STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035296	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Transitional Care	1521 North Pine Cliff Drive Flagstaff, AZ 86001

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51158 Based on closed record review, staff interviews, and policy review the facility failed to ensure that proper documentation was provided to responsible parties and the receiving facility(short-term general hospital) for 1 of 2 sampled residents (#29) and one of two sampled residents (#29) received proper notice of discharge. The deficient practice could lead to notifications of resident transfer/discharge not being made to all required parties. Findings include: Resident #29 was initially admitted on [DATE], with a diagnosis that included unspecified fracture of left foot, subsequent encounter for fracture with routine healing. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMs) assessment score of 15 identifying no cognitive impairment. A discharge MDS dated [DATE], revealed a discharge code 04 indicating that Resident #29 was discharged on [DATE] to a short-term general hospital (acute hospital, inpatient prospective payment system (IPPS)). Review of the resident's clinical record revealed no evidence of provider orders, progress notes, or care plan related to the discharge, or of notification to the receiving facility. Further review of the clinical record revealed a faxed request from the receiving facility (short-term general hospital) on August 5, 2024 requesting a discharge summary. There was no evidence that the facility responded to the request. Review of a police report dated August 1, 2024 revealed that Resident #29 allegedly stole a phone from staff. The report revealed that the Executive Director (ED/staff #59) stated they no longer wanted the resident on the premises. The report revealed that due to necessary health care needs, the resident was transferred to the hospital. The report also included that nursing staff removed wound vac before transfer. Further review of the police report revealed evidence of other contraband (meth, syringes, weapons) being found. (continued on next page)

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A late entry progress note dated August 20, 2024, by the Director of Nursing (DON/staff #32) revealed that the DON (staff #32) was notified at 0700 that a staff member's cell phone and pen were reported missing. The progress note indicated that a phone case was found by a Certified Nursing Assistant (CNA) in Resident #29's room. The progress note also indicated that police were notified. An officer arrived and conducted an investigation, and the cellphone was discovered in Resident #29 's room. An interview was conducted on August 20, 2024 at 1:23 PM, with the Medical Records Director (MRD/staff # 60), who reviewed Resident #29 ' s clinical record and stated there was no evidence of discharge documentation. An interview was conducted on August 20, 2024 at 1:29 PM with the DON(staff# 32), who alleged that Resident#29 had meth, syringes, and all kinds of weapons in his room, and that documentation can be found in the police report. The DON (saff #32) also reviewed clinical records and verified there was no documentation/ summary of discharge. An interview was conducted on August 21, 2024 at 11:19 AM with the alleged victim (Director of Life Enrichment, staff #35), who stated that both the ED (staff# 59) and DON (staff #32) were out of the facility, and she went to the admissions manager to report the missing property. The employee (staff #35) stated that she did not press charges and just wanted her property back. An interview was conducted on August 21, 2024 at 1:35 PM, with DON (Staff #32), with the ED (staff #59) present. The DON (staff #32) stated that the discharge/transfer process is to assess the situation and whether it is emergent or not. She stated that an acute transfer form is filled out and 3 copies are made for the resident, transportation, and the receiving facility, and that an acute transform form should always be completed. The DON stated when a patient is sent out 911, the acute transfer form should still be completed. She further stated for a facility to initiate a discharge (planned or unplanned) one of the following should occur: the resident has met their goals, a breach of admission contract, and change in care (if they need a higher level of care), and a transfer form would be completed. The DON(staff #32) stated she and the ED were off site at time of incident, and she received a message alerting her that there was a missing cell phone. The DON (staff #32) called the manager on duty and advised her to scope out the area surrounding the last known origin of the missing property. The DON (staff #32) stated she was informed that a CNA had seen a cell phone case inside of Resident #29's room. The DON(staff #32) stated she did not want the staff to get involved with Resident #29 due to alleged previous history and she notified police. The DON (staff #32) stated that the police found contraband in Resident #29 's room which included meth, syringes, and weapons. The DON (staff #32) stated that there is room for improvement since the acute care form was not completed and it was not a proper discharge due to the resident going into police custody. The DON (staff #32) stated this does not meet expectations and that the discharge summary should be documented, and the risks could result in residents not receiving proper care due to the receiving facility not having proper information. During the DON (Staff #32) interview, the ED (staff #59) interjected that he stated he asked the on duty manager to enter the resident 's room and ask Resident #29 whether or not he had the phone. The ED (staff #59) stated that he disagreed to the DON 's (staff #32) statement of not meeting expectations, as the resident was arrested and in police custody. An acute care transfer form, bed hold policy, and face sheet were not applicable since it was not a facility initiated discharge. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled, Transfer and Discharge, reviewed October 24, 2023 revealed that non-emergency transfers or discharges require a summary and plan of care to be prepared for the resident. In addition to providing the resident with a statement of the right to appeal the action to the state agency designated for such appeals, along with the name, address and phone number of the state long term care ombudsman. Further review of the policy titled, Transfer and Discharge, revealed emergency transfer procedures should include the following: nursing should complete and send with the resident a Transfer Form which documents, current diagnosis, reasons for transfer/discharge, date, time, physician, current medications, treatments, any indication for transmission based precautions, and functional status. Nursing should document information regarding the transfer, in the medical record.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observation, record review, interviews, and facility policy review, the facility failed to ensure one of one sampled resident (#19) had a baseline care plan and/or comprehensive care plan to address the resident's immediate needs within 48 hours of admission regarding his weightbearing status and proper use of orthotic. The deficient practice could result in a resident not receiving the necessary care, services, or assistance, leading to harm. Findings include: Resident #19 was admitted into the facility on [DATE], with diagnoses that included a history of left proximal tibia fracture, diabetes mellitus, hypertension, and acute anemia. A review of the Admission MDS (minimum data set) assessment dated [DATE] for Resident #19 revealed a BIMS (brief interview of mental status) score of 12, which indicated the resident was moderately cognitively impaired. Upon review of the physical therapy initial evaluation dated July 08, 2024, under the section labeled Precautions, it was documented for Resident #19 to remain Touchdown Flat Foot Weightbearing to the left lower extremity and to wear the knee brace unlocked and on at all times. Review of all physical therapy daily encounter notes from the start of care on July 08, 2024 through August 18, 2024 revealed a continuation of the precautions for Resident #19 to remain Touchdown Flat Foot Weightbearing to the left lower extremity and to wear the knee brace unlocked and on at all times. The care plan initiated July 07, 2024 was reviewed and revealed no evidence of any information regarding the touch down weightbearing status or the knee orthotic for the resident's left lower extremity. In an interview conducted August 20, 2024 at 12:44 PM, a certified nursing assistant (CNA/ staff #19), reported that if a resident has a weightbearing restriction, or if a resident needs an orthotic device, that it would be communicated verbally in report and would also be documented within the care plan. When requested to view the care plan for Resident #19 together, Staff #19 failed to identify anything documented within the care plan regarding the knee orthotic or the weightbearing status of the left lower extremity. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted August 20, 2024 at 1:17 PM, the Director of Rehab (staff #116) stated that the process for admitting a resident from the hospital with orders for a weightbearing status or an orthotic device would include to ensure orders are transcribed accurately into the electronic medical record and to ensure that the supervising therapists collaborate with nursing and then update the baseline care plan to include that necessary information. Staff #116 stated that if that information was not added to the baseline care plan, there would be a risk of no clinical follow through with the rest of the interdisciplinary team and that there would be a risk of further injury for that resident's particular body part if an orthotic device was not worn or if a weightbearing status was not followed. When asked to view the care plan together, Staff #116 could not find any information documented within the care plan regarding the knee orthotic or the weightbearing status of the left lower extremity for Resident #19. In an interview conducted on August 20, 2024 at 2:00 PM, the Director of Nursing (staff #32) stated that there are risks if orders, special instructions, and the care plan do not contain the necessary information. Staff #32 reported that multiple members of the interdisciplinary team to include therapy, nursing, and medical records staff are responsible for transcribing discharge orders from the hospital and updating the care plan. Staff #32 stated that there could be further injury to the affected body part if pertinent information is missing from the medical record and if a weightbearing status is not followed or if a brace is not worn. When asked to locate the information regarding Resident #19's weightbearing status and the knee orthotic in the baseline care plan for Resident #19, Staff #32 confirmed that there were no orders, no special instructions, and no care plan present for the weightbearing status or knee orthotic. Review of the facility's policy titled Baseline Care Plans revealed that the baseline care plan will be developed within 48 hours of resident's admission and is to include the minimum healthcare information necessary to properly care for a resident, including but not limited to physician orders. Review of the facility's policy titled Clinical Documentation revealed that according to the principles of nursing documentation, documentation of nursing care is recorded in the medical record and is to be reflective of the care provided by nursing staff. Additionally, nursing care documented in the medical record will be accurate, complete, and legible.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observation, record review, interviews, and facility policy review, the facility failed to include weightbearing and orthotic orders for one resident (#19) and to provide care and services related to falls for one resident (#432). The deficient practice could result in a resident not receiving the necessary care, services, or assistance, leading to harm. Findings Include: - Regarding Resident #19 Resident #19 was admitted into the facility on [DATE], with diagnoses that included a history of left proximal tibia fracture, diabetes mellitus, hypertension, and acute anemia. A review of the Admission MDS (minimum data set) assessment dated [DATE] for Resident #19 revealed a BIMS (brief interview of mental status) score of 12, which indicated the resident was moderately cognitively impaired. Upon review of the physical therapy initial evaluation completed on July 08, 2024, under the section labeled Precautions, it was documented for Resident #19 to remain Touchdown Flat Foot Weightbearing to the left lower extremity and to wear the knee brace unlocked and on at all times. Review of all physical therapy daily encounter notes for Resident #19 from the start of care on July 08, 2024 through August 18, 2024 revealed a continuation of the precautions for resident 19 to remain Touchdown Flat Foot Weightbearing to the left lower extremity and to wear the knee brace unlocked and on at all times. Upon review of the physician's orders, no evidence was found for any orders regarding the touch down weightbearing status or the knee orthotic for the Resident #19's left lower extremity. In an interview conducted August 20, 2024 at 1:17 PM, the Director of Rehab (Staff #116) stated that the process for admitting a resident from the hospital with orders for a weightbearing status or an orthotic device would include to ensure orders are transcribed accurately into the electronic medical record. Staff #116 stated that if that information was not added to the orders, there would be a risk of no clinical follow through with the rest of the interdisciplinary team and that there would be a risk of further injury for that resident's particular body part if an orthotic device was not worn or if a weightbearing status was not followed. When asked to view Resident #19's orders together, Staff #116 could not find any orders regarding the knee orthotic or the weightbearing status of the left lower extremity. Staff #116 stated that it would not meet standards of practice for Resident #19's weightbearing status and orthotic orders to not be included in the medical record. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on August 20, 2024 at 2:00 PM, the Director of Nursing (Staff #32) stated that there are risks if orders, special instructions, and the care plan do not contain the necessary information. Staff #32 reported that multiple members of the interdisciplinary team to include therapy, nursing, and medical records staff are responsible for transcribing discharge orders from the hospital. Staff #32 stated that there could be further injury to the affected body part if pertinent information is missing from the medical record and if a weightbearing status is not followed or if a brace is not worn. When asked to locate any orders regarding Resident #19's weightbearing status and the knee orthotic in the facility's medical record, Staff #32 confirmed that there were no orders, no special instructions, and no care plan present for the weightbearing status or knee orthotic. Staff #32 stated that it would not meet the facility's expectation and standards of practice to not include orders from the discharging hospital regarding Resident #19's weightbearing status and orthotic use into the medical record. 