STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045207	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ouachita Nursing and Rehabilitation Center	1411 Country Club Road Camden, AR 71701

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42016 Based on observation and interview, the facility failed to ensure privacy and dignity was maintained for 1 Resident (Resident #14) of 1 Resident observed during activity of daily living care. This failed practice had the potential to affect 78 residents currently residing in the facility. Findings included: a. On 05/13/2024 at 01:27 PM, Certified Nursing Assistant (CNA) # 3 and CNA #4 entered Resident # 14's room, to perform brief change and peri-care. b. An observation on 05/13/2024 at 01:33 PM, CNA #3 removed resident's brief. A window, to the left side of the Resident's bed, had a window shade for privacy, and the shade was open. CNA # 4 was standing on the left side of the Resident's bed, in front of the window. CNA #4 turned around and looked out of the window twice and did not close the window shade. CNA #3 removed Resident #14's pants, unfastened and lowered resident's brief, exposing abdomen, private area, and legs. c. During the observation on 05/13/2024 at 01:35 PM, CNA # 4 turned around and closed the window shade. d. On 05/13/2024 at 01:44 PM, Resident # 14's room door was opened during the Resident's transfer from the bed to the wheelchair. CNA #8 did not knock on door and stated Resident #52 was in the hallway. e. During an interview, on 05/13/2024 at 01:47 PM, CNA #4 stated the window shade should have been closed before brief was removed to provide privacy. f. During an interview on 05/13/2024 at 02:07 PM, CNA #3 stated privacy should have been provided prior to the care of Resident #14. g. During an interview on 05/15/2024 at 09:35, the Director of Nursing (DON) indicated staff should provide privacy when providing any care for the resident's dignity, so no one sees them if they are naked, and it is a Resident right. h. During an interview on 05/15/2024 at 02:00 PM, CNA #8 stated, I didn't, but we are supposed to knock for privacy before entering a Resident's room. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. In an interview on 05/16/2024 at 02:55 PM, the Administrator indicated staff should provide privacy during care and should knock and announce, when entering a resident's room it is a dignity issue and for privacy.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48977 Based on observations and interview it was determined that the facility failed to ensure Resident #178's personal and medical information was protected from potential unauthorized persons. The finding include: Resident #178 had a diagnosis of Depression and Cerebral Infraction. According to Quarterly Minimum Data Set (MDS) with the Assessment Reference Date 04/24/23 documented that Resident 178 scored 15 (13-15 indicating cognitive intact) on the Brief Interview of Mental Status prior to discharge from the facility on 05/29/23. Admission MDS dated [DATE] was still in progress. A Care Plan for Resident #178, with the initiate date of 05/06/24, Resident #178 had no discharge plans anticipated at that time and the current plan was to remain in facility for Long Term Care. On 05/15/24 at 09:05 AM, the Surveyor and Licensed Practical Nurse (LPN) #3 entered Resident # 178's room LPN #3 was positioned with back to the medication cart that was in the hallway. The Surveyor noted medication cart was unlocked with keys in the lock, the resident's medication was on top of the cart, the laptop computer was open to the Electronic Medication Administration Record (E-MAR) profile that displayed Resident #178's person information, medical choices, and medication order. On 05/15/24 at 09:10 AM, LPN #3 confirmed the medication on top of the cart was left unattended, the keys were in the lock of the unlocked cart, and the computer screen was unlocked and displaced the Resident's personal and medical information. On 05/16/24 at 09:00 AM, the Director of Nursing confirmed that unauthorized people can see the Resident information including but not limited to date of birth, picture, and orders if the nurse's computer was unlocked to display the resident's profile. On 05/16/24 at 9:05 AM, the Assistant Director of Nursing (ADON) voiced, after pulling up a Resident's E-MAR profile that was displaced on the screen of the unlocked computer, that the Resident's date of birth, picture, name, code status, physician orders, physician's name, room number, allergies, diet, and vital signs could have noted and an unauthorized individual was familiar with electronic facility computer software system other confidential information could have been obtained. On 05/16/24 at 09:58 AM, a policy titled Confidentiality of Social and Medical Record Information was presented to the Surveyor that documented Privacy and Confidentiality Resident/Elders' personal and medical records are protected to assure confidentiality. An in-service titled General In-Service-HIPPA [Health Insurance Portability and Accountability Act] .Examples of failure to comply with HIPPA 1. Leaving resident information out in the open for anyone walking by to see. a.Nurses Not minimizing the computer screen on med cart. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Leaving charts opened out in the common area/nurses desks .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42016 Based on observations and interviews, the facility failed to ensure a sink was properly attached to a bathroom wall, for one bathroom sink of two sinks observed. This failed practice had the potential to affect 1 Resident who had access to room [ROOM NUMBER]. Findings included: a. During an observation on 05/13/2024 at 01:14 PM, the bathroom sink in room [ROOM NUMBER] was not flush with the wall. [NAME] caulking type material, partially covered with paint, spread in globs across top and sides of the sink with an open gap on right side behind the cold-water knob. b. During an interview on 05/14/2024 at 10:37 AM, the Maintenance Director was asked to accompany the surveyor to room [ROOM NUMBER]. The Maintenance Director was asked if there was a gap between the wall and the back of the sink. The Maintenance Director stated, there is a bracket on the wall, screwed into the wall, the sink sits on the bracket, and it would not come off. When asked why the sink was not flush with the wall, the Maintenance Director stated, it gets loose due to residents using them (the sink) to push up when standing back up. The Maintenance Director denies the sink would fall from the wall, It is sturdy. The Maintenance Director grabbed the sink and moved the sink in a side-to-side motion. The sink shifted making a grating noise. The Maintenance Director exited room [ROOM NUMBER], faced the wall in hallway and said, this is the bracket, (moved hands outward in a horizontal line), it is held with screws to the wall and bolts to the sink. It cannot come off the wall. When asked if the screws were coming loose from the wall, the Maintenance Director said, Yes. I guess it could fall. c. During an observation on 05/15/2024 at 08:43 AM, the sink in room [ROOM NUMBER] did not move when touched, no gap appeared between wall and sink, and caulk type material was white without paint covering area to right of faucet, behind the cold-water knob. d. The Administrator was interviewed on 05/16/2024 at 02:55 PM. The Administrator stated there is a preventative maintenance program and the Maintenance Director will be able to provide specifics, he rounds the facility all day long. Correction of any maintenance issues are done as time allows and if it is urgent, it is done immediately. A resident sink that is not properly fastened to the wall would possibly be considered a hazard and needs to be fixed. e. On 05/16/2024 at 03:18 PM, the Maintenance Director stated he does round every day with the renovations going on and he picks a hall and does a different resident room every week. If a Certified Medical Assistant sees an issue or a resident says they need something fixed, there is a notification book at each nurse station that is filled out and I check those daily. There are urgent needs and basic needs, the information they fill out in the book gives those choices. Urgent needs are done right away and the basics are as time allows. The Maintenance Director acknowledged the Resident sink in room [ROOM NUMBER] and was addressed right away.