STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045422	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lakes at Maumelle Health and Rehabilitation	103 Alexandria Drive Maumelle, AR 72113

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48977 Based on the observations, interviews, and facility policy review the facility failed to ensure 1 sampled (Resident #20) did not self-administer medication prior to an assessment conducted by the interdisciplinary team to determined it clinically appropriate and safe for the Resident to do so. The findings include: Resident #20 had a diagnosis of dysphagia, acute kidney failure, and chronic pulmonary edema. Resident #20 had an order for sore throat oral liquid (Acetaminophen) give 1 spray by mouth every 2 hours as needed for pain - moderate related to COVID-19 throat pain. Quarterly Minimum Data Set with an Assessment Reference Date of 04/09/24 that documented that Resident #20 was unable to complete the Brief Interview of Mental Status and had long term memory problems. A Care Plan for Resident #20 did not document that Resident self-administers medications. On 06/03/24 at 8:45 AM, the Surveyor noted sore throat spray was on Resident #20 ' s bedside table. On 06/03/24 at 8:56 AM, the Surveyor asked the Director of Nursing (DON) are there any residents in the facility that self-administers medications? The DON voiced that the facility did not have any residents in the facility that self-administers medications. On 06/03/24 8:75 AM, the Surveyor asked the DON should there be medications on the Resident's bed side table? The DON voiced that there should not be medication on the bedside table. 06/05/24 at 9:34 AM, the Surveyor asked the DON what could be a potential negative outcome from the Resident self-administering medications unknowingly? The DON voiced the Resident could overdose, the medication could interfere with other medication the Resident is prescribed, or another Resident could get the medication. On 06/05/24 at 10:32 AM, the Surveyor was provided a policy titled Self-Administration of Medications that documented Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so.

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

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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. 48977 Based on observations, interviews, and facility policy reviews the facility failed to protect the Patient Health Information (PHI) of 1 (Resident #2) sampled resident. This failed practice had the potential to affect all residents residing in the facility. The findings include: 1. On 06/03/2024 at 7:38 AM, the Surveyor observed Licensed Practical Nurse (LPN) #8 walk to the dining leaving the computer screen on the laptop mounted to a medication cart unlocked displaying Resident #2's personal and medical information. The following was observed: a. Facility name b. Resident's name c. Status d. Location e. Gender f. Date of birth g. Age h. Physician i. Allergies j. Code status k. Ordered medications 2. On 06/03/2024 at 7:40 AM, the Director of Nursing (DON) observed the Surveyor standing at the medication cart taking notes and pictures and instructed LPN #8 to leave the facility. The Surveyor was unable to conduct an interview with LPN #8 due to LPN #8 no longer being in the building. 3. On 06/05/2024 at 9:34 AM, the Director of Nursing (DON) confirmed the computer screen should be locked or closed to protect Resident #2's privacy. The DON voiced that it was a Health Insurance Portability and Accountability Act (HIPAA) issue if the computer screen was unattended and unlocked with a resident's personal and medical information displayed. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. On 06/05/2024 at 10:32 AM, the Surveyor was provided with a policy titled Protected Health Information (PHI), Management and Protection of that documented It is the responsibility of all personnel who have access to the resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 38200 Based on record review and interview, the facility failed to complete an accurate Minimum Data Set (MDS) for 01 (Resident #40) of 1 sample mix residents. The findings are: Resident #40's Quarterly MDS with an Assessment Reference Date (ARD) of 02/29/2024 documented the Resident as taking an anticoagulant, however there is no physician order on the order recap report dating back to 02/28/2024 noting the resident taking an anticoagulant. On 06/04/24 at 10:23 AM, the Surveyor interviewed the MDS Coordinator and asked, Does resident #40's MDS with an ARD of 02/29/2024 indicate the Resident is taking an anticoagulant? MDS Coordinator stated, It's saying yes. When asked, Can you tell me when resident #40 was ordered an anticoagulant? She stated, On [Resident #40] current orders it doesn't say [Resident #40] takes one let me look on [Resident #40's] other. I'm not seeing where [Resident #40] had an anticoagulant. When asked, Is Resident #40's MDS coded correctly? She stated, No ma'am it's not and we will be doing a modification on that.