51239 Finding Include: Resident #432 was admitted on [DATE] with Alzheimer's Disease, Dementia, Unspecified Severity with Anxiety, Acute Respiratory Failure with Hypoxia, Hypertensive Chronic Kidney Disease with stage 1 through 4 Chronic Kidney Disease, Unspecified Protein-Calorie Malnutrition, and Chronic Kidney Disease, Stage 3 Unspecified. Review of Nurse's note on 08/08/2024 revealed that the nurse was notified that resident #432 had tripped and fallen in her room, due to her long oxygen tubing that became trapped around the resident's wheelchair. The nurse's note also revealed that she was notified by the Certified Nursing Assistant (CNA) that housekeeping helped the patient off the floor into her wheelchair on 08/08/24 at 2:35PM. The admission Minimum Data Set (MDS) assessments was performed on 08/9/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 signifying the resident had no cognitive impairment. MDS revealed the resident does not have Potential indicators of psychosis: Hallucinations, delusions. Also, no concerns on were stated for any behavioral symptoms such as no wandering -presence & frequency, and no change in behavior were indicated. Moreover, MDS revealed that the resident has shortness of breathing and is receiving pain medication regimen, and no presence of pain notated. During the interview with the resident (#432) on 08/19/24 at 01:43 PM, she stated that she tripped over her oxygen tubing when walking to the restroom and fell . An interview was conducted with the housekeeper (Laundry Assistant/ Staff #42) on 08/20/24 at 01:35 PM. Staff #42 stated that she should not have helped the resident. Further she stated that when this incident happened she was walking into the resident #432 room to give her laundry and the resident was going out to play bingo. The staff #42 stated that she observed that while the resident #432 was walking, her oxygen tubing got trapped into wheelchair and fell . Staff #42 stated she was unable to locate any clinical staff so she assisted the resident to stand up from the floor-she locked the wheelchair so the resident was able to sit in the chair. Then she stated she notified the CNA that resident #432 fell . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Registered Nurse (RN/ Staff #27) on 08/20/24 at 1:49 PM. The Staff #27 stated the facility process when it comes to falls, first she will see if the resident is hurt, ensure if they are on blood thinner, contact the provider, and then contact the family member if resident wishes to. Staff #27 was aware of resident #432 fall that occurred on 8/8/24 assisted by the housekeeper. She also stated she was notified by the CNA immediately. Staff #27 further stated that residents fall was due to resident's oxygen tubing got trapped around resident's wheelchair. An additional interview was conducted with the RN (Staff #27) on 08/22/24 at 2:30PM. Staff #27 stated that she did post fall assessment on Resident #432 immediately upon being notified by the CNA approximately one minute after the incident. After the fall assessment was completed the provider was notified. Staff #27 also stated that the resident #432 stated that the family does not need to be aware as she was okay. However, the family members were notified the following morning while the family visited the facility. An interview was conducted with the Director of Nursing (DON/Staff #32) on 08/22/24 at 02:55PM. Staff #32 stated that the facility process upon falls is that first patient is checked, then vitals are taken, resident's provider is called immediately and the family is notified. DON further stated that her expectation is that CNA and Nurses or anyone who trained may help the resident pick them off the floor upon fall. DON also stated that the housekeeper should not be assisting after fall as it may pose lots of risks to the resident and the staff member if they are not trained. DON #32 stated that housekeeper (staff #42) does not have specific training on assisting falls and does not meet the facility expectations. Upon review of the job description of laundry assistant #42, it does not contain verbiage regarding assisting resident after a fall. Review of the facility policy titled, Training Requirements revised on 10/03/2023, revealed that training requirements should be met prior to staff and volunteers independently providing services to residents. Additional policy review titled, Post Fall Assessment Policy revised on 10/24/23, revealed that the nurse will respond to the resident sustaining a fall. Review of the facility's policy titled Transcribing Physician Orders revealed that Licensed Nursing staff will transcribe physician/medical provider's orders according to clinical standards of practice.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51239 Based on personnel file review, staff interviews, facility policy review, the facility failed to ensure that two of ten sampled staff (Staff # 19 and #49) had current Cardio Pulmonary Resuscitation (CPR) certification. The deficient practice could result in staff not knowledgeable of how to provide emergency care to residents. Findings include: Review of the personnel file records for a Licensed Practical Nurse (LPN/ Staff #49) revealed a hire date of [DATE] with a valid CPR certification issued on [DATE], however, the CPR expired on [DATE]. Further review revealed no evidence of current CPR certification. Review of the personnel file for a Certified Nurse Assistance (CNA/Staff #19), revealed a hire date of [DATE] with valid CPR certification issued on February 18, 2022, however, CPR certification expired on February 28, 2024. Further review revealed no evidence of current CPR certification. Review of staff #49 punch detail revealed that the Staff #49 worked as LPN at this facility after CPR certification had expired. Staff #49 worked shifts from [DATE]-[DATE], and [DATE]-[DATE]. Review of staff #19 punch detail revealed that the Staff #19 worked as CNA at this facility after CPR certification had expired, Staff #19 worked on [DATE]. An interview was conducted with the Business Office Assistant (Staff #52) on [DATE] at 11: 25 AM and reviewed LPN employment records and stated the LPN did not have current CPR certification. Further, the Business Office Assistant (Staff #52) stated that she is responsible for monitoring the CPR certification for staff and she did not think the LPN or CNA should be working on the floor without current CPR certification. An Interview was conducted on [DATE] at 1:49 PM with the Director of Nursing (DON/Staff #32), who stated she expected staff to complete CPR certification upon hire. She also stated that risk of staff not having CPR certification could result in patient suffering. She further states that she was aware that they were not compliant. Review of the facility policy titled, CPR- Providing Basic Life Support revised on [DATE], revealed that CPR certified staff will be available at any time and staff will maintain current CPR certification for healthcare providers through CPR provider.

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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** 50166 Based on record review, observations, staff and resident interviews, and policy review, the facility failed to ensure that the environment remained free from accident hazards for 3 residents (#281, #26, and #482). The deficient practice could result in potential harm to residents due to unsupervised access to sharps. Findings include: - Regarding Resident #281 Resident #281 was admitted on [DATE]. Record review of the medical diagnoses for resident #281 revealed type two diabetes mellitus accompanied by unspecified dementia and a need for assistance with personal care. Review of the admission MDS (Minimum Data Set) assessment dated [DATE] revealed that resident #281 had a BIMS score of 08 that indicated moderate cognitive impairment. Within the same MDS assessment it was documented that resident #281 was able to utilize a walker and wheelchair to mobilize. On August 19, 2024 at 2:08 p.m, an observation of the resident environment revealed a blood glucometer and an opened container of lancets on a table in the room of resident #281. An interview was conducted on August 22, 2024, at 8:37 a.m with resident #281 who stated that nurses had left lancets and the blood glucometer in his room without explaining their purpose. Resident #281 stated the equipment was already in his room when he arrived at the facility. Resident #281 stated that he used the needles once to get the blood out and obtain a reading for the nurses without any staff present at that time. Resident #281 stated that staff did not inform him that he could not use the needles, nor were they aware that he had used them. The resident recalled that staff had asked him once if he had used a needle, to which he responded yes. No further action was taken, and the resident was not assessed. - Regarding Resident #26 Resident #26 was readmitted on [DATE]. Record review of the medical diagnoses for resident #26 revealed type two diabetes mellitus. Review of the admission MDS from August 6, 2024 revealed that resident #26 had a BIMS score of 13 that indicated resident cognition was intact. Within the same MDS assessment it was documented that resident #26 was able to utilize a walker and wheelchair to mobilize, and