top of the nebulizer on Resident #298's nightstand next to the bed. It was not contained and had a clear liquid in it. g. On 3/11/2020 at 2:09 PM, Licensed Practical Nurse (LPN) #1 was asked, Can you tell me what the clear liquid is in (R#34) nebulizer? LPN #1 d stated, It's updraft treatment. LPN #1 was asked, Should oxygen tubing be in the floor? LPN #1 stated, No. LPN #1 was asked, How should nebulizer masks be stored? LPN #1 stated, In a zip lock plastic bag with their name and a date. LPN #1 was asked, Would this be considered an infection control issue? LPN #1 stated, Yes. h. On 3/11/2020 at 3:00 PM, the Administrator was asked, How should oxygen tubing and nebulizer masks be stored? The Administrator stated, In a plastic bag. The Administrator was asked, Would oxygen tubing in the floor and nebulizer masks left out in the open be considered an infection control issue? The Administrator stated, It could be. 2. Resident #40 had [DIAGNOSES REDACTED]. The Incomplete Quarterly MDS with an ARD of 2/11/2020 documented the resident was severely impaired<br>for daily decision making. a. A physician's orders [REDACTED].[MEDICATION NAME] Solution for nebulization; 1.25 mg/3ml; amount: one dose; inhalation .Inhale one unit dose every 2 hours as needed for shortness of breath and or wheezing . b. The Medication Administration Record [REDACTED]. c. On 03/09/2020 at 2:19 PM, Resident #40 was lying in her bed. The nebulizer mask was laying on the nightstand and was not stored in a container. Resident #40 was asked, Do you take breathing treatments? Resident #40 stated, Yes. e. On 03/10/2020 at 9:20 AM, R#40 was in his wheelchair in his room. The oxygen cannula was in the floor and the nebulizer mask was laid across the nightstand. It was not dated and not stored in a container. f. On 03/11/2020 at 2:09 PM, LPN #1 was asked, How should nebulizer masks be stored? LPN #1 stated, In a zip lock bag with name and date. LPN #1 was asked, Would leaving the nebulizer masks out in the open be considered an infection control issue? LPN #1 stated, Yes. g. On 03/11/2020 at 2:17 PM, R #40 was in his room. The nebulizer mask was laying on the nightstand and was not stored in a container. LPN #1 picked up the nebulizer mask from the nightstand and placed 1 vial of updraft medication in the nebulizer chamber and placed the mask on R #40. LPN #1 turned the nebulizer on. LPN #1 did not replace, or rinse/wash the nebulizer mask prior to administering the updraft treatment. 3. The policy titled Departmental (Respiratory Therapy) - Prevention of Infection documented, .Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use . 4. The policy titled .Administering Medications through a Small Volume (Handheld) Nebulizer documented, .when treatment is complete, turn off the nebulizer and disconnect T-piece, mouthpiece and medication cup . Rinse and disinfect the nebulizer equipment according to facility protocol . when equipment is completely dry, store in a plastic bag with resident's name and the date on it . |
| F 0759<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure medication error rates are not 5 percent or greater.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation of the 12:00 PM medication pass on 3/12/20 and the 8:00 AM medication pass on 3/13/20, record review, and interview the facility failed to ensure physician orders [REDACTED].#38 and #70) of 3 residents observed during the medication passes resulting in medication errors. Medication errors were made 1 Licensed Practical Nurse (LPN) #1 and 1 Registered Nurse (RN) #1 of 2 LPNs and one RN observed administering medications in the facility. The medication error rate was 5.26% based on observation of 38 medications administered, and a total of 2 errors detected. This failed practice had the potential to affect 41 residents who received medications from these 2 nurses, as documented on a list provided by the administrator on 3/13/20. The findings are: 1. Resident #70 had [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. b. On 3/13/2020 at 7:46 AM, LPN #1 administered [MEDICATION NAME] 20 mg one tablet by mouth. c. On 03/13/2020 at 10:50 AM,<br>Licensed Practical Nurse # 1 was asked to look at Resident #70's physician's orders [REDACTED]. The medication card documented, .[MEDICATION NAME] 20mg take one tablet daily . She was asked should the resident have received 1 and 1/2 tablet to equal 30 mg. She stated, .Yes. It should have been 1 1/2 . d. On 3/13/2020 at 12:24 PM, the Director of Nursing (DON) was asked to clarify the medication order for [MEDICATION NAME] against the medication card label. At 12:45 PM the DON stated, .The label on the bubble pack is wrong, it should be 1 and 1/2 . 