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 38200 48977 Based on record review and interview, the facility failed to ensure the comprehensive care plan was individualized to addressed appropriate care and services for use of fall mats for 2 (Resident #26, and #43) of 2 sampled residents. The findings are: 1. Resident #26 had a diagnosis of fall from slipping, tripping, and stumbling with subsequent striking against other objects and displaced intertrochanteric fracture of right femur. a. Annual Minimum Data Set with the Assessment Reference Date of 04/17/24 that documented that Resident #26 scored 04 (0-7 indication severe cognitive impairment) on the Brief Interview of Mental Status and b. A Care Plan for Resident #26, revision date 03/25/22, documented that Resident #26 was at risk for falls related to (r/t) poor balance, weakness, Cerebrovascular accident (CVA), Hypertension (HTN), Diabetes Mellitus (DM), and Seizures. The Care Plan for Resident #26 did not note that a fall mat was put into place as an intervention. c. On 06/02/24 at 10:34 AM, the Surveyor observed Resident #26 lying in bed and the fall mat was placed under the bed. On 06/02/24 at 1:35 PM, the Surveyor observed Resident #26 lying in bed and the fall mat was placed under the bed. On 06/03/24 at 9:00 AM, the Surveyor observed Resident #26 lying in bed fall mat was next to bed. The Surveyor observed that the fall mat was slanted causing a gap between the fall mat and the head of the bed. On 06/03/24 at 3:20 PM, the Surveyor observed Resident #26 lying at the edge of the bed fall mat next to bed. The Surveyor observed that the fall mat was slanted causing a gap between the fall mat and the head of the bed. d. On 06/03/24 at 3:34 PM, the Surveyor asked the LPN #9 is the fall mat noted on Resident #26 Care Plan? LPN #9 voiced after reviewing the care plan it is not documented on Resident #26 Care Plan, but the fall mat was in place as an intervention for risk. e. On 06/05/24 at 9:34 AM, The Surveyor asked the Director of Nursing (DON) should an intervention that was place for fall prevention such as a fall mat be noted on the Resident's Care Plan? DON voiced that it should be documented on the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 06/02/24 at 2:52 PM, the Surveyor observed Resident #43 lying in bed, with the over the bed table sitting on fall mat that has tears and edges peeling up. The surveyor interviewed Certified Nurse Aide (CNA) #6 and asked, Describe Resident ' s fall mat? She stated, Its ripped and sides are coming up. When asked, Is the fall mat in proper working order? She stated, No, it makes it more of a fall risk. a. On 06/02/24 at 3:05 PM, the Surveyor interviewed the DON and asked, Can you describe Resident ' s fall mat for me? She stated, Its torn and the edges are coming up. When asked, Is the fall mat in proper working order? She stated, Nope. It increases the fall risk. b. On 06/03/24 at 9:54 AM, the Surveyor observed the same fall mat on Resident #43's floor as on 06/01/2024 that was discussed with the CNA and DON. c. On 06/03/24 at 12:21 PM, Resident #43 has a diagnosis of Metabolic Encephalopathy, and Overactive Bladder. d. Progress note dated 04/12/2024 at 12:59 noted Nursing (Nsg) Incident and Accident (I&A) Incident Description: Was found on the floor of bedroom. was lying on left side. Aide found resident on the floor. Pick up and put back in bed. Immediate Intervention: Check head to make sure resident didn't hit it. complained of pain in the left arm and left hip. looked and no bruising on the hip. But was discoloration on the left forearm. e. Progress note dated 4/16/2024 at 3:01 noted Nsg-Hot Rack Charting: Neuro checks completed. No delayed injury noted. Resident in bed resting with no c/o. No distress or discomfort noted. Call light (C/L) and water (H20) in reach and bed in low position. f. Care plan with a date of 04/16/2024 revealed The resident has had an actual fall with minor injury 04/12/24- unwitnessed fall 04/12/24- Unwitnessed fall with minor injury- bed maintenance repair. Continue interventions on the at-risk plan . g. 06/03/24 03:30 PM A review Resident #43's care plan does not document fall mat in room. h. On 06/04/24 at 10:19 AM, the Surveyor interviewed the Minimum Data Set (MDS) Coordinator and asked, Is Resident #43 care planned for a fall mat? She stated, Not on this care plan. Last fall on [Resident #43] was 4/12 and it's a bed maintenance repair. When asked, If a resident has a fall mat on their floor due to fall should the fall mat be listed on their care plan as an intervention? The MDS Coordinator stated, Yes, ma'am. When asked, Why? The MDS Coordinator stated, So that the staff know to put it in place for a safety measure. The facility provided a policy titled,Care Plans, Comprehensive Person-Centered with a revision date of December 2016 that documented, Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.