many of his ADLs were done independently with the exception of supervision for showering, toileting, and dressing of the lower body. On August 22, 2024 at 9:40 AM, an observation of the resident environment revealed resident #26 had a blood glucometer, lancets, and supplies on the table in the room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Regarding Resident #482 Resident #482 was readmitted on [DATE]. Record review of the medical diagnoses for resident #482 revealed type two diabetes mellitus. Review of the admission MDS from August 18, 2024 revealed that resident #482 had a BIMS score of 13 that indicated resident with no cognitive impairment. Within the same MDS assessment it was documented that resident #482 was able to utilize a wheelchair to mobilize, and many of his ADLs were done independently with the exception of supervised showering, toileting, and dressing of the lower body. On August 22, 2024 at 9:58 AM, an observation of the resident environment revealed resident #482 had a blood glucometer, lancets, and supplies on the table in the room. On August 22, 2024, at 10 a.m., an interview was conducted with a Certified Nursing Assistant (CNA/Staff #15), who reported that medical devices, including blood glucometers, were stored in the rooms of every resident with diabetes. Staff #15 stated that lancets were kept in cabinets, and if any lancets were found in the resident rooms, she would have removed them. Each resident who had their blood taken had a bucket of medical equipment in their room. According to Staff #15, each bucket included test strips, a blood glucometer, alcohol wipes, cotton pads, and lancets. Staff #15 stated that if a resident with dementia had access to lancets, they could hurt themselves. On August 22, 2024, at 10:11 a.m., an interview was conducted with a Registered Nurse (RN/Staff#27), who stated that blood glucometers were kept in resident rooms, but residents did not check their own blood sugar. She also stated that only nurses and certified nursing assistants were authorized to perform blood sugar tests. Staff #27 stated that lancets were stored in a big cup in the resident rooms for convenience, as this arrangement prevents staff from having to visit the central supply each time a blood sugar check was needed. She stated that she believed there was minimal risk in leaving lancets in the rooms because 99.9 percent of patients cannot get up without assistance, and these lancets are atypical, so most people would not recognize them. However, Staff #27 stated that if residents managed to open the packaging, they could potentially poke their own finger, which was not in line with facility expectations. She emphasized that no resident should have used a lancet to perform such tasks without staff supervision, as it was not appropriate for them to handle such procedures on their own. An interview with the Director of Nursing (DON/Staff #32) was conducted on August 22, 2024, at 11:02 a.m., who stated that the facility's protocol involved storing blood glucometers in resident rooms to prevent cross-contamination. Staff #32 also stated that lancets were classified as sharps, and there were concerns about exposure if residents had access to sharps without staff supervision. The risks included the potential misuse of lancets to poke residents inappropriately, which would not align with the facility's expectations for lancet storage. Review of the facility's Exposure Control Plan for Blood Borne Pathogens revealed that lancets were classified as sharps, and contaminated sharps will be disposed of immediately or as soon as feasible after use. Contaminated sharps should have been disposed of in containers that were closable, puncture resistant, and leak proof. (continued on next page)

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Aspire Transitional Care	1521 North Pine Cliff Drive Flagstaff, AZ 86001

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Accident Prevention and Supervision policy revealed that the resident environment should have remained as free of accident hazards as possible, and residents should have received adequate supervision to prevent accidents. The policy emphasized the identification of hazard and risk factors for each resident to identify the potential risks of a resident having an avoidable accident. Review of the facility's Blood Glucose Monitoring policy revealed that all proper disposal techniques should have been used when using the equipment to comply with approved biohazard waste standards.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49325 Based on observations, staff interviews, and review of clinical records and policy the facility failed to ensure dialysis care and services, including nutrition, assessments, or coordination of care, were appropriately followed for 3 Residents (#15, #10, and #234). The deficient practice may result in complications of care and services to residents receiving dialysis. Findings include: -Regarding Resident # 15 Resident # 15 was admitted into the facility on [DATE] with diagnoses that included dependence on renal dialysis, implants and grafts, and end stage renal disease. A review of the Admission MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 8, which indicated the resident was moderately cognitively impaired. The care-plan initiated on August 06, 2024 revealed that Resident # 15 needs dialysis (hemo) related to renal failure. The goal was for resident to have no signs or symptoms through the review date. Interventions included to not draw blood or take blood pressure in arm with graft. Review of electronic medical records (EMR) revealed a physician order initiated on August 01, 2024 as follows: - No Blood Draws or Blood Pressure on Left Upper Extremity due to Shunt/Fistula. Review of EMR revealed three instances of staff measuring blood pressure on the left arm for Resident # 15 since his admission on August 01, 2024 as follows: August 16, 2024 at 04:53 AM reading of 129/48 mmHg lying left arm. August 20, 2024 at 05:32 AM reading of 140/51 mmHg sitting left arm. August 20, 2024 at 08:53 PM reading of 122/60 mmHg sitting left arm. An interview was conducted on August 21, 2024 at 02:11 PM with Certified Nursing Assistant (Staff # 28) who stated night shift will obtain blood pressure reading of the residents who are expected to be going out for dialysis in the morning. Staff # 28 stated that blood pressure readings for dialysis residents are not obtained from certain sites when there is a limb alert bracelet on the residents; and that, it is a reminder to avoid taking blood pressure at that area. An observation was conducted on August 21, 2024 at 02:16 PM which noted Resident # 15 wearing bracelet with lettering, limb alert. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on August 21, 2024 at 02:17 PM with Registered Nurse (Staff # 16) who stated that prior to dialysis appointments vital signs are taken including blood pressure. Staff # 16 stated that taking blood pressure reading from an arm with shunt or fistula would result in inaccurate reading or deep vein thrombosis. Staff # 16 reviewed electronic medical records for Resident # 15 and confirmed that blood pressure readings should not be taken from left arm as per physician orders. Staff # 16 stated that the three blood pressure readings from the left arm would not meet facility's expectations. An interview was conducted on August 21, 2024 at 02:38 PM with Director of Nursing (DON/Staff # 32) who stated that taking resident's blood pressure measurement from an arm which had an alert bracelet and orders instructing not to be taken from would not meet the facility's expectation. Furthermore, DON stated would assume that this information would be on the facility's dialysis agreement that was unavailable at that time. 50553 Regarding Resident #10: Resident #10 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, muscle weakness, end stage renal disease, and dependence on renal dialysis. Review of the care plan initiated on July 18, 2024 revealed a focus that resident receives dialysis, and an intervention that included communicating and coordinating care with the dialysis center. Review of physician orders revealed an order dated July 20, 2024 that indicated the resident received dialysis every Tuesday, Thursday, and Saturday