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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 08/26/24 through 08/29/24. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M620, M1205, and M1570.	M 000		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure perineal care was provided in a manner to prevent complications for one (1) of two (2) residents reviewed for care catheter/bowel and bladder care. (Resident #83) Findings Include: A review of the facility's "Perineal Care Policy," revised 1/2010, revealed: " ...It is the policy of this facility to provide perineal cleanliness and comfort to the resident, to prevent infections and skin irritation, and observe the resident's skin condition ...Procedure ...For a male resident ...b. Wash perineal area starting with urethra and	M 620	1. On 08/29/2024, the Director of nursing assessed resident #83 for signs and symptoms of urinary tract infection. There were no signs of infection noted. The Director of Nursing provided individual in-services to Certified Nursing Assistants #1 and #2, including skill pass-offs for perineal and catheter care. 2. All incontinent residents have the potential to be affected by this deficient practice. 3. Infection Prevention Nurse began in-servicing all certified nursing assistants and nurses on 8/29/2024, to be completed by 09/01/24. 4. Once a week for three weeks, beginning 08/30/24, then weekly for three months. An observation of four residents	9/25/24

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M 620	Continued From page 1 working outward ...(3) Continue to wash the perineal area including the penis, scrotum, and inner thighs ..." On 08/28/24 at 10:05 AM, during an observation of catheter and perineal care, Certified Nursing Assistant (CNA) #1, with the assistance of CNA #2, used pre-moistened disposable wipes to clean Resident #83's penis, catheter tubing, and buttocks. After stating that perineal care was completed, CNA #1 prepared to apply a clean brief to the resident. When asked by the State Agency (SA) to check below the resident's anus for feces, CNA #1 wiped the area a total of nine (9) additional times, each time revealing a moderate amount of feces. The resident was turned over, and when the SA asked CNA #1 to check underneath his scrotum, it was found that feces were present in that area as well. An additional six (6) wipes were used to clean the scrotal area, again revealing a moderate amount of feces. On 08/28/24 at 10:37 AM, during an interview, CNA #1 stated that she should have ensured the resident was completely clean before applying a clean brief. She admitted, "I thought he was clean. I did not think to check under his scrotum." She acknowledged that improper cleaning could lead to skin breakdown and infection. On 08/28/24 at 4:04 PM, in an interview, the Director of Nursing (DON) stated that CNA #1 should have ensured the resident was completely clean and emphasized that the CNA's actions could result in infection and cause skin breakdown. A record review of "Admission Record" revealed that the facility admitted Resident #83 on 2/3/23	M 620	with incontinence being provided by the Infection Prevention Nurse, the Assistant Director of Nursing, or the Director of Nursing. Observations will be recorded on the weekly observation form. Observations will be reported monthly for three months beginning 09/25/24, to the Quality Assurance Performance Improvement Committee by the Infection Prevention Nurse. The committee will review documentation to verify that staff are demonstrating appropriate infection control practices.	

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M 620	Continued From page 2 with current diagnoses including Pressure Ulcer in the sacral region. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/17/24 revealed Resident #83 had a Brief Interview for Mental Status (BIMS) score of nine (9), indicating that the resident was moderately impaired. Section GG indicated that the resident was dependent on staff for toileting care.	M 620		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to provide respiratory care in a manner to prevent the possibility of complications as evidenced by oxygen tubing that was not dated to indicate weekly oxygen tubing/nasal cannula changes for one (1) of one (1) resident reviewed for respiratory care. Resident #18. Findings Include: A review of the facility's "Nebulizer and Oxygen Tubing Storage Policy", dated 4/2007, revealed, " ...It is the policy of the facility to reduce the risk of	M 655	1. On 08/29/24, resident # 18 was assessed for signs and symptoms of infection. No signs or symptoms of infection were noted. At this time, resident #18 had oxygen tubing replaced and dated. Licensed Practical Nurse #2 was in-serviced on Nebulizer and Oxygen Tubing storage policy on 08/29/24 by the Director of Nursing. 2. All residents with oxygen have the potential to be affected by the deficient practice. 3. Assistant Director of Nursing began in-servicing all Nurses on oxygen tubing storage policy, starting 08/30/24 and completed on 09/06/24, to ensure all	9/25/24