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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. 38200 48977 Based on observation, record review, and interview the facility failed to ensure residents that require fall mats at the bedside have them placed in a manor to prevent injury in event of a fall for 1 (Resident #26) of 1 sample mix residents; to ensure fall mats at the bedside were properly maintained for 1 (Resident #43) of 1 sample mix residents; to ensure housekeeping carts and janitors closet was kept secure. The findings are: On 06/02/24 at 2:52 PM, the Surveyor observed Resident #43 lying in bed, lunch tray with 25% eaten on over the bed table sitting on fall mat that has tears and edges are peeling up. Progress note dated 04/12/2024 noted Nursing Incident and Accident Report showed the following: Description: Was found on the floor of bedroom lying on left side. Aide found resident on the floor. Immediate Intervention: Check head to make sure resident didn't hit it. Complained of pain in the left arm and left hip, no bruising on the hip, but was discoloration on the left forearm. Progress note dated 4/16/2024 at 03:01 noted Nursing-Hot Rack Charting: Neuro checks completed. No delayed injury noted. No distress or discomfort noted. Care plan with a date of 04/16/2024 revealed Resident #43 has had an actual fall with minor injury 04/12/24 that was unwitnessed. Interventions were bed maintenance repair, continue interventions on the at-risk plan . On 06/02/224 at 2:52 PM, the Surveyor interviewed Certified Nurse Aide (CNA) #06 and asked, Describe Resident #6's fall mat? She stated, Its ripped and sides are coming up. When asked, Is the fall mat in proper working order? She stated, No, it makes it more of a fall risk. On 06/02/24 at 3:05 PM, the Surveyor interviewed the Director of Nursing (DON) and asked, Can you describe the fall mat? She stated, Its torn and the edges are coming up. When asked, Is the fall mat in proper working order? She stated, Nope. It increases the fall risk. On 06/03/24 at 9:54 AM, the Surveyor observed same fall mat on Resident #43's floor as on 06/01/2024 that was discussed with the CNA and DON. On 06/03/24 at 02:42 PM, the Surveyor interviewed the DON and asked, When should Resident #43's fall mat been replaced? She stated, When we found it. When asked, Why should it have been replaced when you found it? She stated, Because of safety. Resident #26 had a diagnosis of fall on same level from slipping, tripping, and stumbling with subsequent striking against other objects and displaced intertrochanteric fracture of right femur. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Annual Minimum Data Set with the Assessment Reference Date of 04/17/24 that documented that Resident #26 scored 04 (0-7 indication severe cognitive impairment) on the Brief Interview of Mental Status. A Care Plan for Resident #26, revision date 03/25/22, documented that Resident #26 was at risk for falls related to (r/t) poor balance, weakness, Cerebrovascular accident (CVA), Hypertension (HTN), Diabetes Mellitus (DM), and