2. Resident #38 had [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. b. On 3/13/2020 at 8:43 a.m., RN #1 administered [MEDICATION NAME] propionate 50mcg. RN #1<br>closed the resident's left nostril, inserted the application tip into the resident's right nostril and asked the resident to breath in without spraying medication. At 8:44 AM, the nurse closed the resident left nostril, inserted application tip into the resident's right nostril and asked the resident to breath in without spraying medication. At 8:45 AM the nurse closed the resident's right nostril, inserted application tip into the resident's left nostril and asked the resident to breath in without spraying medication. At 8:46 AM the nurse closed the resident's right nostril, inserted application tip into the resident's left nostril and asked the resident to breath in without spraying the medication. c. On 3/13/2020 at 9:02 AM, RN#1 was asked if she sprayed the [MEDICATION NAME] into the resident's nostrils or did she ask her to breath in without spraying the medication. She stated, .I sprayed .? The surveyor asked, Is the order for one spray or two? She stated, .One . The surveyor asked, Should you have administered 2 sprays per nostril? She stated, .No . 3. A document titled Administering Medications provided by the Administrator on 3/13/2020 documented, .Medications must be administered in accordance with the orders . |
| F 0812<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**<br><br>Based on observation, record review, and interview the facility failed to ensure staff wore hair restraints and wore hair restraints appropriately to ensure full coverage to prevent potential contamination and failed to ensure staff wore gloves when handling resident food items for residents who received meals from 1 of 1 facility kitchen. These failed practices had the potential to affect 87 residents who received meal trays from kitchen (Total Census: 88), as documented on the Daily Census Report, provided by the Administrator on 3/13/2020. The findings are: 1. On 03/09/2020 at 11:41 AM, Dietary Employee (DE) #1 had approximately 2 inches of hair on the right and left side of their head by the ears. The hair was sticking out of a hair restraint. She used her bare, right hand to cut tomatoes with a knife. With her bare hand, she put the slices of tomatoes in approximately 30 clear cups sitting on a cart. 2. On 03/09/2020 at 11:44 AM, DE #2 wore a ball |

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| F 0812<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 2)<br>cap, on his head, that was turned backwards. There was a hole that measured approximately 2.5-inch in the ball cap. There was approximately 2 inches of hair sticking out the front of the ball cap. He dished approximately 6 resident lunch menu items onto their plates. DE #2 was asked, Why are you not wearing a hair restraint? DE #2 stated, State's always let me every year wear a hat . 3. On 3/13/2020 at 8:20 AM, the Administrator was asked, Should staff wear hair restraints while in the kitchen? She stated, Yes. She was asked, Should Dietary staff touch resident's food with their bare hands? She stated, No . 4. On 3/13/2020 at 9:36 AM, record review of the Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices policy documented, Policy Statement, Food Services employees shall follow appropriate hygiene and sanitary procedures to prevent spread of foodborne illness .Ungloved Hands 8. Contact between food and bare (ungloved) hands is prohibited .Hair Nets, 12. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens . |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and interview the facility failed to ensure soiled disposable briefs and wipes were disposed of appropriately on the Secure Unit to prevent odors and potential cross-contamination which could result in infection; and gloves used in an isolation room were disposed of appropriately, to prevent potential cross-contamination which could result in infection for 1 (Resident (R) #28) sampled residents. The facility failed to ensure a catheter bag and tubing was not touching or dragging on the floor to prevent possible infection for 2 (Resident #7 and #94) sampled residents. 1. Resident #7 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) assessment dated [DATE] documented<br>the resident was moderately impaired for cognitive skills and had an indwelling catheter. a. A physician's orders [REDACTED].Foley care Q (every) shift and PRN (as needed) . b. The Plan of Care dated 7/22/19 documented, .resident has a Foley cath (catheter) that is surgically replaced each month by (physician) .Foley care q shift . c. On 03/09/20 at 12:34 PM, Resident #7 was sitting in a wheelchair in the main dining room eating lunch. A catheter collection bag was sitting on the floor. A photograph of the catheter bag was taken at this time. d. On 03/09/20 at 3:13 PM, the resident was propelling down the 500 hallway. The catheter collection bag was dragging on the floor under the wheelchair. A photograph of the catheter bag was taken at this time. e. On 03/12/20 at 11:12 AM, the Director of Nursing (DON) was asked, Should a catheter collection bag or tubing be dragging on the floor? She stated, .No . She was asked, What would be the problem? She stated, .Infection control .