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M 655	Continued From page 3 potential and/or direct exposure to infectious diseases, air contaminants, and bacterial exposure. We will provide our residents with the proper storage and cleaning of respirator equipment. Procedure ...The facility will replace all respiratory tubings weekly. These tubings will be dated ...Documentation will be placed on the residents treatment record (TAR) of the weekly changing of tubing" A record review of the "Admission Record" revealed that the facility admitted Resident #18 on 2/7/24 with current diagnoses including Chronic Obstructive Pulmonary Disease (COPD). A record review of the "Order Summary Report" revealed Resident #18 had a Physician's Order, dated 7/11/2024, for oxygen therapy at 2 liters per minute (LPM) per nasal cannula as needed. On 08/26/24 at 10:30 AM, during an observation, Resident #18 was in the day room and was wearing a nasal cannula connected to oxygen. The oxygen tubing was not dated to indicate when the nasal cannula and tubing was last changed. On 08/27/24 at 11:10 AM, during an observation, Resident #18 was wearing oxygen per a nasal cannula while in the day room. The tubing of the nasal cannula was not dated to indicate the last tubing change. On 08/27/24 at 11:10 AM, during an interview, Licensed Practical Nurse (LPN) #2, who was responsible for Resident #18's care, confirmed the oxygen tubing was not dated. LPN #2 stated that she was unaware that the oxygen tubing needed to be dated but assured that she would label it moving forward. LPN #2 acknowledged	M 655	respiratory equipment is properly stored and dated. 4. Three residents on oxygen will be monitored by the Director of Nursing or Assistant Director of Nursing two times weekly for three weeks then once weekly for three months to determine if respiratory equipment is being properly stored and dated beginning 08/30/24. Results will be presented to the Quality Assurance Committee by the Director of Nursing beginning on 9/25/24 then monthly for three months, to ensure compliance has been obtained.	

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M 655	Continued From page 4 that the facility's policy indicated that oxygen tubing should be dated. On 08/28/24 at 09:10 AM, during an interview with the Director of Nursing (DON), she confirmed that the facility's policy required replacing oxygen tubing weekly and dating the tubing to indicate the date it was last changed. She explained the oxygen tubing is usually changed on Sunday night by the night shift. She stated that the policy was reviewed with all staff during orientation, and she emphasized the importance of adhering to the policy to reduce the risk of infectious diseases and bacterial exposure.	M 655		
M1205	45.40.6 Floors Floors. All floors shall be smooth and free from defects such as cracks and be finished so that they can be easily cleaned. This Statute is not met as evidenced by: Level II Based on observation, staff interview, and facility policy review, the facility failed to ensure the resident's rights for a safe and homelike environment as evidenced by broken floor tiles in two areas of the hallway for one (1) of eight (8) hallways observed. (Therapy room hallway). Findings Include: A review of the facility policy titled "Safe and Homelike Environment," undated, revealed, "...In accordance with resident's rights, the facility will provide a safe, clean, comfortable, and homelike environment... This includes ensuring that the	M1205	1. The Nursing Home Administrator will purchase concrete patch to fill and level the deficient/unsafe flooring on the Therapy room hallway. On 08/28/24 the Nursing Home Administrator and the Maintenance Supervisor assessed the Therapy room hallway flooring to see how much material is needed to correct/patch/mend the unsafe flooring. The rest of the facility flooring was also assessed. An area approximately 12inch by 12 inch or the equivalent of one tile was missing on B-Hall in the dining room area in front of the B-Hall nurses' station. The remaining floor throughout the facility is clear of any unsafe flooring/indentations.	9/25/24

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M1205	Continued From page 5 resident can receive care and services safely, and that the physical layout of the facility maximizes resident independence and does not pose a safety risk ..." On 8/27/24 at 9:07 AM, during an observation, there were several broken floor tiles in the hallway in front of an exit door. There was also an area in which the floor tiles were missing in a straight line across the hallway, causing an indention in the hallway which was approximately six inches wide. This hallway led to the Therapy Room. On 8/27/24 at 11:01 AM, during an interview with the Rehabilitation Technician, she stated that she was aware of the broken and missing floor tiles outside of the therapy gym door. She was not aware of any residents who had fallen as a result of the broken and missing floor tiles, but acknowledged it was a hazard and someone could trip if the floors were not repaired. During an interview with the Administrator on 8/27/24 at 10:35 AM, he revealed that the facility had an area near the physical therapy gym, across the hall, with broken tile and cracks in the cement. He acknowledged that the crack was long and deep enough to potentially be a tripping hazard for both residents and staff. On 8/27/24 at 1:58 PM, during an interview with the Maintenance Director, he confirmed that the back hall near the therapy gym had a crack across the hallway in both the cement and tile that could potentially be a tripping hazard for residents going to the therapy gym.	M1205	2. All residents have the potential to be affected by this deficient practice. 3. On 9/3/24 the concrete patch, carbon wire brush and steel concrete trowel were ordered by the Nursing Home Administrator. 4. Beginning 9/4/24 on the Therapy room hallway the Maintenance Supervisor used the Carbon Wire Brush to clean the indented area to remove dirt, debris and wax. He then proceeded to vacuum the area to remove all loosened material. Next, he proceeded to fill the indented area with concrete patch then smooth and level it with the existing floor/tile. Lastly, the Maintenance Supervisor placed a barrier around the area in which he worked to allow proper curing time. The Maintenance Supervisor completed the Therapy room hallway on 9/4/24. After completing the Therapy room hallway, the Maintenance Supervisor began on the B-Hall dining room area in front of the nurses' station and completed the same tasks. The Maintenance Supervisor completed the B-Hall dining room area on 9/4/24. The entire facility flooring was corrected/patched/mended by 9/4/24. The Maintenance Supervisor will assess the Therapy room hallway and B-Hall dining room once a week for three weeks beginning 9/11/24 and ending 9/25/24 to ensure the areas have not cracked or become brittle. He will report the result to the QA committee on 9/25/24. Following the 9/25/24 QA meeting the Maintenance Supervisor will assess the Therapy room hallway and B-Hall dining room once a month for three months to continually ensure the repair of the deficient/unsafe	