Seizures. On 06/02/24 at 10:34 AM, the Surveyor observed Resident #26 lying in bed the fall mat was placed under the bed. On 06/02/24 at 1:35 PM, the Surveyor observed Resident #26 lying in bed and the fall mat was placed under the bed. On 06/03/24 at 9:00 AM, the Surveyor observed Resident #26 lying in bed fall mat was next to bed. The Surveyor observed that the fall mat was slanted causing a gap between the fall mat and the head of the bed. On 06/03/24 at 3:20 PM, the Surveyor observed Resident #26 lying at the edge of the bed fall mat was partially next to bed. The Surveyor observed the fall mat slanted causing a gap between the fall mat and the head of the bed. On 06/03/24 at 3:25 PM, the Surveyor asked CNA #2 was the fall mat in place as an intervention for falls? CNA #2 voiced the fat was an intervention for falls. The Surveyor asked CNA #2 was it placed in the correct manner? CNA #2 stated no. On 06/03/24 at 3:32 PM, the Surveyor asked Licensed Practical Nurse (LPN) #9 was the fall mat an intervention used to protect Resident #26 in an event of a fall. LPN #9 voiced that Resident #26 had several falls after admission and the fall mat was put in place as an intervention. LPN #9 voiced that the fall mat would not be effective under the bed or partially away from the bed. On 06/05/24 at 9:34 AM, the Surveyor asked the DON what is the proper way to place a fall mat? the DON voiced the fall mat should be parallel to the Resident's bed. The Surveyor asked the DON if the fall mat is not properly place what could be a potential negative outcome? The DON verbalized that the fall mat would not catch the Resident and it was useless. On 06/02/24 at 10:41 AM, the Surveyor observed a door to a closet titled Janitor, with a lock pad on the exterior of the door, unlocked. The Surveyor opened the door and observed several cleaning chemicals stored in the closet. On 06/02/24 at 10:58 AM, the Surveyor observed a housekeeping cart unattended in the hallway with the door slightly ajar. The Surveyor opened the door on the housekeeping cart and noted chemicals stored inside. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. cart in the hallway of 200 hall labeled 200 & 400 hall? Housekeeping staff #10 voiced that it was her cart. The Surveyor asked Housekeeping Staff #10 was it locked? Housekeeping Staff #10 voiced the lock is broken on the cart therefore it cannot be locked. The Surveyor asked Housekeeping Staff #10 how long had the lock been broken? The Housekeeping Staff #10 voiced the lock had been broken about a month. The Surveyor asked Housekeeping Staff #10 what could be a negative outcome of the chemicals being unlocked and unattended? Housekeeping Staff #10 voiced a resident could get into the chemicals. On 06/05/24 at 9:30 AM, the Surveyor asked the Housekeeping Supervisor what intervention did you put into place after you became aware that the lock was broken on the housekeeping cart? The Housekeeping Supervisor voiced that he educated staff on putting the cart up when not in use but was unable to provide documentation of any in-services on that matter.