<br><br>2. On 03/09/20 at 11:34 AM, a used, wet, brief with a brown substance on it and used wipes were rolled up and laying in the wheelchair in Resident room [ROOM NUMBER]. a. On 03/11/2020 at 2:48 PM, Licensed Practical Nurse (LPN) #1 was asked, Should used, dirty briefs with wipes be left out in the open in the resident's room. LPN #1 stated, No. LPN #1 was asked, Would that be considered an infection control issue? LPN #1 stated, Yes. b. On 03/11/2020 at 2:59 PM, the DON was asked, Should used, dirty briefs with wipes be left out in the open in the resident's room? The DON did not answer the question. c. On 03/11/2020 at 03:00 PM, the Administrator was asked, Should used, dirty briefs with wipes be left out in the open in the resident's room? The Administrator stated, No. The Administrator was asked, Would this be considered an infection control issue? The Administrator stated, It could be. 3. Resident #28 had [DIAGNOSES REDACTED]. The Incomplete MDS with an Assessment Reference Date (ARD) of 1/29/2020 documented the resident was unable to complete the Brief Interview for Mental Status (BIMS). a. The Care Plan dated 2/18/19 documented the resident required extensive to total assistance for toileting. b. The Care Plan dated [DATE]20 documented, .in contact/droplet isolation . c. On 03/09/20 at 11:43 AM, the Biohazard box in Resident #28 bathroom was open with a purple/blue glove on the floor and items hanging over the sides of the biohazard box. d. On 3/13/2020 at 9:44 AM, Certified Nursing Assistant (CNA) #4 was asked, How should Biohazard trash be stored if it's in a resident room? CNA #4 stated, In the bathroom, in a box. CNA #4 was asked, Should Biohazard trash be on the floor? CNA #4 stated, No. CNA #4 was asked, Would this be considered an infection control issue? CNA#4 stated, I would think so. e. On 3/13/2020 at 9:47 AM, LPN #4 was asked, How should Biohazard trash be stored if it's in a resident room? LPN#4 stated, Red bagged, and contained. LPN #4 was asked, Should Biohazard trash be on the floor? LPN#4 stated, No. LPN #4 was asked, Would this be considered an infection control issue? LPN #4 stated, Yes. f. On 3/13/2020 at 9:49 AM, LPN #5 was asked, How should Biohazard trash be stored if it's in a resident room? LPN#5 stated, In a box with a red bag. LPN #5 was asked, Should Biohazard trash be on the floor? LPN#5 stated, I hope not. LPN #5 was asked, Would this be considered an infection control issue? LPN #5 stated, yes. g. On 3/13/2020 at 9:51 AM, the DON was asked, How should Biohazard trash be stored if it's in a resident room? The DON stated, In a red bag in a receptacle that's labeled Biohazard. The DON was asked, Should Biohazard trash be on the floor? The DON stated, No. The DON was asked, Would this be considered an infection control issue? The DON stated, It could be. h. 3/13/2020 09:57 AM The Administrator was asked, How should Biohazard trash be stored is it's in a resident room. The Administrator stated, In the Biohazard container. The Administrator was asked, Should Biohazard trash be on the floor? The Administrator stated, No. The Administrator was asked, Would this be considered an infection control issue. The Administrator replied, Yes.<br><br>4. Resident #94 had [DIAGNOSES REDACTED]. The Significant Change MDS with an ARD [DATE] documented resident has severe<br>impairment and requires total assistance with toilet use and has a urinary catheter. a. A physician order [REDACTED].Change 22 FR (French) Foley cath with 10 cc (cubic centimeters) bulb with bag PRN occlusion or dislodgement . b. On 03/09/20 at 12:40 PM, R #94 was sitting in a wheelchair, in assist dining room. Approximately 5 inches of the Resident's catheter and tubing was touching the floor. 5. On 3/13/20 at 9:36 AM, record review of a document titled, Catheter Care, Urinary documented, Infection Control .b. Be sure the catheter tubing and drainage bag are kept off the floor . 6. The policy titled .Briefs/Under pads . documented, The purpose of this procedure is to provide guidelines for the proper handling of briefs and under pads .Dispose of waste (soiled brief) in appropriate receptacle/container . 7. The policy titled .Personal Protective Equipment - Using Gloves documented, .To prevent the spread of infection .Remove gloves .discard them into the designated waste receptacle inside the room . |