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. 48977 Based on observation, record review and interview, the facility failed to prevent the misappropriation of narcotics for 2 Residents (Resident #72 & #74) to prevent possible complications of pain management. This failed practice had the potential to affect all residents taking narcotics in the facility. The findings are: 1. a. On 05/14/2024 at 10:26 AM, the Surveyor noted the controlled medication on hand did not match what was documented in the narcotic book for 2 Residents. b. On 05/14/2024 at 10:35 AM, the Surveyor noted the following discrepancies in the controlled medication book: 1. Resident #72 Pregabalin 75 mg there were 23 pills documented and 22 on hand. 2. Resident #72 Oxycodone 20 mg there were 2 pills documented and 1 on hand. 3. Resident #74 hydromorphone 2 mg 47 documented and 45 on hand. c. On 05/14/2024 at 10:35 AM, Licensed Practical Nurse (LPN) #4 voiced she had gotten sidetracked with an Incident and Accident report along with other things and had forgotten to sign them out. d. On 05/14/2024 at 03:00 PM, a review of the electronic records documented that the last administration was 05/13/2024 at 7:00 AM. e. On 05/14/2024 at 03:03 PM, LPN #4 confirmed she knew a controlled substance should be signed out immediately after administration and documented on the Medication Administration Record (MAR). LPN #4 stated she had administered the hydromorphone at 08:40 AM and at 10:15 AM. The Surveyor informed LPN #4 the order (Hydromorphone 2 mg give 2 mg by mouth every 4 hours as needed for pain) did not state every 2 hours as need and LPN #4 changed the 10:15 AM to 12:15 PM and stated she gave the 2nd does at 12:15 PM (12:15 PM was after the time discrepancies was noted by the Surveyor). LPN #4 confirmed not documenting in the MAR neither administration of the hydromorphone and that she would fix it. f. On 05/14/2024 at 03:12 PM, the Surveyor notified the Director of Nursing (DON) of the discrepancies with the narcotic count and the administration have not been documented in the MAR. The Director of Nursing (DON) voiced she had in-serviced the nurse. The DON also voiced she knew there was a problem, but she did not know how to handle it that it depended on how the Surveyors were investigating it. g. On 05/14/2024 at 03:30 PM, the Resident #74 voiced he had not received or asked for any pain medication today. Resident #74 voiced he was having pain earlier in the day during therapy and had told the therapist and rated the pain at a 7 on a 0-10 pain scale. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. On 05/14/2024 at 03:43 PM, the therapist said Resident #74 did voice he was in pain and rated his pain as a 7, but she did not inform the nurse because she did not believe he was a true 7 due to the lack of grimacing and other signs of pain.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 48390 Based on record review and staff interview, the facility failed to ensure a referral for Pre-Admission Screening and Resident Review (PASRR) was made for one (Residents #72) sampled resident reviewed for PASARR. Specifically, the facility failed to ensure Resident #72's PASRR Level 1 pre-screening was completed prior to admission. The findings include: 1. A review of the Care Plan revealed the facility admitted Resident #72 on 03/30/2024 with diagnoses that included bipolar II disorder. 2. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/01/2024, revealed Resident #72 had a Brief Interview for Mental Status [BIMS] score of 15 which indicated the resident is cognitively intact. 3. A review of Resident #72's Care Plan, revised 04/10/2024, revealed the resident had bipolar disorder and depression, would exhibit indicators of depression, anxiety, or sad mood, and had interventions in place that included administering medications as ordered and observing the resident for signs of depression. 4. A review of a Level I Preadmission Screen for Resident #72 revealed the screening was completed on 05/14/2024 and indicated the resident had a Diagnosable Major Mental Disorder identified as Bipolar Disorder. 5. During an interview on 05/15/2024 at 2:16 PM, the Assistant Director of Nursing [ADON] was asked who completed the PASRR screenings in the facility. The ADON indicated she started working in the facility on April 12, 2024, and that she has been responsible for the PASRR screenings since that date. The surveyor asked the ADON when a PASRR Level 1 screening is required to be completed. The ADON indicated the screening should take place before residents are admitted to the facility. The surveyor asked ADON when Resident #72's PASRR Level 1 was completed. The ADON indicated the screening took place on 05/14/2024. 6. During an interview on 05/16/2024 at 3:00 PM, the ADON stated the facility did not have a policy for Minimum Data Set [MDS] or PASRR.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 42016 Based on observations, interviews, record review and review of facility policy and procedures, the facility failed to provide perineal care in accordance with professional standards of care, for 2 (Resident #14 and Resident #52) of 2 residents observed. This failed practice had the potential to affect 7 residents residing in 300 hall who required assistance with perineal care. The findings are: 1. a. A review of an Admission Record, indicated the facility admitted Resident #14 with diagnoses that included Hemiplegia and Hemiparesis following cerebral infarction affecting left, non-dominant side, interstitial pulmonary disease, pulmonary edema, cerebral vascular disease, and cerebrovascular disease. b. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/02/2024, revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 5 which indicated the resident had severe cognitive impairment. Resident was dependent on staff for toileting hygiene, lower body dressing, sitting to lying and lying to sitting, sit to stand and chair to bed transfers. Resident required substantial assistance with rolling from left to right. c. A review of Resident #14's Care Plan, revised 02/02/2024, revealed the resident was dependent on staff for toileting hygiene. Interventions included 1 or more staff members to complete the activity. d. During an observation and interview, on 05/13/2024 at 01:27 PM, Certified Nursing Assistant (CNA) #3 and CNA #4 entered Resident's room, closed the door, pulled the curtain, explained procedure to Resident #14, transferred from wheelchair to bed. CNA #3 pulled back foreskin and used 1 wipe to clean private area using one swipe across the tip of the private area. Pulled skin back over tip of the private area. CNAs rolled Resident #14 onto the right side, 1 wipe used to clean both buttocks. CNA #3 placed a clean brief under resident. Resident was rolled onto left side. CNA #4 adjusted brief under resident. Resident rolled onto back as both CNAs fastened back of brief to front. CNAs put Resident #14's pants back on. Resident transferred from bed back into wheelchair. e. CNA #3 did not know if Resident #14 was circumcised, I just know there is a lot of skin there and I had to keep pulling it up to clean it. CNA #3 stated gloves should be changed and hands sanitized during brief changes, I just forgot to bring in extra gloves. 2. a. A review of an Admission Record, indicated the facility admitted Resident #52 with diagnoses that included Ataxic Cerebral Palsy, hypertension, iron deficiency anemia, polyosteoarthritis, and urinary incontinence. b. The quarterly MDS, with an ARD of 04/16/2024, revealed Resident #52 had a BIMS score of 2 which indicated the resident had severe cognitive impairment. Resident was dependent on staff for toileting hygiene, personal hygiene, upper and lower body dressing, sitting to lying and lying to sitting, and rolling from left to right. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. A review of Resident #52 ' s Care Plan, revised 04/17/2024, revealed the resident was dependent on staff for toileting hygiene. Interventions included 1 or more staff members to complete the activity. d. On 05/13/24 at 01:52 PM, CNA #3 and CNA #9 entered Resident #52 s room, explained procedure, provided privacy by closing door, and pulling privacy curtain between door and bed and between bed A and B. No hand hygiene was performed, both aides gloved. Resident #52 was transferred to the bed using a lift. CNA #3 explained brief change process to resident. CNA #9 assisted with lift movement, legs of device not spread during transfer to fit under bed, wheels remained unlocked. Resident lowered into bed, Resident's head was positioned against headboard causing chin to be at chest, shoulders on pillow. CNA #9 left room after transfer. No hand hygiene performed. CNA #3 placed two clear trash bags at the foot of bed, rolled Resident onto left side, providing explanation of removing sling. CNA #3 removed Resident's pants and placed them into the clear trash bag near wall. CNA then unfastened brief and lowered front of brief exposing Resident's lower body. One wipe used to wipe for personal care in circular motion one time. Wipe placed in clear trash bag close to the edge of bed away from wall. 1 wipe used to wipe downward motion on left groin. Wipe placed in clear trash bag. One wipe used in downward motion on right groin. Disposed of in clear trash bag. Resident rolled onto right side, away from CNA, sling removed. One wipe used upward motion to lower back. Two wipes used to clean stool from gloves. Five more wipes used to clean lower back in upward motion. One wipe used to clean left and right buttock, swipe up on right across back and down on left. Clean brief placed under Resident and Resident rolled to left side to brief could be positioned under Resident. Resident rolled onto back and brief fastened. Resident moaning and grimacing. CNA #3 removed glove from left hand, placed package of wipes in drawer of bedside table. No hand hygiene done. Covered resident with blanket, held clear trash bags in, still gloved, right hand. e. At 02:03 PM, Resident # 52 was positioned to comfort, raising head of bed, clipping call light to blanket in reach, bed placed in low position. No hand hygiene performed during brief change and no glove change performed. Trash and soiled pants taken to hallway and placed in appropriate bins. f. 05/13/24 02:07 PM CNA #3 stated gloves should be changed, and hands sanitized during brief changes, I just forgot to bring in extra gloves. Hands should be sanitized before providing a beverage and after, I just didn't think about it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. Review of the facility's undated document titled, Peri Care Check Off, instructed to Gather all supplies . Use the overhead table for your items. Put gloves on. Undo soiled brief and roll up and tuck under resident. Start at the waist (belly button is landmark) and work your way down to the knees. At the belly button line farthest away from you (hip bone) start with your first swipe. Takes approximately 3 swipes, maybe more depending on size. Be sure to get under the belly roll. Make sure to get the . pubis area. Next outer long leg toward pubis are on inner thigh on both sides. Male: pull the foreskin back and clean the head in a circular motion. Depending on how dirty make take a couple of times cleaning. Then the shaft to the base (away from the [male private area]). Clean the scrotum and under the scrotum. Be sure to pull the foreskin back over the {private area].Clean the thighs (inner and outer) to the knees. Be sure to get all areas of the legs. Take towel longways and lay on resident from waist to the knees and pat dry. Do not move towel while pat drying When finished place in bag. Change gloves from front to back. (both people change gloves clean and dirty person) Hand gel between glove change. (state says had gel not required) (optional only if soiled) Reposition resident on side. Start on the back at the waist. Make the swipe across. Then butt cheek up/butt cheek up. /Crack up. Ensure area is clean. Male (ensure under scrotum is clean). Clean both legs down to the knees be sure to get all area of the leg. Change gloves. Place clean brief. Roll resident toward you. Then the other person will finish cleaning resident on opposite side of bed. Pat dry. Changes gloves and apply cream.Wash hands. Offer fluids etc.Comments: .Always 2 people to do peri-care with sate in the building. One person be clean, and one does care. When in doubt change gloves. Always one swipe with 1 wipe. Front to back. h. A review of the Peri Care Check Off for Certified Nursing Assistant (CNA) #3, provided by the Assistant Director of Nursing (ADON) on 05/16/2024 at 03:14 PM, revealed the facility evaluated CNA #3 on 08/01/2023 and a Y was documented for each area of the check off. i. A review of the Peri Care Check Off for CNA #4, provided by the Assistant Director of Nursing (ADON) on 05/16/2024 at 03:14 PM, revealed the facility evaluated CNA #4 on 08/04/2023 and a Y was documented for each area of the check off. j. A review of the Peri Care Procedure for CNA #3, provided by the ADON on 05/16/2024 at 03:14 PM, revealed CNA #3 was evaluated on 03/26/2024 and given a check mark under the heading PASS for each item in the procedure. The first step in procedure indicated Prepare . GATHER SUPPLIES: Knock before entering . Provide privacy . set up supplies and work area named moisture shield etc. On towel . Explain . Position resident . Spray peri-cleanser ./ or pre-moistened wipes. Wash area from lower abdomen to pubic bone including waist and hips (anywhere a wet brief may have been in contact with the skin). Place dirty cloth in linen trash bag. Use dry cloth and dry this area. Place this cloth in linen trash bag. Clean front of resident using one wipe for each swipe (left side, middle, right side) utilizing front to back procedure. Please remember to pull back foreskin on male residents that are not circumcised gently and clean the head of the [male private area].Catheters: . Pat dry using clean, dry wash cloth. Put on clean gloves and turn resident over to expose buttocks. Clean back side front to back, wash entire buttocks area - pat dry Apply named moisture shield - (named) ointment - (named) - skin barrier as needed, remove gloves sanitize hands Make resident comfortable .Offer fluids . Close trash bags and dispose of properly . Wash hands with soap and water . k. A review of the Peri Care Procedure for CNA #3, provided by the ADON on 05/16/2024 at 03:14 PM, revealed CNA #3 was evaluated on 03/26/2024 and given a check mark under the heading PASS for each item in the procedure. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	l. A review of the Peri Care Procedure for CNA #4, provided by the ADON on 05/16/2024 at 03:14 PM, revealed CNA #4 was evaluated on 03/26/2024 and given a check mark under the heading PASS for each item in the procedure. m. Review of the facility document titled, All Staff Inservice Education Report, dated 05/01/2024, with a topic Importance of Good Hand Hygiene specified, . 1. When properly washing hands the correct way it helps to reduce and prevent the spread of germs 2. Hand washing helps protects . the resident . from getting sick . 4. One should wash hands before/after the use of gloves, .before and after peri-care of resident . The signature page contained CNA #3's signature and did not contain CNA #4 ' s signature. n. A review of a facility document titled, All Staff Inservice Education Report, dated 05/01/2024, with a topic Use of Hand Sanitizer instructed, 1.can be used when soap and water is not available. 2. Sanitizers can quickly reduce the number of germs on hands . The signature page contained CNA #3's signature and did not contain CNA #9's signature. o. Review of the facility undated policy and procedure titled, Hand Hygiene, specified, Perform Hand Hygiene When: 5. After contact with inanimate objects in immediate vicinity of the patient. Alcohol-based Hand Rub: is the preferred method of decontamination if hands are not visibly dirty, contaminated with proteinaceous material, or visibly soiled with blood or body fluids. Alcohol Based Hand Rub Procedure: 1. Apply dime-sized amount of product into the palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. This usually takes 15 seconds of less.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42016 Based on observation, interview, record review and policy review, the facility failed to follow manufacturer guidance to transfer a Resident from the wheelchair to the bed and from the bed back to the wheelchair for 1 Resident (Resident #14) of 1 Resident observed during a transfer. This failed practice had the potential to affect 3 residents (Resident #14, #42, and #45) who are transferred using a sit to stand lift. Findings include: a. A review of an Admission Record, indicated the facility admitted Resident #14 with diagnoses that included Hemiplegia and hemiparesis following cerebral infarction affecting left, non-dominant side, other reduced mobility, cerebral vascular disease, and cerebrovascular disease. b. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/02/2024, revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 5 which indicated the resident had severe cognitive impairment. Resident was dependent on staff for toileting hygiene, lower body dressing, sitting to lying and lying to sitting, sit to stand and chair to bed transfers. Resident required substantial assistance with rolling from left to right. c. A review of Resident #14's Care Plan, revised 02/02/2024, revealed the Resident is dependent on staff for activities of daily living. Interventions included . Sit to stand with 2 staff assistance for transfers. d. On 05/13/2024 at 01:27 PM, Certified Nursing Assistant (CNA) #3 and CNA #4 explained to Resident #14 they were going to do a transfer from wheelchair to bed to perform a brief change. Resident #14 did not want to remain in bed. CNA #3 stated they would return Resident to the wheelchair after the brief change. CNA #3 placed a sling around Resident's back, under both arms, with the opening and loops at the chest. CNA #3 and CNA #4 attached loops to the device, placed Resident's feet on what is identified as the footplate on page 6. Resident #14 has a left-hand that will not fully open, fingers are stiff, and index finger not able to curl around the handle. Resident was able to grip the right-side handle. CNA #3, took resident's left hand and strained to open the hand to allow fingers to hook on the left side handle, talking to Resident, Let's get your hand up here, hold on. The strap for the leg was not on device and no leg stabilization was done. Resident #14 was not standing, the assist sling, around upper torso, was suspending Resident's upper body, Resident's feet were on the footplate, knees bent, Resident's body was in a bent position with chest above feet and buttocks sticking outward past footplate. Buttocks was not supported. Resident #14 was transferred to bed. After the care Resident was transferred back to wheelchair using same method, left hand unable to grip handle, CNA #3 hooked fingers on handle, sling applied to upper torso, no buttock strap used. e. On 05/14/2024 at 02:01 PM, the named lift, sit to stand device, was on 300 hallway, to the left of Resident #14's room. The Caution label documented, . 2. This equipment shall be operated by trained caregivers only. 5. For details of operation of this equipment, please refer to your Owner's Manual. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Review of the (named) lift manufacturer packet dated 2021.09, provided by the Director of Nursing (DON) on 05/14/2024 04:00 PM, when policy was requested. The packet was identified as the policy facility uses by the Assistant Director of Nursing (ADON) on 05/16/202024 at 02:55 PM. Page 21, Fitting Stand Assist Buttock Strap, documented a triangle with exclamation point in the center, the Buttock strap MUST be used with the Stand Assist sling. These slings are designed to complement one another in providing the greatest comfort and security for the patient being transferred. Page 3 listed the symbol explanation as Warning! Failure to heed this warning may result in damage to the product or serious injury to the operator and/or user. On page 22, Lift and Transfer from Bed, number 5, instructed, Have the patient's hands holding the handles. For patients who cannot hold the handles, have them hold their arms around chest. g. During an interview on 05/15/2024 at 09:35 AM, the Director of Nursing (DON) indicated staff should follow manufacturer safety guidance when operating a lift to prevent injury. h. During an interview on 05/16/2024 at 02:55 PM, the Assistant Director of Nursing indicated staff should follow the safety guidelines, and the Administrator stated, I would think so. i. Review of [NAME] Sit to Stand Lift Skills Checklist, dated 02/05/2024, revealed CNA #3 was evaluated by the DON, and received check marks on all eleven items reviewed. This checklist was not specific for the (named) lift.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 47916 Based on observation, record review and interview, the facility failed to ensure peg tubes were flushed with the appropriate amount of tap water as ordered by the physician to prevent peg tube complications in 1 (Resident #53) of 2 Residents that received tube feeding, and flushes. The findings are: a. A Physician Order (dated, 12/20/2021) documented, Flush feeding tube with 60 cc of water before and after medication administration. b. A Care Plan documented, .Resident #53 has potential for nutritional deficits related to dysphagia, aphasia, dependent of g-tube for nutrition. (Revision on: 02/03/2024) .2/20/24-tube feeding changed, see orders. Administer feedings as ordered Check g-tube for placement as ordered. Cleanse g-tube site as ordered . c. A Physician Order (dated, 02/23/2024) documented, Zenpep Oral Capsule Delayed Release Particles 5000-24000 UNIT (Pancrelipase (Lipase-Protease-Amylase)) Give 1 capsule via G-Tube before meals related to EXOCRINE PANCREATIC INSUFFICIENCY d. A Physicians Order (dated, 03/14/2024) documented, NPO diet NPO texture. e. On 05/15/24 at 11:39 AM, the Surveyor observed Licensed Practical Nurse (LPN) #1 check for tube placement on Resident #53. LPN #1 flushed with 30 cc of tap water, administered Zenpep crushed in water, and flushed with 30 cc after. f. On 05/15/24 at 11:42 AM, LPN #1 was asked to check the orders on peg tube flushes before and after medications. LPN #1 confirmed that Resident #53 should receive 60 cc of water before and after medications. LPN #1 was asked to explain the process of confirming the amount of flush before and after medications are given. LPN #1 said, We should check the order before giving medicine. LPN #1 said that getting too little water flushes could cause stomach contents to not clear, and a medication may not be absorbed correctly. g. On 05/15/24 at 12:02 PM, the Surveyor asked the Assistant Director of Nursing (ADON) if there is a process staff are expected to follow prior to administering medications and flushes to residents with a peg tube. The ADON confirmed that nursing should check the physician orders prior to administering medication and flushes. The Surveyor asked if there were any concerns if a resident did not get the ordered amount of water flushes. The ADON said it could cause the peg tube to not be cleared of stomach content, keeping the peg tube patent, and it could cause nutritional issues. h. 05/15/24 01:33 PM, the ADON provided an In-service (dated, 05/31/2023) titled Medication Administration documenting, .Verification of Order All medications MUST be administered according to the physicians order. Every medication given must be checked against the eMAR . In-service titled G tube orders did not provide documentation of material that was covered. No policies on peg tubes or medication administration were provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 42016 48977 49596 Based on observation and interview, the facility failed to ensure medications were stored and labeled in accordance with state laws and accepted standards of pharmacy practice, failed to ensure nasal spray was administered appropriately for 1 (Resident #178), and failed to ensure medications were secured in 1 medication cart of 2 medication carts observed. This failed practice had the potential to affect 47 residents residing in the facility with the ability to ambulate independently or propel in a wheelchair independently. Findings include: Resident #27's Care Plan identifies Resident #27 with impaired cognitive function r/t Dementia Date Initiated: 08/10/2023. Resident #62 Care Plan identifies Resident #62 with impaired cognitive function due to cerebral vascular accident. Date Initiated: 12/30/2022. On 05/13/24 at 11:40 AM, a medicine cup containing a solid-tubular clear substance was found sitting on the dresser of Resident #27 and a second medicine cup containing a solid-tubular white substance was found sitting on the nightstand of Resident #62. The surveyor asked the Director of Nursing (DON) to identify the substances. The DON stated, I can only guess, maybe zinc, but it should not have been left in the room. The DON asked Resident #62, What is this the resident responded, I don't know, what is it. The DON asked Resident #62, When was this left in your room? Resident #62 stated, yesterday. The DON stated the substances were dried and they were probably left in the room yesterday. On 5/14/24 at 3:25 PM, the surveyor interviewed the DON. The surveyor asked, did you determine what medications were in the two medication cups in the resident's rooms? The DON stated, No, the white was probably zinc and the clear probably ointment. The surveyor asked why is it important to keep medication stored per facility pharmacy and state laws regarding storage. The DON stated, So other residents don't get into them. The surveyor asked what is the danger of medication being left at bedside? The DON stated Another resident could ingest it. Or it could be put in the wrong area or misused or inappropriately used. On 5/14/24 at 3:25 PM, the DON provided the facility Medication Storage in the Facility policy. The policy states: . Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 4:00 PM, the DON provided a copy of an in-service the facility started on Do Not leave Meds in the room. 05/15/24 09:05 AM, the Surveyor observed LPN #3 pass Resident #178's Fluticasone Propionate nasal spray and the resident self-administered. Resident #178 administered 2 sprays in the right nostril and 1 spray in the left nostril. The order documented Fluticasone Propionate Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) 1 spray in both nostrils one time a day. On 05/15/24 at 09:05 AM, the Surveyor and LPN #3 entered Resident #178's room for medication administration. The Surveyor noted medication cart was unlocked with keys in the lock, the resident's medication was left on the cart, the screen open to display Resident #178's personal information (including date of birth, picture, orders etc.) On 05/16/24 09:00 AM, the DON confirmed the nurse's key should not be left unattended because someone not authorized could get them and have access to the medication. During an observation on 05/15/24 at 10:05 PM, medication cart for the left side of 300 hall, 400 hall and 600 hall, being used by Licensed Practical Nurse (LPN) #2, rolled cart to the nurses station and parked it, to the right side of the door, of the medication room, located between 300 and 400 hall. LPN #2 then moved to the nurses' station and sat facing 500 and 600 hall. LPN was unable to see the medication cart over the counter while seated. During an interview on 05/15/2024 at 10:12 PM, the DON stated the medication cart should not be left open and unattended. The DON instructed LPN #2 to secure the medication cart. On 05/15/2024 at 10:15 PM, during an interview, LPN #2 stated the medication cart should be locked when unattended and out of sight, so no one can access the medications including confused residents or staff. During an interview on 05/15/2024 at 10:30 PM, the Assistant Director of Nursing (ADON), stated the medication cart should be locked at all times if out of sight of the nurse. It is a safety concern if someone opens the cart and removes something, drinks it or consumes it. Review of a facility policy titled, Medication Storage in the Facility, with an effective date of 01/01/2015, stated, . Policy Medications and biologicals are stored safely, securely, and properly . The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures .B. Only licensed nurses, .permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access.E. Except for those requiring refrigeration . medications intended for internal use are stored in a medication cart.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 03508 Based on observation, record review and interview, the facility failed to ensure meals were prepared and served according to the planned written menu to meet the nutritional needs of the residents for 2 of 2 meals observed. This failed practice had the potential to affect 5 residents who received pureed diets and 15 residents who received mechanical soft diets from 1 of 1 kitchen. The findings are: 1. The menu for lunch documented residents who received pureed diets were to receive a #8 scoop (1/2 cup) of pureed Spanish rice. The menu also specified for each resident on the mechanical soft diets to receive one tortilla bread each. 2. On 05/13/2024 at 12:51 PM, the following observations were made during the noon meal service: a. The residents who required pureed diets were served pureed beef enchilada, pureed vegetable blend and pureed flour tortilla. There was no pureed Spanish rice served to the residents on pureed diets. There were no substitutes given to the residents on pureed diets, in place of rice not served. b. The residents on mechanical soft diets were served beef enchilada, Spanish rice, and vegetable blend. There was no tortilla bread served to them as specified on the menu. c. On 05/13/2024 at 12:53 PM, the surveyor asked the Dietary Employee (DE) #3 the reason the residents on pureed diets were not served pureed rice. DE #3 stated, I overlooked it. d. On 05/14/2024 at 09:22 AM, the surveyor asked the DE #3 the reason the residents on mechanical soft diets were not served tortilla bread with their lunch meal on 05/13/24. DE #3 stated, I overlooked it.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 03508 Based on observation and interview, the facility failed to ensure that pureed food items were blended to a smooth, lump free consistency to minimize the risk of choking or other complications for those residents who required pureed diets for 2 of 2 meals observed. The failed practice had the potential to affect 5 residents who received pureed diets. The findings are: 1. On 05/13/2024 at 11:17 AM, Dietary Employee (DE) #3 used a #6 scoop (2/3) cup to place 6 servings of beef enchilada into a blender, added chicken broth pureed, and poured into a pan. At 11:21 AM DE #3 poured the pureed beef enchilada into a pan. The consistency of the pureed beef enchilada was gritty. 2. On 05/13/2024 at 11:24 AM, DE #3 used a #8 scoop (1/2 cup) to place 6 servings of vegetable blends, chicken broth and thickener into a blender, pureed, and poured into a pan. The consistency of the pureed vegetable blend was not form. 3. On 05/13/2024 at 11:41 AM, DE #3 placed 6 servings of flour tortilla into a blender, added chicken broth and pureed. At 11:43 AM, DE #3 poured the pureed flour tortilla into a pan. The consistency of the pureed flour tortilla was thick, sticky, and lumpy. At 12:53 PM, the surveyor asked DE #3 to describe the consistency of the pureed flour tortilla served to the residents for lunch. DE #3 stated, It was thick, sticky, and lumpy. 4. On 05/13/2024 at 12:56 PM, the surveyor asked a certified nursing assistant #1 who was assisting resident in the dining room to describe the consistency of the pureed flour tortilla served to the residents on pureed diets. She stated, It was thick, sticky and lumpy. 5. 05/14/2024 07:40 AM, the pureed sausage served to the residents on pureed diets for breakfast meal was lumpy and not smooth. At 08:10 AM, the surveyor asked Certified Nursing Assistant (CNA)#2 who was assisting residents in the dining room to describe the consistency of the pureed sausage served to the residents on pureed diets. She stated, It was not smooth. The Director of Nursing stated, It was more like mechanical. She asked CNA #2 to ask the kitchen for another pureed sausage. The kitchen did and she showed the comparison to the CNAs. On 05/14/24 at 08:17 AM, the surveyor asked the DE #3 to describe the consistency of the pureed sausage served to the residents on pureed diets. DE #3 stated, It was not smooth.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03508 49413 Based on observation, record review and interview, the facility failed to ensure the dietary staff washed their hands and changed their gloves before handling food items to prevent the potential for cross contamination for the residents who received meals from 1 of 1 kitchen, ensure leftover foods were not used to maintain food quality; food items stored in the refrigerator/freezer were covered, sealed, and foods were dated when opened to ensure first in, first out usage to prevent potential for food bone illnesses: ceiling vents and lights were maintained in clean, sanitary conditions for food preparation These failed practices had the potential to affect 76 residents who received meals from the Kitchen. The findings are: 1. On 05/13/224 09:15 AM, Dietary Employee (DE) #1 was standing by the clean area of the dish washing machine when she pulled an apron around her waist and tied it in a knot. She picked up a coffee cup, placed her finger inside the cup and removed the debris inside the cup, then placed the cup on the tray to be used in serving coffee to the resident for lunch. 