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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. 48977 Based on observations, interviews, and facility policy reviews the facility failed to store drugs and biologicals in accordance with professional principles and the facility's policy. This failed practice had the potential to affect every Resident residing in the building. The findings include: 1. On 06/03/24 at 7:38 AM, the Surveyor observed the Licensed Practical Nurse (LPN) #8 walk to the dining room, with a medication cup in hand, leaving the medication cart unlocked. a. On 06/03/24 8:31 AM, the Surveyor observed an unattended unlocked medication cart in the hallway up against the wall not in front of a doorway. The Surveyor could hear talking in the room across the hall encouraging a Resident to take medication. The Surveyor walked up the hall father to see in the room and observed LPN #9 at the head of bed with her back to the door. b. On 06/03/24 at 8:35 AM, LPN #9 confirmed she was the nurse who left the medication cart unlocked and the medication cart was not viewable from position in the room. c. On 06/05/24 at 9:34 AM, the Director of Nursing (DON) voiced the cart should be unlocked when unattended because anyone can get anything. d. On 06/05/24 at 10:32 AM, a policy was provided titled Storage of medications that documented 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to other.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38200 49981 50580 Based on observation, interview, and record review, it was determined that the facility failed to provide palatable food to Residents. The findings are: Resident #4 has a medical diagnosis of: Encephalopathy, muscle wasting & atrophy, pulmonary edema, anxiety disorder, restlessness, Type II Diabetes with Hyperglycemia, Parkinsonism, and edema. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date [ARD] of 4/12/2024 shows Resident to have a score of 15 on the Brief Interview for Mental Status (BIMS), cognitive assessment summary. On 6/03/24 at 9:00 AM, Surveyor asked Resident #4 if pleased with the food received at this facility. Resident told surveyor that the food doesn't taste very good most of the time. On 6/03/2024 at 1:02 PM, the surveyor checked the Resident's meal card and there was an order for sweet and low. The Resident told the surveyor there was none on the tray. The surveyor observed there to be no sweet and low on resident's meal tray to go in resident's beverage. On 6/04/2024 at 8:57 AM, the surveyor observed the Resident's breakfast meal being set up for resident in the room. The tray consisted of sausage, scrambled eggs, waffles, and cream of wheat. Resident had sweet and low (which is ordered) on tray. There was no butter for the waffles or cream of wheat. Surveyor asked Director of Nursing (DON) for butter for the waffles and hot cereal. On 6/04/2024 at 1:42 PM, the surveyor asked Dietary Manager (DM) who is responsible for getting meal trays ready that go to the hallway. DM stated the Dietary Aides. Surveyor asked DM if hall trays get the usual condiments with their meals. DM stated, absolutely. Surveyor informed DM that on two separate occasions, resident received a tray without the ordered sweet and low artificial sweetener and butter for breakfast that included waffles and cream of wheat. Based on record review, Resident #4's last dietary assessment was on 7/05/2022. On 06/02/24 at 11:51 AM, the surveyor interviewed Resident #41 and the resident stated Food is not too good. Served black beans 3 days in a row. Family brings in food or I wound starve to death. On 06/02/24 at 11:57 AM, the Surveyor interviewed Resident #6 who confirmed meals are not palatable or seasoned. Review of Resident #6's Order Summary Report revealed the resident is ordered a regular diet, regular texture, regular consistency. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #6's Care Plan dated 11/19/2021 revealed the resident feeds self with tray set up. Review of Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/10/2024 did not reveal any swallowing disorder but did reveal the resident is edentulous. 06/02/24 1:35 PM, the Surveyor received test tray from the facility kitchen. The meal consisted of pork roast, mashed potatoes with gravy, green beans, dinner roll and vanilla ice cream. Ice cream was melted, pork was slightly over cooked, dry, and chewy, green beans and mashed potatoes were bland with no seasoning. On 06/05/24 at 10:17 AM, the Surveyor interviewed the Dietary Manager and asked, Should resident ' s meals be palatable? He stated, Yes. When asked, Why should meals be palatable? He stated, Because no one wants to eat anything not palatable. We want it to taste good. When asked, Should meat be overcooked, dry and chewy? He stated, No. It doesn't taste good. When it's chewy the older residents can't eat it and you cook out too much of the nutrients.