at US Renal Dialysis Center. The order further indicates that a pre-dialysis form should be completed and faxed to the dialysis center, then placed in the Medical Doctor (MD) box on every day the resident goes out for dialysis. Review of the EMR revealed 8 instances since July 20, 2024 in which the dialysis communication form had indicated that the dialysis center has own form they will return with resident, instead of sending the form with resident to dialysis or faxing to dialysis center: July 20, 2024 July 25, 2024 July 27, 2024 August 3, 2024 August 6, 2024 August 10, 2024 August 17, 2024 August 20, 2024 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Admission MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 10, which indicated the resident was moderately cognitively impaired. An interview was conducted with Resident #10 on August 21, 2024 at 8:25 AM, in which he denied receiving a snack or meal from the staff to take with him to dialysis. He further stated that he is normally picked up for dialysis between 8AM and 9AM. He attempts to eat breakfast before going. He further denied being provided food from the dialysis center while in treatment. The resident also stated that on August 20, 2024, he arrived late to the facility after dialysis, and was unable to eat dinner, as it was already over. He stated that he was provided a sandwich and had dinner in the middle of the night instead. An interview was conducted with a Registered Nurse (RN/ Staff #1) on August 21, 2024 at 8:35AM who stated that the staff do not typically give a snack or to-go lunch to residents going to dialysis but will provide one on request. The nurse further states that the overnight nurses are responsible for printing out the pre-dialysis communication form, which is sent with the resident to the dialysis center. An interview was conducted with the Director of Nursing (DON/ Staff #32) on August 21, 2024 at 11:43AM who stated that her expectation is that every resident going out for dialysis is provided a hot lunch to-go. She also expected her staff to complete the dialysis communication form, which includes how the form is communicated to the dialysis center. She states that it is typically given to transport or the patient, who is expected to hand it to the dialysis center. Another interview was conducted with the DON (Staff #32) on August 21, 2024 at 2:38PM. In this interview, the DON states that when it is not charted that the dialysis communication form was printed and sent with the resident, she cannot ensure it occurred. She states that the facility does not have dialysis contracts or agreements for as long as she has been employed there (for the past three years). The DON also states that she believes the dialysis center is responsible for resident comfort and nutrition while at dialysis. When further questioned as to how the facility ensures the dialysis staff addresses this and provides competent care, the DON stated that I guess if we had the dialysis contracts in place, then we could ensure that. 51124 -Regarding Resident #234 Resident #234 was admitted into the facility on [DATE], with diagnoses that included end stage renal disease, enterocolitis due to Clostridium Difficile, and dependence on renal dialysis. Resident #234's care plan dated August 17, 2024 indicated that the resident received dialysis services and that an intervention was to communicate with dialysis center regarding medication, diet, and lab results. The care plan also indicated that the resident had C. Difficile, contracted at the hospital, and that the interventions were to use as much disposable equipment as possible or use dedicated equipment such as thermometer and blood pressure cuff and to monitor for symptoms of weakness, dehydration, fever, nausea and vomiting and blood in stool. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the orders dated August 19, 2024, revealed Resident #234 was to be on the transmission-based precaution, specifically Contact Precautions, due to her diagnosis of C. Difficile. Review of the orders also revealed that Resident #234 had an order for her dialysis appointment: Patient on hemodialysis Monday, Wednesday, and Friday (MWF) at Dialysis Center chair time (09:30). The order additionally contained the information Please complete pre-dialysis form and fax to dialysis center then place the form in MD box. On August 21, 2024 at 12:31 PM, a review of the clinical record revealed that there was no evidence of any dialysis communication assessment that was completed for Resident #234's first day of dialysis treatment on August 19, 2024. Further, there was a dialysis communication assessment dated for August 21, 2024, and it was signed and timestamped: 8/21/2024 01:33. On August 21, 2024, at 11:53 AM, a phone interview was conducted with the receptionist and receiving staff at Resident #234's dialysis treatment center. It was confirmed that the resident had received two dialysis treatments, one on August 19,, 2024 and one that was currently ongoing at the time of the phone call on August 21, 2024. The staff stated that the dialysis treatment center had not received any medical information from the facility prior to the resident's first dialysis treatment on August 19, 2024. Further, the staff confirmed that no information was provided from the facility to the dialysis treatment center regarding the resident having any medical diagnoses that may pose a risk to other staff or patients, and any transmission-based precautions that the resident was on. The staff also confirmed that the resident never came with any dialysis communication form that was specified in the resident's orders. On August 21, 2024, at 12:36 PM, a follow-up phone interview was conducted with the clinic manager at Resident #234's dialysis treatment center. The manager confirmed that the dialysis center had not received any information from the facility on or prior to August 19, 2024 regarding the resident's medical diagnoses, the resident's current condition and status, or the transmission-based precautions that the resident was ordered to maintain. The dialysis clinical manager confirmed that they had received no dialysis communication assessments either of the treatment dates. The dialysis center manager further stated that we would need that information timely to protect staff and residents while the resident was under their care at the dialysis treatment center. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On August 21, 2024, at 2:38 PM, an interview was conducted with the Director of Nursing (staff #32) who stated that the facility does not have any dialysis contracts or agreements for as long as she has been employed there (for the past three years). Staff #32 reported that the facility only relies on their own dialysis policy for guidance on communication and collaboration of care. Staff #32 confirmed that it was her understanding that the dialysis treatment center was solely responsible for ensuring the provision of the dialysis treatments and care of the residents while at dialysis, and that it meets the current standards of practice for the safe administration of dialysis. When further questioned as to how the facility ensures that this is followed by the dialysis treatment center, staff #32 stated that I guess if we had the dialysis contracts in place, then we could ensure that. Staff #32 additionally confirmed that either on or prior to August 19, 2024, no clinical information regarding Resident #234 was given to the dialysis treatment center. Also, staff #32 agreed that at that time, on August 19, 2024, Resident #234 was to be on contact precautions for her diagnosis of C. Difficile, and that this was never communicated to the dialysis treatment facility. Staff #32 stated that the risk if a resident were to go to dialysis and that information regarding transmission-based precautions was not communicated to the dialysis treatment center, then other residents or staff could be exposed to those infections. Review of the facility's policy titled Dialysis Communication and Site Monitoring revealed that In order for continuity of care, communication between the dialysis center and facility is required and that all communication between the dialysis center and the facility will be maintained in the resident's chart.