2. 05/13/24 At 09:16 AM, DE #1 picked up a clip board from the counter and gave it to DE #2. She touched her mask contaminated her hands. Without washing her hands, she picked up glasses by their rims and stacked them on the trays to be used in serving beverages to the residents for lunch meal. DE #1 picked up plates from the rack in the dish washing machine room and when DE #1 was ready to place them on the plate warmer, the surveyor immediately asked DE #1 what should you have done after touching dirt object and before handling clean or food items? DE #1 stated, I should have washed my hands. 3. On 05/13/24 at 09:18 AM, DE #1 turned on the hand washing sink faucet and washed her hands. She used her bare hands to turn off the faucet, contaminating her hands. Without washing her hands, DE #1 picked up glasses by their rims and stacked them on the trays to be used in serving beverages to the residents for lunch. 4. On 05/13/24 at 09: 22 AM, DE #2 was on the dirty side of the dish machine. He picked up a water hose and used it to remove leftover food items from the plates. Without washing his hands, he picked up plates and placed them on the rack to be used in portioning food items to be served to the residents for noon meal. The surveyor asked the DE #2 what should you have done after touching dirty objects before handling clean equipment? DE #2 stated, I should have washed my hands. 5. On 05/13/24 at 09:25 AM, the following dented cans were observed on a rack with non-dented cans to be used. a. A can of dented pumpkin. b. A can of peach pie filling. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. On 05/13/24 at 09:36 AM, the following observations were made on a shelf in the walk-in refrigerator. a. A plastic lock bag that contained leftover sausage, leftover scrambled eggs, and leftover bacon. At 10:37 AM the surveyor asked DE #3 what do you use the leftover scrambled eggs, sausage, and bacon in the refrigerator for? DE #3 stated, We use them for the residents we go to dialysis in the morning, residents who received mechanical soft diets and residents on pureed diets the next day. b. There were 4 bags of shredded lettuce with a received date of 05/08/2024. The shredded lettuce leaves were discolored. The surveyor asked the Dietary Supervisor to describe the appearance of the shredded lettuce. She stated they were discolored. We just got them in on 05/08/2024. 7. On 05/13/24 at 09:39 PM, the following observations were made in the walk-in freezer. a. An opened box of beef patties was on a shelf in the freezer. The box was not covered or sealed. 8. On 05/13/24 at 09:52 AM, an opened bottle of lemon juice was on a rack in the storage room. The manufacturer's specification on the bottle documented, Refrigerator after opening. The surveyor asked the Dietary Supervisor what do you use lemon juice for? She stated, We use it when we have a food or dessert that calls for it. 9. On 05/13/24 at 10:14 AM, DE #3 opened a box that contained bags of flour tortilla and placed them on the counter. She united the bags of flour tortilla. At 10:16 AM, DE #3 picked up a spray bottle and sprayed it inside the pan. She pulled the gloves out of the glove box and placed them on her hands, contaminating them. She removed slices of tortilla from the bag and placed each slice in a pan to be used in making beef enchilada to be served to the residents for lunch. The surveyor immediately asked the Dietary Employee what should you have done after touching dirty object and before handling equipment and or food items? (DE) #3 stated, I should have removed gloves and washed my hands. 10. On 05/13/24 at 10:40 AM, the following observations were made in the dish washing room: a. The ceiling/wall above a metal rack on the dirty side of the dish machine had a gray/black residue on it. b. The door frames leading to the dish washing machine room were rotted out and chipped. The areas that were chipped were exposed to the metal. c. The right-side corner of the door leading to the dishwashing machine was missing the baseboard. The area where base board was missing had an accumulation of gray/black residue on it. d. The ceiling air conditioning wood cover had brown stains on it. e. The wall above the counter on the clean side of the dish machine was peeling paints, exposing the cement. f. The areas around the 3-compartment sink, oven, and the corners of the fluorescent lights had rust stains and black stains on them. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	g. The door frame leading to the outside was pushed in, exposing the metal. h. The floor leading to the janitor's closet was chipped, the area that was exposed had black stains on it. i. The door frames leading to the storage room were chipped exposing the metal. j. The walls in the kitchen, around the food preparation counter, storage room and dishwashing area had black stains that had dried in a drip formation, running down the wall in different areas. k. The ceiling tile by the 3-compartment sink was broken, exposing the concrete. l. Throughout the Storage Room, the corners where the wall and the ceiling meet had a discoloration of black residue. The Surveyor asked the Dietary Supervisor to describe the appearance of the area. She stated, It looks like mildew. 11. On 5/13/24 at 12:01 PM, the Certified Nursing Assistant (CNA) #1 picked up tray card and placed them on the food trays. Then, pulled the utility cart that contained opened tray covers to be used in covering food plates to be served to the residents for lunch towards her. Without sanitizing her hands, she picked up plate covers with her fingers touching the inside of the covers and covered the plates of food items. 12. The facility policy titled, Handwashing and glove usage in food service .When food handlers must wash their hands. Document, Before starting work. After leaving and returning to the kitchen/pre area and after touching anything else such as dirty equipment, work surfaces or cloths. 13. The following observations were made: a. 05/13/24 12:15 PM, thumb touching inside of dome cover with thumb of CNA #1 b. 05/13/24 12:17 PM, CNA #1 thumb touching inside of dome cover. c. 05/13/24 12:17 PM, CNA #1 pulling cart with dome lids - not sanitizing hands then picking up dome lid with hands touching inside of lid with fingers. 14. On 5/13/24 at 12:22 PM, Registered Nurse (RN) #1 confirmed hands should be sanitized after touching a cart and should not have fingers or thumbs touching the inside of the food dome cover.

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Ouachita Nursing and Rehabilitation Center	1411 Country Club Road Camden, AR 71701

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42016 47916 48390 Based on observations, interview, record review, document review and policy and procedure review, it was determined the facility failed to ensure hand hygiene and gloves were changed during perineal care for 2 residents (Resident #14 and Resident #52) of 2 residents observed for perineal care. This failed practice had the potential to affect 7 residents who required assistance with perineal care. The facility failed to ensure hand hygiene was performed during clean laundry delivery, before and after entry into room [ROOM NUMBER]. The facility failed to ensure doors for 3 (Resident #18, #28, #54) on droplet precautions remained closed, and COVID positive residents wore the appropriate protection when leaving the room. The Facility failed to ensure staff followed droplet precautions to prevent cross contamination and the spread of disease affecting all 78 residents in the building. Findings include: Review of the facility undated policy and procedure titled, Hand Hygiene, specified, Perform Hand Hygiene When: 5. After contact with inanimate objects in the immediate vicinity of the patient. Alcohol-based Hand Rub: is the preferred method of decontamination if hands are not visibly dirty, contaminated with proteinaceous material, or visibly soiled with blood or body fluids. Alcohol Based Hand Rub Procedure: 1. Apply dime-sized amount of product into the palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. This usually takes 15 seconds or less. During an interview on 05/13/2024 at 02:39 PM, the Infection Preventionist stated the last Inservice on hand hygiene was week before last. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's undated, document titled, Peri Care Check Off, instructed to Gather all supplies (box of gloves, 2 packages of wipes, hand sanitizer, 3 towels, brief, butt cream, 2 plastic bags, linens if bed needs changed) and place all items in clean trash bag to bring to the room. Close the blinds and pull your curtain then wash your hands before starting peri-care. Place a towel over the table to set up a field. 2 plastic bags at the end of the bed. One for dirty wipes and the other for dirty linen. Put gloves on. Undo soiled brief and roll up and tuck under resident. Change gloves if you touch any area soiled. Start at the waist . and work your way down to the knees. Takes approximately 3 swipes, maybe more . Make sure to get the . pubis area. Male: pull the foreskin back and clean the head in a circular motion. Then the shaft to the base (away from the head of [private]). Clean the scrotum and under the scrotum.Clean the thighs .to the knees.Take towel longways and lay on resident .pat dry.When finished place in bag. Change gloves from front to back. (both people change gloves clean and dirty person) Hand gel between glove change. (state says had gel not required) (optional only if soiled) Reposition resident on side. Start on the back at the waist. Make the swipe across. Then butt cheek up/butt cheek up. /Crack up. Ensure the area is clean. Male (ensure under scrotum is clean).Change gloves. Place clean brief. Roll resident toward you. Then the other person will finish cleaning the resident on the opposite side of bed.Changes gloves and apply cream.Wash hands. Offer fluids etc.Comments: .Always 2 people to do peri-care with sate in the building. One person be clean, and one does care. When in doubt change gloves. Always one swipe with 1 wipe. Front to back. A review of the Peri Care Check Off for Certified Nursing Assistant (CNA) #3, provided by the Assistant Director of Nursing (ADON) on 05/16/2024 at 03:14 PM, revealed the facility evaluated CNA #3 on 08/01/2023 and a (Y) was documented for each area of the check off. A review of the Peri Care Check Off for CNA #4, provided by the ADON on 05/16/2024 at 03:14 PM, revealed the facility evaluated CNA #4 on 08/04/2023 and a (Y) was documented for each area of the check off. A review of the Peri Care Procedure for CNA #3, provided by the ADON on 05/16/2024 at 03:14 PM, revealed CNA #3 was evaluated on 03/26/2024 and given a check mark under the heading PASS for each item in the procedure. The first step in the procedure indicated Prepare . GATHER SUPPLIES: . GEL HAND SANITIZER, . GLOVES (SEVERAL PAIRS) . The third step listed is, KNOCK BEFORE ENTERING AND WAIT FOR RESPONSE . The fourth step in the procedure indicated, PROVIDE PRIVACY . CLOSE BLINDS . A review of the Peri Care Procedure for CNA #4, provided by the ADON on 05/16/2024 at 03:14 PM, revealed CNA #4 was evaluated on 03/26/2024 and given a check mark under the heading PASS for each item in the procedure. The first step in procedure indicated . PROVIDE PRIVACY . CLOSE BLINDS . Review of the facility document titled, All Staff Inservice Education Report, dated 05/01/2024, with a topic Importance of Good Hand Hygiene specified, showed . 1. When properly washing hands the correct way it helps to reduce and prevent the spread of germs 2. Hand washing helps protect . the resident . from getting sick . 4. One should wash hands before/after the use of gloves, .before and after peri-care of resident . The signature page contained CNA #3's signature and did not contain CNA #4's signature. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility document titled, All Staff Inservice Education Report, dated 05/01/2024, with a topic Use of Hand Sanitizer instructed, 1.can be used when soap and water is not available. 2. Sanitizers can quickly reduce the number of germs on hands . The signature page contained CNA #3's signature and did not contain CNA #9's signature. A review of an Admission Record, indicated the facility admitted Resident #14 with diagnoses that included Hemiplegia and hemiparesis following cerebral infarction affecting left, non-dominant side, interstitial pulmonary disease, pulmonary edema, cerebral vascular disease, and cerebrovascular disease. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/02/2024, revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 5 which indicated the resident had severe cognitive impairment. Resident was dependent on staff for toileting hygiene, lower body dressing, sitting to lying and lying to sitting, sit to stand and chair to bed transfers. Resident requires substantial assistance with rolling from left to right. A review of Resident #14's Care Plan, revised 02/02/2024, revealed the Resident was dependent on staff for toileting hygiene. Interventions included 1 or more staff members to complete the activity. During an observation on 5/13/2024 at 01:27 PM, CNA #3 and CNA #4 entered Resident # 14's room, and closed the door, pulled the room dividing privacy curtain, and explained to Resident #14 they were going to perform a brief change. CNA # 3 pulled back Resident's sheet and comforter. CNA #3 and CNA # 4 donned gloves. No hand hygiene was done upon entering the Resident's room or prior to beginning care. During the transfer of Resident #14 from wheelchair to bed, the Resident's call light fell to floor and was picked up by CNA #4. The call light fell a second time landing as if draped over the legs of the sit to stand, touching floor between device legs and button end on floor. The call device remained on floor from 01:30 PM to 01:32 PM when picked up by CNA # 4 and placed on Resident's bedside table. At 01:33 PM, CNA # 3 removed Resident's brief. A window to the left side of the Resident's bed had a window shade open. A window was behind CNA # 4, who was standing on the left side of Resident's bed. CNA # 4 turned around and looked out window twice and did not close the window shade. CNA # 3 removed Resident # 14's pants, unfastened and lowered Resident's brief, exposing abdomen, private area, and legs. CNA # 3 used 1 wipe to clean the tip of the private area wiping in a straight line. At 01:35 PM, CNA #4 turned around and closed the window shade. CNAs rolled Resident onto the right side. CNA #3 used 1 wipe to clean both buttocks, swiping up on left buttock and down on right buttock. CNA # 3 placed a clean brief behind Resident and tucked edge under Resident's right side. Resident was rolled to the left side and CNA #4 adjusted the brief under the Resident. Resident was rolled onto their back and both CNAs fastened the brief on each side. At 01:38 PM, CNA # 3 pushed clean wipes, sticking out of the top of the soft pack, back into the package using the tips of her pointer and middle fingers and resealed the top. CNAs put Resident #14's pants back on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 01:45 PM, CNA # 3 using gloved right hand, straightened Resident 14's pillow, removed the soiled bed pad, straightened the top sheet, and comforter, while holding bed pad in left hand. Resident 14's call light placed on top of comforter. CNA #3 was still wearing gloves from the start of the brief change. No hand hygiene or glove change was done during peri-care or the brief change. The call light was not sanitized prior to placing it on the bedside table or on Resident's bed. During an interview, on 05/13/2024 at 01:47 PM, CNA # 4 stated the window shade should have been closed before brief was removed to provide privacy. During an interview on 05/13/2024 at 02:07 PM, CNA # 3 stated privacy should have been provided prior to care of Resident #14, and gloves should be changed, and hands sanitized during brief changes, I just forgot to bring in extra gloves. A review of an Admission Record, indicated the facility admitted Resident #52 with diagnoses that included Ataxic Cerebral Palsy, hypertension, iron deficiency anemia, Poly osteoarthritis, and urinary incontinence. The quarterly MDS, with an ARD of 04/16/2024, revealed Resident #52 had a BIMS score of 2 which indicated the Resident had severe cognitive impairment. Resident is dependent on staff for toileting hygiene, personal hygiene, upper and lower body dressing, sitting to lying and lying to sitting, and rolling from left to right. A review of Resident #52's Care Plan, revised 04/17/2024, revealed the resident was dependent on staff for toileting hygiene. Interventions included 1 or more staff members to complete the activity. During observation on 05/13/2024 at 01:52 PM, CNA #3 and CNA #9 brought Resident #52 into room and provided privacy. No hand