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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. 49981 Based on observation, record review, and interview it was determined that the facility failed to ensure dishes were properly sanitized. The findings are: 1. On 6/03/2024 at 11:06 AM the surveyor asked Dietary Consultant if she could check the temperature of the dishwasher. The dishwasher was currently in a rinse cycle. Dietary Consultant placed the thermometer in bowl of hot water inside dishwasher. The temperature reached 130. Dietary Consultant then ran the rinse cycle a little longer and then rechecked the water. The thermometer then reached the temperature of 140. The Dietary Manager stated, sometimes the dishwasher may need to run a few cycles before the temperature climbs. The surveyor then showed the Dietary Consultant the binders where temperatures should be documented. The book had not yet been documented for the month of June. The Dietary Consultant stated that the kitchen staff most likely have the temperatures written down on paper that had not yet been added to the binder. a. On 6/04/2024 at 7:47 AM, Surveyor spoke with Dietary Manager (DM) regarding temperatures from the day before not reaching 180 during rinse cycle. The surveyor asked DM to run a rinse cycle so it could be checked. DM tried 8 times, in various places to get the temperature of rinse water. The highest temperature recorded is 150 degrees. DM stated that there is a feature on the dishwasher that can be initiated when temperatures aren't high enough so a chemical can be added. DM stated that he would do that until somebody could check the dishwasher. b. On 6/04/24 at 1:48 PM Surveyor went back into kitchen to have DM check a chemical test strip from the dishwasher. DM informed surveyor that he purchased a new thermometer and had checked the temperature of the dishwasher, and it was rinsing hot enough. DM placed the thermometer on tray and ran through dishwasher. Thermometer showed a temperature of 182.3. c. On 6/05/2024 at 8:30 AM, the Dietary Manager provided the training materials that kitchen staff are in-service on titled Employee Food Safety: Maintaining and Cleaning Equipment. d. On 6/05/2024 at 8:55 AM, the Administrator provided in-services for dietary and kitchen staff regarding sanitation and hazards.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045422	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lakes at Maumelle Health and Rehabilitation	103 Alexandria Drive Maumelle, AR 72113

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50580 Based on observation, record review, interview, and facility policy review it was determined the facility failed to ensure staff washed/cleaned hands after changing gloves during incontinent and wound care for 1 (Resident #32) of 1 sampled resident reviewed for pressure ulcers; to ensure wound care supplies were cleaned or replaced when contaminated to reduce the risk infection for Resident # 32. The findings are: 1. Resident # 32 with diagnoses of: Complete traumatic amputation at level between right hip and knee, gastrointestinal hemorrhage, pulmonary embolism, esophagitis, muscle wasting, pressure ulcer of sacral region, stage 2, pressure ulcer, unspecified site stage 2, schizophrenia. a. A physicians order dated 6/3/24 documented, . Order Summary: Treatment: Pressure Ulcer to Right superior dorsal thigh area, (W #3). Clean with wound cleanser, pat dry, apply Silvadene, cover with foam dressing. Change daily and as needed every day shift for Wound care. skin integrity. Replace dressing and notify Treatment nurse. and as needed for Ineffective or soiled dressing. Change and notify treatment nurse. Physicians order dated 6/3/24- documented .Treatment left posterior trochanter area for skin integrity and protection. Change M, W, F [Monday, Wednesday, Friday] and as needed. Cleanse with wound cleaner, pat dry and apply Foam dressing Treatment: Stage 2 Pressure Ulcer to coccyx area (W #1). Clean with wound cleanser, pat dry, apply Silvadene cream, cover with foam dressing. Change daily and as needed b. Care Plan Entry Date Initiated: 05/30/2024 showed, Focus . The resident has multiple pressure ulcers to dorsal buttocks and thigh region along with areas of fragile skin related to pressure and compromised skin integrity. Goal .The residents will Pressure ulcer will show signs of healing and remain free from infection by/through review date. Date Initiated: 06/03/2024 Created byLicensed Practical Nurse, (LPN) Target Date: 08/28/2024 The resident will have intact skin, free of redness, blisters, or comorbidities. Interventions . Monitor dressing (specify frequency) to ensure it is intact and adhering. Report lose dressing to Treatment nurse. c. On 06/3/2024 at 11:08 AM, during wound