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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** 51158 Based on observations, staff interviews, and policy review, the facility failed to ensure that medications and controlled substances were kept locked. The deficient practice could result in residents, staff, and visitors having access to medications. Findings include: An observation of a medication cart on Hall A was conducted on August 19, 2024 at 11:58 AM. The medication cart was unlocked and unattended outside of room [ROOM NUMBER]. An observation of a treatment cart on Hall A was conducted on August 21, 2024 at 10:30 AM. The treatment cart was unlocked in the 140 ' s hall. An interview was conducted with a Registered Nurse (RN/staff #36) on August 19, 2024 at 12:11 PM, and confirmed that the medication cart was left unlocked. The RN stated that medication carts are secured and keys are passed between staff each shift, and when leaving the unit. He further stated that the risk of leaving the cart unlocked could result in patients or visitors accessing the medication. An interview was conducted with an RN (Staff # 33) on August 21, 2024 at 9:53 AM, who stated that treatment carts were left unlocked. The RN further stated that the treatment carts should be locked, and she is unaware if there are keys to unlock the carts. An interview conducted with the Minimum Data Set Coordinator RN (MDS RN/Staff # 40) on August 21, 2024 at 10:30 AM, who stated the treatment cart was left unlocked. The MDS RN stated that RN ' s are responsible for treatment carts and have the keys to unlock the carts. The MDS RN further stated the risk could result in patients accessing medications. An interview was conducted with the Director of Nursing (DON/Staff #32) on August 22, 2024 at 9:31 AM, who stated that she expects nurses to ensure medication carts are locked. A facility policy titled, Medication Storage (Medication Cart/Narcotics), revealed that all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. Only authorized personnel will have access to the keys to locked compartments. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50166 Based on observations, staff interviews, resident interviews, and policy review, the facility failed to ensure that food was stored under sanitary conditions that maintained freshness in the kitchen fridge and nourishment refrigerator. The deficient practice could result in potential foodborne illness. Findings include: An observation was conducted on [DATE] at 10:44 a.m. of the walk-in fridge during the initial kitchen tour which revealed the Dining Services Director (staff#68) attempted to discard macaroni and cheese labeled with a discard date of ,d+[DATE] - ,d+[DATE], cheese sauce labeled with a discard date of ,d+[DATE] - , d+[DATE], turkey gravy with a discard date of ,d+[DATE] - ,d+[DATE], and bread stuffing without a label or discard date. Moreover, a bowl of unlabeled cooked potatoes without a discard date was observed on the fridge shelf. A follow-up observation was conducted on [DATE] at 11:05 a.m. which revealed a gallon of cow's milk labeled [DATE] and another labeled [DATE]. On [DATE] at 11:29 a.m., an observation by surveyor #51124 revealed a wait staff/server (staff#14) attempted to discard a personal milk carton with a discard date of [DATE], another personal milk carton with a discard date of [DATE], sushi with a discard date of [DATE], and two yogurts with a discard date of [DATE] from one of the nourishment refrigerators. During a follow-up visit to the kitchen on [DATE] at 12:49 p.m., an additional observation of the walk-in fridge revealed a steel container with seven lemons, two of which were coated in a fluffy, white, greenish, and blueish substance on the peel. Additionally, a full bag of lemons was observed on the walk-in fridge shelf with one mushy, slimy, and sour-odored lemon at the bottom of the bag. An observation of the kitchen conducted on [DATE] at 10:12 a.m. revealed multiple opened and used packages of bread and hot dog buns without labels and missing discard dates. During an interview conducted regarding the unlabeled breads, the dining services director (staff#68) stated the opened packages are supposed to be labeled and he thought they were. Staff#68 stated that not labeling foods and failure to put a discard date would leave residents at risk for foodborne illness. An interview was conducted with the Dining Services Director (staff#68) on [DATE] at 10:50 a.m. who stated that once something is cooked, the kitchen staff will store it for seven days before they must discard it. An interview was conducted with the Dining Services Director (staff#68) on [DATE] at 11:20 a.m. who stated that he was unsure of when the stuffing was cooked, or if the kitchen intended to use it later that day. On [DATE] at 11:28 a.m., an interview with resident #235 revealed they had received grapes on [DATE] that were moldy. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the wait staff/server (staff#14) on [DATE] at 11:29 a.m. who stated that the foods have been expired for some time, and that, sometimes staff forgets about them. An interview was conducted with the Dining Services Director (staff#68) on [DATE] at 12:55 p.m. who stated that he observed a substance on the lemons in the steel container that appeared to be mold. Further inspection of the bag of lemons was conducted by staff #68 who stated it's mold, it's bad. The dining services director (staff#68) stated if he found what appeared to be mold on the food, he would take the plate away for sure and make sure none of the other fruits were bad. Interview was conducted with the Executive Director (ED/Staff#59) on [DATE] at 2:39 p.m. who stated that the facility's process for food dating is that all foods should be dated when opened, and expired or outdated foods should be removed from wherever it is located. He also stated that outdated foods could put people at risk of getting sick from the food, or could contaminate other foods. When asked about the facility ' s expectations for food coming from the kitchen to be fresh and appropriate for consumption, he said yes, and the potential risk could discourage residents from eating, which has the potential to cause weight loss or reduced healing. Review of the facility 's Food Storage policy revealed that food is to be stored in an area that is clean, dry and free from contaminants. Food is to be stored by methods designed to prevent contamination. The policy included that all storage areas should have temperature and humidity controls to prevent condensation of moisture and growth of mold. The food storage policy also included that all containers must be legible and accurately labeled and dated, and date marking should indicate the date or day by which a ready-to-eat, time/temperature control for safety food should be consumed, sold, or discarded, which should be visible on all high-risk foods.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on clinical record review, staff interviews, facility documentation, and facility policy, the facility failed to ensure that clinical records accurately reflected care and services provided to two out of two sampled residents (#281 and #19), regarding fluid restriction, care interventions, and the use of an air mattress. The deficient practice has the potential for clinical records to inaccurately and incompletely reflect the status of residents and alter the actual care that is provided. Findings Include: - Regarding Resident #281 regarding fluid restriction: Resident #281 was admitted to the facility on [DATE] with diagnoses that included unspecified injury of head, dementia, unsteadiness on feet, repeated falls, syndrome of inappropriate secretion of antidiuretic hormone, and hypo-osmolality and hyponatremia. Review of the care plan initiated on August 04, 2024, revealed that Resident #234 had potential for alteration in nutrition needs related to conditions associated with confusion, dementia, and related diagnoses. As an intervention, the care plan specified to Encourage fluids. There was no evidence of any care plan regarding a fluid restriction for Resident #281. Review of the MD Admission Summary dated August 05, 2024 revealed that Resident #281's medical doctor (staff #117) documented that the resident had signs and symptoms consistent with SIADH (syndrome of inappropriate antidiuretic hormone secretion), and Patient will need to abide by a fluid restriction. Under the note section Assessment/Plan, staff #117 documented Continue fluid restriction. Review of the Provider Progress Note dated August 06, 2024, revealed Resident 281's nurse practitioner (staff #118) documented under the note section Assessment/Plan to Continue fluid restriction. Review of the Provider Progress Note dated August 07, 2024, revealed staff #118 again documented under the note section Assessment/Plan to Continue fluid restriction and added 8/7/24: stable at 128. Review of Resident #281's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. Additionally, in section K, under Nutritional Approaches, no evidence of a therapeutic diet or altered diet was specified. Review of the physician's orders revealed no evidence of orders regarding a fluid restriction for Resident #281. On August 19, 2024, an observation of Resident #281's room revealed 1.5 fluid restriction written on the facility's whiteboard hanging on the wall. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview conducted on August 21, 2024, at 7:44 AM, a certified nursing assistant (CNA, staff #58), stated that CNAs or nurses are the staff members who write information on the whiteboards located in each of the residents' rooms. She stated that the information is in regard to that resident's care. Upon entering Resident #281's room to examine the whiteboard together, and when asked to clarify what the writing 1.5 fluid restriction meant, staff #58 stated, I don't know, I would have to ask the nurse. In an interview conducted on August 21, 2024, at 7:48 AM, a registered nurse (RN, staff #36) stated that he was not aware of any fluid restriction for Resident #281. When asked to clarify what the writing on Resident #281's whiteboard 1.5 fluid restriction meant, staff #36 stated I will have to find out. Staff #36 stated that the process for when a resident admits from an outside hospital into the facility and is supposed to be on a fluid restriction, is that the facility has a piece of paper in the resident's room for nursing staff to track fluid intake, that there would be an order in place, and that it would be documented on two times per day by the nurse. When asked to review the Resident #281's Provider Progress Notes from August 06 and August 07, 2024 where it was documented continue fluid restriction, staff #36 stated that yes the resident should have been on a fluid restriction. Staff #36 also stated that there were no orders for Resident #281 to be on a fluid restriction. Additionally, staff #36 reported that it is the responsibility of the medical provider to ensure that all necessary orders are in the medical record, and that the facility's process requires an order and a tracking sheet to ensure that a fluid restriction for a resident was followed. Further, staff #36 stated it would not meet the facility's expectation for Resident #281 to have continue fluid restriction documented in a provider note and fluid restriction written on the resident's whiteboard with no order and tracking sheet in place. In an interview on August 21, 2024, at 8:17 AM, the nurse practitioner (staff #118) reported that his involvement in the facility's process for ensuring a resident receives a fluid restriction is for him to assess the resident's cognitive capacity for the fluid restriction, to ensure an order is in place, to communicate with the Director of Nursing, and to review the progress weekly, and monthly if needed. Staff #118 confirmed that his progress notes would indicate if a resident was supposed to be on a fluid restriction, and that this would be communicated to nursing staff through an order in the medical record. When asked to review his progress notes from August 06 and August 07, 2024, staff #118 confirmed that Resident #281 was supposed to be on a fluid restriction at that time. When asked to review if there were ever any orders placed for fluid restriction for Resident #281, staff #118 stated that there were no orders placed. Staff #118 stated that there was supposed to be an order from the hospital for 1.5L fluid restriction transcribed into resident 281's orders from the discharge orders from the hospital, and that's where the breakdown is. Staff #118 confirmed that there is risk for harm if a resident has written on their whiteboard in the room for a fluid restriction and no orders or tracking sheet to track the fluid restriction. In an interview conducted on August 21, 2024, at 8:34 AM, the Director of Nursing (staff #32), stated that the process for admitting a resident from an outside hospital who was supposed to be on a fluid restriction would be to ensure the order for fluid restriction is in place and then monitor the fluid restriction. Staff #32 reported that it is the responsibility Director of Nursing, the Administrator, or the Admissions Coordinator to ensure that discharge orders from the hospital are accurately transcribed into the medical record at this facility. When reviewing Resident #281's medical record together, staff #32 confirmed that the resident came in with a discharge order for a 1.5 liter fluid restriction, and it was not activated or followed up on, and further, that this would not meet the facility's expectation for accurate documentation. (continued on next page)

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	035296	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Transitional Care	1521 North Pine Cliff Drive Flagstaff, AZ 86001

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regarding Resident #281 and documented interventions Review of the care plan initiated on August 04, 2024, revealed that Resident #281 had potential for falls due to confusion and weakness. As an intervention, the care plan specified to Educate and provide reminders regarding safety precautions. Additionally, in the same care plan, Resident #281 was noted to have an alteration in skin integrity, with an intervention to Educate resident on the importance of offloading and pressure reduction as appropriate. There was no evidence of any care plan regarding use of an air mattress, or wheelchair cushions, or specialized wheelchair modifications for Resident #281. Review of Resident 281's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. Additionally, in Section M Skin Conditions, it was not documented in the checkbox that Resident #281 had a Pressure reducing device for the chair or a Pressure reducing device for the bed. Review of the daily System Notes dated August 05, 06, 07, 15, 18, 19, 20, 21, and 22, 2024, revealed that several interventions under the section Current preventative safety measures in place were checked off in the documentation system and included room close to nurse's station. The System Note on August 18, 2024 additionally noted that an anti-rollback device was on the wheelchair. Review of the System Note on August 18, 19, 21, 22, 2024, revealed that several interventions under the section SKIN were checked off in the documentation system and included that a wheelchair cushion was noted to be in the wheelchair. The System Note on August 16, 2024 under the section SKIN included that an air mattress was in place and that a wheelchair cushion was in the wheelchair. Review of the physician's orders revealed no evidence of orders clarifying the type of mattress (standard or air mattress), wheelchair cushions, or specialized wheelchair modifications for Resident #281. During observations conducted on August 20, 2024, at 2:57 PM, and again on August 21, 2024 at 7:02 AM, Resident #281 did not have an air mattress in place, it was observed to be a standard mattress. Resident #281 also did not have a wheelchair cushion in place in the wheelchair. Additionally, the wheelchair did not have any anti-rollback devices or any other specialized devices on it. The resident's room was not near the nurse's station. In a direct line between Resident #281's room and the nearest nurse's station, traveling down the same side of the hallway, was 6 resident rooms, a clinical supply room, two office rooms, a storage room, and a medical preparation room as specified by the facility map and confirmed by observation. In an interview conducted on August 21, 2024 at 8:34 AM, the Director of Nursing (staff #32) stated that a System Note is something that automatically triggers on the treatment administration record (TAR) or the medication administration record (MAR), or a skilled charting note. Staff #32 confirmed that a nurse would have to click off particular items in a checklist form for them to appear in the generated System Note, and that those items should accurately reflect the nurse's assessment. After reviewing the System Notes for Resident #281, staff #36 stated that is would not meet the facility's expectation if a nurse was clicking off on