hygiene was performed. Both aides donned gloves. Resident #52 was placed in bed by using a lift. CNA #3 explained the process to the Resident. Resident lowered into bed, Resident's head was positioned against headboard causing chin to be at chest, shoulders on pillow. CNA #9 left room. No hand hygiene done. CNA #3 placed two clear trash bags at the foot of bed, rolled resident onto left side, providing explanation of removing sling. CNA #3 removed Resident's pants and placed them into the clear trash bag near wall. CNA then unfastened brief and lowered front of brief exposing the Resident's abdomen, private area, and lower body. One wipe used to wipe the private part, in circular motion, one time. Wipe placed in clear trash bag, closest to the edge of bed, away from wall. One wipe used to wipe in a downward motion on left groin. Wipe placed in the clear trash bag. One wipe used in a downward motion on right groin. Disposed of in clear trash bag. Resident rolled onto right side; sling removed. One wipe is used in an upward motion to gluteal cleft which then becomes soiled. CAN #3 used 2 wipes to clean soiled area from gloves. Five more wipes used to clean gluteal cleft, 1 swipe each. One wipe used to clean left and right buttock, swipe up on right across back and down on left. CNA #3 placed a clean brief under Resident and Resident rolled to left side to allow brief to be positioned under Resident. Resident rolled onto back and brief fastened. CNA #3 removed glove from left hand, placed package of wipes in drawer of bedside table. No hand hygiene observed. CNA covered Resident with a blanket, while holding clear trash bags in, still gloved, right hand. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/13/2024 at 02:03 PM, CNA #3 re-positioned Resident #52 to comfort, raising head of bed, clipping call light to blanket in reach of Resident, placed the bed in low position. No hand hygiene performed during brief change and no glove change performed. Trash and soiled pants taken to hallway and placed in appropriate bins. On 05/13/2024 at 02:04 PM, CNA #3 returned to Resident #52's room and held a water cup and straw providing resident a drink. No hand hygiene performed prior to re-entering Resident's room or after exiting resident room. In an interview on 05/13/2024 at 02:07 PM, CNA #3 stated gloves should be changed and hands sanitized during brief changes, I just forgot to bring in extra gloves. Hands should be sanitized before providing a beverage and after, I just didn't think about it. On 05/14/2024 at 10:07 AM, Housekeeping #1 was observed entering room [ROOM NUMBER], delivering a blue and gray colored folded blanket. No hand hygiene was done while going into room [ROOM NUMBER]. Housekeeping #1 knocked on the room door and announced entry. Housekeeping #1 delivered blanket and stood in doorway of room speaking with residents. Housekeeping #1 exited room and did not perform hand hygiene. During an interview with Housekeeping #1, stated they were never told to sanitize going into rooms only coming out. Housekeeping #1 stated their hands were sanitized, and there is no sanitizer on the laundry cart as they cannot keep them on the cart, only a small bottle in their pocket if they want. Housekeeping #1 stated they did not have a small bottle of sanitizer. On 05/14/2024 at 10:16 AM, observation of the wall sanitizer dispenser, hanging on the wall in room [ROOM NUMBER], to the left of the television, was checked and contained sanitizer. Review of the facility document titled, All Staff Inservice Education Report, dated 05/01/2024, with a topic Importance of Good Hand Hygiene specified, . 1. When properly washing hands the correct way it helps to reduce and prevent the spread of germs 2. Hand washing helps protects . the resident . from getting sick . 4. One should wash hands before/after the use of gloves, .before and after peri-care of resident . Signature page did not contain Housekeeping #1's signature. Review of the facility document titled, All Staff Inservice Education Report, dated 05/01/2024, with a topic Use of Hand Sanitizer instructed, 1.can be used when soap and water is not available. 2. Sanitizers can quickly reduce the number of germs on hands . The signature page did not contain Housekeeping #1's signature. In an interview on 05/14/2024 at 09:35 AM, the Director of Nursing (DON) indicated staff should be changing gloves when going from dirty to clean, when gloves become visibly soiled, and performing hand hygiene with glove change to avoid cross contamination. On 05/15/2024 at 09:45 AM, the Administrator stated there was not a different hand hygiene policy for laundry, and there was not a policy for clean laundry handling. In an interview on 05/15/2024 at 10:15 AM, CNA #5 stated gloves should be changed during care if they are soiled or if doing peri care and always sanitize. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/16/2024 at 02:55 PM, the Administrator indicated gloves should be changed during peri care per policy. On 05/13/2024 at 02:39 PM, interview with the Infection Preventionist (IP); Isolation confirmed that residents with COVID should remain in their room with the door closed if they test positive for COVID. On 05/14/24 at 08:30 AM, while walking down 300 Hall the Surveyor observed the doors to room [ROOM NUMBER] and 305 open with droplet precaution signs, and personal protective equipment (PPE) sitting outside of the rooms. room [ROOM NUMBER] had appropriate droplet signs and the door was closed. Residents were observed sitting at the bedside in wheelchairs without masks. On 05/14/24 at 02:01 PM, The Surveyor observed the doors to room [ROOM NUMBER] and 305 open with droplet precaution signs, and PPE sitting outside the rooms. On 05/14/2024 at 03:18 PM, the Surveyor was standing at the nurses' station and observed Resident #28, who was on droplet precautions walking down the hall with a rolling walker and no mask in place. As Resident #28 walked past a room, Resident #18 who was also on droplet precautions was observed without a mask coming out of the room and spinning around 3 times in a specialty chair and going back to the room. The Surveyor walked down hall and observed the door to Resident #18's room was open with resident sitting near the bedside table. Resident #54, who was also on droplet precautions, was resting with eyes closed with the door open. The Surveyor observed Registered Nurse (RN) #2 walking to the open door of Resident #28's room and shut the door and removed an isolation gown from the PPE hanging on the outer door. The Surveyor asked RN #2 if the doors to isolation rooms are supposed to be left open, and why. RN #2 told the Surveyor the rooms should be closed because the residents have COVID. The Surveyor asked RN #2 to explain their isolation process for the hall. RN #2 confirmed that the doors to the room of residents with COVID should remain closed because COVID is an airborne disease, and it puts others at risk. On 05/14/2024 at 10:58 AM, Nurses note documented, . (Resident #28) Continues on isolation r/t to COVID+ diagnosis . On 05/15/2024 at 00:50 AM, Nurses note documented, . (Resident #18) Remains on droplet isolation precautions for COVID-19 . On 05/15/2024 at 01:16 AM, Hot Rack Charting note documented, . (Resident #54) Remains on droplet isolation precautions for COVID-19 . On 05/13/24 at 2:28 PM, Surveyor observed the Maintenance Man pushing a cart down the 600 hall, he was wearing a blue mask over his nose and mouth. He stopped at the end of the hall and pushed open the door of room [ROOM NUMBER] which had signage on the door to wear personal protect equipment Personal Protection Equipment (PPE) due to droplet precautions. Surveyor asked the Maintenance Man if he knew he was supposed to wear PPE into the room? The Maintenance Man stated: I don't know what she has, I was just taking her about her Mother's Day present. On 05/15/24 at 10:25 PM, the DON indicated they do not have a mask policy, they can ask staff to wear them, but they cannot make them wear them. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Infection Prevention and Control policy submitted by the Administrator on 05/15/24 at 4:00 PM indicates, . The nursing facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .All persons shall adhere to the infection prevention and control program by referencing said resources. COVID-19 Guidance policy submitted by Administrator on 05/15/24 at 4:00 PM indicates, .Staff will be alert to signs of COVID-19.