care/pressure ulcer care the surveyor observed Licensed Practical Nurse (LPN) #1 perform care to Resident #32. The surveyor observed enhanced precautions signs and Personal Protection Equipment (PPE) cart outside Resident #32 ' s door. d. On 6/3/2024 at 11:08 AM LPN #1 prepared wound care supplies. Applied gloves without washing hands and placed a red bag on top of 4x4's. Resident is on enhanced barrier precautions. LPN#1 donned gown, donned gloves, and did not wash/cleanse hands prior to donning PPE equipment. Entered Resident ' s room changed resident brief, did not remove gloves, touched dresser drawer, bathroom door, exited Resident ' s room searching for new brief without removing gloves or cleansing hands. e. On 06/03/2024 at 11:12 AM, LPN # 1 returned to Resident ' s room with new brief. Put on clean gloves without cleansing hands, removed old dressing from right thigh pressure ulcer, removed gloves, donned new gloves, cleaned wound with cleanser, applied a gel to hip to right wound, removed gloves, donned clean gloves, and applied foam dressing to wound on right hip. Removed gloves and disposed of them in red bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. On 06/03/24 at 11:20 AM, LPN #1, donned clean gloves removed and dressing from coccyx area. Changed gloves, scratched head, picked up a 4x4 to clean coccyx area with wound cleanser applied, applied gel to coccyx wound, changed gloves, applied foam dressing to coccyx. g. On 06/03/24 at 11:30 AM, LPN #1 changed gloves, removed dressing from left hip, applied new foam dressing to wound. LPN #1 went to Resident ' s dresser removed shorts and placed them on the Resident, then removed gloves and exited room. h. On 6/3/2024 at 11:33 AM, Surveyor conducted an interview with LPN # 1, the surveyor stated you scratched your head and touched your scrubs while providing wound care, what did you potentially do? LPN #1 stated, cross contaminated. The surveyor asked: You changed your gloves 12 times, what should you have done between each glove change? LPN #1 stated, Washed my hands or used hand sanitizer. The Surveyor asked LPN #1, You opened the red bag, placed on tray on top of 4x4's on dressing change tray, what did you potentially do? LPN #1 stated, cross contamination. The surveyor asked LPN #1 After removing Resident's soiled brief you went Resident ' s dresser and bathroom with gloves on, what did you potentially do?' LPN #1 stated, cross contamination. Surveyor asked LPN #, The foam dressing in package laid it on top of your cart, opened it, labeled dressing, then placed package on top of 4x4 gauze pads, what potentially did you do? LPN #1 stated, cross contamination. i. The facility provided a policy titled Infection Control Guidelines for All Nursing Procedures that documented Purpose: To provide guidelines for general infection control while caring for resident. General Guidelines 3. Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or nonantimicrobial soap and water under the following conditions: a. Before and after direct contact with residents; .d. After removing gloves . e. After handling items potentially contaminated with blood, body fluids or secretions .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 49981 Based on observation and interview, it was determined that the facility failed to ensure kitchen equipment was in safe, working condition. The findings are: 1. On 6/02/24 at 11:07 AM, the surveyor entered the facility kitchen. Upon entry, the surveyor found water in a puddle between the dishwasher and sinks. 2. On 6/04/24 at 7:42 AM, the surveyor entered the kitchen to find a large puddle of water in the floor between the steam table and refrigerators. The surveyor showed Director of Nurse's (DON) and Dietary Manager (DM) the dishwasher had water coming from it and going all over the floor and running down the table beside the dishwasher. a. On 6/04/2024 at 7:50 AM, the surveyor asked DM how long dishwasher had been leaking water on the floor. DM said he did not know but not for that long. b. On 6/04/2024 at 7:51 AM, the surveyor asked DM if he had reported the dishwasher to anybody. DM said he had not, but he would let somebody know. c. On 6/04/2024 at 7:52 AM, the surveyor noticed a long strip of white trim that runs between the dishwasher and the wall with a black substance. The surveyor asked DM what the black colored substance was on a strip of wood between the stainless-steel table and the wall. DM said he wasn't sure if it was mildew or mold. d. On 6/05/2024 at 8:30 AM, the Dietary Manager provided the training materials that kitchen staff are in-serviced on titled Employee Food Safety: Maintaining and Cleaning Equipment. e. On 6/05/2024 at 8:55 AM, the Administrator provided in-services for dietary and kitchen staff regarding sanitation and hazards.