interventions in a System Note that were not actually in place. Regarding Resident #19 and use of an air mattress (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #19 was admitted into the facility on [DATE], with diagnoses that included a history of left proximal tibia fracture, diabetes mellitus, hypertension, and acute anemia. A review of the Admission MDS (minimum data set) assessment dated [DATE] for Resident #19 revealed a BIMS (brief interview of mental status) score of 12, which indicated the resident was moderately cognitively impaired. Under Section M Skin Conditions, it was documented that the resident had a Pressure reducing device for chair, a Pressure reducing device for bed and Pressure ulcer/injury care in place. Review of orders revealed no evidence of any orders for Resident #19 regarding an air mattress. Review of the care plan initiated on July 07, 2024 revealed that Resident #19 had an alteration in skin integrity related to impaired mobility. The care plan was noted to contain a revision added on July 18, 2024 to include the intervention of Cushion in wheelchair. No evidence was found of any intervention regarding an air mattress within the care plan. Review of a System Note dated July 08, 2024 revealed that several interventions under the section SKIN were checked off in the documentation system and included W/c cushion in W/C and Air mattress in place. Review of a Progress Note for Resident #19 dated July 16, 2024, at 3:09 PM, revealed that a registered nurse (staff #18) documented that CNAs called me in this morning to show me the pressure injury on this resident's sacrum. I took a re-evaluation picture and alerted (Resident #19's provider) of the new picture. New orders have been added and I just moved an air mattress into his room to help with offloading. In a phone interview conducted on August 20, 2024, at 11:31 AM, staff #18 stated that on the date of the July 16, 2024 progress note, she had noticed that Resident #19 was not on an air mattress and then proceeded to get the resident an air mattress due to her concerns of pressure related injury to Resident #19. In an interview on August 21, 2024 at 8:34 AM, the Director of Nursing (staff #32) stated that a System Note is something that automatically triggers on the treatment administration record (TAR) or the medication administration record (MAR), or a skilled charting note. Staff #32 confirmed that a nurse would have to click off particular items in a checklist form for them to appear in the generated System Note, and that those items should accurately reflect the nurse's assessment. She further stated that it would not meet the facility's expectation if a nurse was clicking off on interventions in a System Note that were not actually in place. Review of the facility's policy titled Clinical Documentation revealed that Nursing care documented in the medical record will be accurate, complete, and legible.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51159 Based on the clinical review, interviews, facility documentation and policy review, the facility failed to maintain Enchanced -Based Precautions (EBP) for 2 of 5 sampled residents (#430, #234).The deficient practice could result in spread of infection. Findings Include: - Regarding Resident #430: Resident #430 was admitted on [DATE] with diagnosis Type 2 diabetes mellitus, atherosclerotic heart, necrotizing fasciitis, chronic respiratory failure with hypoxia, acute on chronic systolic (congestive) heart failure, hypokalemia, hypomagnesemia and klebsiella pneumoniae. Physician orders included to wear PPE (Personal Protective Equipment) for Enhanced Barrier Precaution (EBP) and to use EBP sign as refers for direct care. The order also included that staff would need to wear non-sterile gown, gloves, every shift for wound care. The Progress notes for resident #430 revealed resident had first degree Av block & history of ESBL E coli infection. During an observation conducted on August 19, 2024 11:23 AM an EBP sign was posted outside Resident # 430's room. Staff # 62 ,Certified Nurse Assistant (CNA), was observed assisting with catheter tubing, and heard telling resident #430 that she would be transferred into her bed. Staff # 62 (CNA) was observed not wearing a gown while performing transfer. Staff # 67, Registered Nurse (RN), was helping during the transfer and was observed to be wearing a gown. The two staff turned Resident # 430 onto her right side, straighten out bed pad, then they turned the resident on her back, continued to reposition the resident, turning her onto her left side, and staff #19 certified Nurse Assistant (CNA) was observed not wearing gown entering the room to reposition Resident # 430. -Regarding Resident #234: Resident # 234 was admitted on [DATE] with the diagnosis end stage renal disease, enterocolitis difficile, type 2 diabetes mellitus, dependence on renal dialysis, atherosclerotic heart disease. Progress notes dated on August 21, 2024 revealed that Resident # 234 is c-diff positive and Resident # 234 would be placed on Enhanced barrier precaution. Observation outside Resident #234 revealed that there were no precaution signs on the entrance door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Staff # 67, Regertister Nuser (RN), on 08/20/2024 at 12:29PM. Staff #67 stated that a way to tell that a resident is on Transmission- Based precaution would be to look at their orders which will include the reason why. Staff #67 stated staff can identify those on EBP by looking for signs outside the resident ' s door and the signs would state if the resident is droplets, airborne, or contact base precaution. Staff #67 stated resident #430 Transmission-Based Precaution was taken down by the request of staff # 32, Director of Nursing (DON). Staff #67 stated training on Infection control is done annually. An interview was conducted with Staff # 28, Certified Nurse Assistant (CNA), on August 20, 2024 12:21 PM. Staff #28 stated that the staff has worked at the facility for over 3 years, and completes training yearly on infection control. Staff #28 explained the different types of transmission based precaution and stated contact based precaution would need to gown up, use hand sanitizer, and wash hands. Staff #28 stated there would be an orange sign outside the entrance of a resident to identify what type of Transmission Based Precaution they would need. Staff #28 stated there are times when a Transmission Based precaution sign is forgotten to be placed for a resident and stated those with a history with ESBL should be on enhanced precaution. An interview was conducted with Staff # 32, Director of NUrsing (DON), on August 20, 2024 01:42 PM. The DON stated that staffs receive in-service training informing them about TBP and the in-service training would inform staff on how to give care for residents on TBP. The DON stated Infection control training is done yearly with staff. When asked regarding the difference between each Transmission- Based precaution, the DON explained that for droplet Transmission based one would need to wear full surgical, mask and gloves, for Airborne Transmission-Based Precaution staff need to wear a N-95, gown up, and wear gloves and for resident with C-diff, staff would need to gown up, and wash their hands with soap. The DON stated not having a Sign for a resident needing a Transmission Based Precaution does not meet Facilities expectation. An interview was conducted with Staff # 36, RN, on August 21, 2024 at 12:17 PM. Staff #36 stated that resident # 234 is C-diff positive but the provider requested it to be taken off since the resident doesn't have soft stool. Review of clinical records showed there was no testing done to verify that resident #234 is no longer c-diff positive. Review of the facility's policy titled Management of C. Difficile Infection revealed that contact precautions shall be implemented in accordance with a physician order and facility policy for transmission-based precautions. Additionally, If a resident with C. Difficile infection is transferred or discharged , information related to the infection and contact precautions shall be communicated to the receiving facility/provider. Review of the facility policy titled Transmission-Based Precautions revealed that for a resident on Contact Precautions, healthcare personnel must wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. Review of the facility policy title Enhance [NAME] Precaution revealed EBP would need to be followed outside the resident room during activities of daily living, transferring, mobility, and any close physical contact with residents.