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M1205	Continued From page 6	M1205	flooring and report the findings during the monthly QA meeting.	
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review, and policy review, the facility failed to ensure hands were cleaned with soap or hand sanitizer before, during, and after providing	M1570	1. On 08/29/24, resident # 69 was assessed for signs and symptoms of infection by the Director of Nursing. There were no signs of infection noted. Licensed Practical Nurse #2, Certified Nursing Assistant #3, and Certified Nursing	9/25/24

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M1570	Continued From page 7 perineal care for one (1) of two (2) residents observed for catheter/perineal care. (Resident #69) Findings Include: A review of the facility's "Hand Sanitizing Procedure," revised 4/2015, revealed: " ...It is the policy of this facility to use hand sanitizer ...between handwashing when hands are not visibly soiled or dirty. Procedure ...use an alcohol-based hand rub ...for all the following situations: 1. Before and after direct contact with residents ...10. After removing gloves." A review of the facility's "Procedure for Handwashing," revised 4/2015, revealed, " ...2. Apply one squirt of soap ..." On 08/28/24 at 10:45 AM, during an observation of perineal care, Certified Nursing Assistant (CNA) #3, assisted by CNA #4, was observed preparing to provide perineal care for Resident #69. CNA #3 turned on the water and attempted to use the soap dispenser but found it empty. CNA #4 suggested using a bottle of soap from the resident's counter, but CNA #3 declined, stating, "I cannot use resident soap." CNA #3 and CNA #4 proceeded to wash their hands without soap before starting perineal care. CNA #4 left the room to get Licensed Practical Nurse (LPN) #2 to pause the feeding pump, but did not perform hand hygiene after removing gloves or before applying new gloves. LPN #2 entered the room wearing gloves, paused the feeding pump, and exited the room wearing the same gloves. During perineal care, CNA #3 removed and reapplied her right glove multiple times due to contamination with feces but failed to remove both gloves and perform hand hygiene between	M1570	Assistant #2 were all in-serviced on Hand Sanitizing procedures with skills pass-offs by the Director of Nursing on 08/29/24. 2. All residents have the potential to be affected by the deficient practice. 3. Assistant Director of Nursing and Infection Prevention Nurse began in-servicing all Certified Nursing Assistants and Licensed Nursing staff on Hand Sanitizing policy with skills pass-offs, starting 08/30/24 and completed on 09/01/24, to ensure all staff use proper hand hygiene/ hand sanitizing procedures 4. Three patient care staff members will be monitored by the Director of Nursing, Assistant Director of Nursing, or Infection Prevention Nurse two times weekly for three weeks then once weekly for three months to determine if proper hand sanitation is being performed beginning 08/30/24. Results will be presented to the quality assurance committee by the Director of Nursing monthly for three months, beginning on 9/25/24, to ensure compliance has been obtained.	

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M1570	Continued From page 8	M1570		

glove changes. CNA #3 stated, "I should have brought my own hand sanitizer to use." Both CNAs removed their gloves at the end of care and washed their hands without soap.

On 08/28/24 at 2:25 PM, during an interview, CNA #4 confirmed that there was no soap in the room and acknowledged that they should not have used the resident's liquid soap. She admitted that not using soap during handwashing could allow bacteria to remain on their hands and pose a risk of infection to the resident.

On 08/28/24 at 2:35 PM, CNA #3 admitted that she should have used soap during handwashing, noting that washing hands without soap would not remove germs. She acknowledged that she should have sanitized her hands between glove changes to prevent exposing the resident to bacteria.

On 08/28/24 at 2:43 PM, LPN #2 admitted that she should have washed her hands and should have removed her gloves before exiting the room. She stated that failing to do so could spread infection and pose a risk to the resident.

On 08/28/24 at 3:07 PM, during an interview, the Infection Preventionist (LPN #1) confirmed that LPN #2 should not have entered the room wearing gloves and should have performed hand hygiene upon entering and exiting the room. She stated that improper hand hygiene and glove changes could increase the resident's risk of infection.

On 08/28/24 at 3:32 PM, the Assistant Director of Nursing (ADON) confirmed that LPN #2 should not have entered the room wearing gloves and should have performed hand hygiene. The ADON

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M1570	Continued From page 9 emphasized that CNA #3 should have removed both gloves, washed her hands, and applied new gloves, as improper glove handling could lead to contamination and infection. On 08/28/24 at 4:15 PM, the Director of Nursing (DON) acknowledged that LPN #2 and CNA #3 failed to follow infection control protocols. She confirmed that their actions could lead to cross-contamination, posing risks of infection and skin breakdown. A record review of the "Admission Record" revealed the facility admitted Resident #69 on 07/11/24 with current diagnoses including Hemiplegia and Unspecified Hemiparesis following a cerebral infarction. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/17/24 revealed Resident #69 was severely cognitively impaired, and she was dependent on staff for toileting hygiene.	M1570		