STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055407	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cupertino Healthcare & Wellness Center	22590 Voss Avenue Cupertino, CA 95014

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 40141 Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 3 (Residents #50, #65, and #159) of 33 sampled residents. Findings included: 1. An Admission Record revealed the facility admitted Resident #50 on 07/30/2016. According to the Admission Record, the resident had a medical history that included diagnoses of paranoid schizophrenia, schizoaffective disorder, and major depressive disorder. An annual MDS, with an Assessment Reference Date (ARD) of 08/23/2023, revealed Resident #50 was not considered by the state level II preadmission screening and resident review process to have a serious mental illness and/or intellectual disability or a related condition. A letter from the State of California-Health and Human Services Agency Department of Health Care Services, dated 09/23/2022, revealed a level II evaluation was conducted on 08/12/2022 and specialized services were recommended. 2. An Admission Record revealed the facility readmitted Resident #65 on 08/29/2023. According to the Admission Record, the resident had a medical history that included diagnoses of major depressive disorder and adjustment disorder with mixed anxiety and depressed mood. An annual MDS, with an Assessment Reference Date (ARD) of 04/17/2024, revealed Resident #65 was not considered by the state level II preadmission screening and resident review process to have a serious mental illness and/or intellectual disability or a related condition. A letter from the State of California-Health and Human Services Agency Department of Health Care Services, dated 05/09/2023, revealed a level II evaluation was conducted on 05/08/2023 and specialized services were recommended. During an interview on 05/31/2024 at 10:53 AM, the MDS Nurse stated Resident #50's MDS with an ARD of 08/23/2023 and Resident #65's MDS with an ARD of 04/17/2024 were inaccurate as both should have indicated the residents were considered to have a serious mental illness or related condition. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/31/2024 at 1:28 PM, the Administrator stated Resident #50 and Resident #65's MDS assessments were not accurate. The Administrator stated he expected staff to follow policy and procedure. During an interview on 05/31/2024 at 1:41 PM, the Director of Nursing stated Resident #50 and Resident #65's MDS assessments were inaccurate. 46194 3. An Admission Record revealed the facility admitted Resident #159 on 02/17/2024. According to the Admission Record, the resident had a medical history that included diagnoses of history of Parkinson's disease without dyskinesia and type two diabetes. The Admission Record revealed the reside discharged to a private home/apartment with home health services on 03/12/2024. A discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/12/2024, revealed Resident #159 discharged to an short-term general hospital on 03/12/2024. Resident #159's Discharge Planning Review, dated 04/07/2024, revealed the resident discharged home. During an interview on 05/31/2024 at 11:30 AM, the MDS Nurse reviewed Resident #159's discharge MDS and stated the MDS indicated the resident was discharged to the hospital. The MDS Nurse stated the discharge MDS was not correct as the resident discharged home. During an interview on 05/31/2024 at 11:41 AM, the Director of Nursing (DON) stated the MDS should be coded correctly according to the discharge order. The DON reviewed the discharge MDS and stated it was coded the resident discharged to the hospital. The DON stated the discharge MDS was inaccurate as the resident discharged home. During an interview on 05/31/2024 at 12:04 PM, the Administrator stated coding the discharge MDS was important for tracking the resident for emergencies. The Administrator stated the discharge MDS should have been coded correctly.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46258 Based on observation, interview, record review, facility policy review, the facility failed to develop a care plan to address the yelling behavior for 1 (Resident #17) of 1 sampled resident reviewed for behavior emotional. Findings included: A facility policy titled, Comprehensive Person-Centered Care Planning, revised in 11/2028, specified, Purpose To ensure that a comprehensive person centered care plan is developed for each resident. The policy revealed, Additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident. An Admission Record revealed the facility admitted Resident #17 on 12/20/2023. According to the Admission Record, the resident had a medical history that included diagnoses of mild cognitive impairment, schizophrenia, and major depressive disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/28/2024, revealed Resident #17 had a Staff Assessment for Mental Status, which indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS indicated the resident had no behaviors. Resident #17's comprehensive care plan, with an admitted [DATE], revealed no evidence to indicate the resident had a care plan to address their behaviors of yelling. During an observation on 05/27/2024 between 10:38 AM and 11:49 AM, Resident #17 was heard yelling intermittently. On 05/27/2024 at 2:44 PM, Resident #17 was heard yelling. On 05/29/2024 at 10:02 AM, Resident #17 was heard yelling unintelligible words. On 05/29/2024 at 1:43 PM, Resident #17 was heard yelling. During an interview on 05/29/2024 at 9:47 AM, Certified Nurse Aide (CNA) #19 stated Resident #17 yelled often. CNA #19 stated he would have expected the resident yelling to be care planned. During an interview on 05/29/2024 at 10:07 AM, Registered Nurse (RN) #20 stated Resident #17 did yell. RN #20 stated sometimes Resident #17 needed something from staff and other times Resident #17 would just yell. RN #20 stated she would have thought the resident yelling would be care planned. During an interview on 05/31/2024 at 9:44 AM, Licensed Vocational Nurse (LVN) #21 stated she would expect Resident #17's yelling to be care planned. LVN #21 stated Resident #17 did yell a lot and had a strong voice and it could be loud. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator and the Director of Nursing (DON) on 05/31/2024 at 1:05 PM, the Administrator stated he would expect all behaviors to be care planned. The Administrator stated Resident #17 should have a care plan specifically for yelling. The DON stated Resident #17's yelling should have been care planned.

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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. 46659 Based on observation, interview, record review, and facility policy review, the facility failed to ensure nail care was provided for 2 (Resident #20 and Resident #93) of 5 sampled residents reviewed for activities of daily living (ADLs). Findings included: A facility policy titled, Grooming Care of the Fingernails and Toenails, revised on 10/21/2021, revealed, Purpose Nail care is given to clean the nail bed and keep the nails trimmed. Policy Fingernails are trimmed by Certified Nursing Assistants (CNAs), except for Residents with diabetes or circulatory impairments, this includes all toenails except for high-risk Residents. Note: A Licensed Nurse will trim those Residents' nails. 1. An Admission Record indicated the facility admitted Resident #20 on 04/27/2015. According to the Admission Record, the resident had a medical history that included diagnoses of contracture of left elbow, wrist, and hand and hemiplegia and hemiparesis following cerebral infarction. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/12/2024, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS indicated the resident was dependent on staff for personal hygiene. Resident #20's care plan, revised on 05/21/2022, revealed the resident had an ADL self-care performance deficit related to limited mobility, musculoskeletal impairment secondary to cerebrovascular accident (CVA) with left hemiparesis, contractures of left shoulder, elbow, hand, and muscle weakness. Interventions directed staff to check the resident's nail length and trim and clean on bath day and as necessary. During a concurrent observation and interview on 05/27/2024 at 12:38 PM, Resident #20 was observed to have long fingernails on both hands. Resident #20 stated their fingernails needed to be trimmed. During a concurrent observation and interview on 05/28/2024 at 11:40 AM, Resident #20 was observed to have long fingernails on both hands. Resident #20 stated they would like to have their fingernails trimmed, but staff did not trim their fingernails. On 05/29/2024 at 9:14 AM, Resident #20 was observed to have long fingernails on both hands. During a concurrent observation and interview on 05/30/2024 at 9:34 AM, Resident #20 was observed to have long fingernails on both hands. Resident #20 stated staff had not cut their fingernails. 2. An Admission Record indicated the facility admitted Resident #93 on 12/18/2023. According to the Admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus, muscle weakness, and need for assistance with personal care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/26/2024, revealed Resident #93 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS revealed Resident #93 required substantial/maximal assistance from staff for personal hygiene. Resident #93's care plan, initiated on 12/19/2023, revealed the resident had an ADL self-care performance deficit related to fatigue, impaired balance, risk for pain, and two-person assist per history and physical. Interventions required staff to check nail length and trim and clean on bath day and as necessary. During an interview on 05/27/2024 at 11:24 AM, Resident #93 stated the CNAs did not trim their nails and the nurses did not offer to trim their nails. On 05/28/2024 at 11:47 AM, Resident #93 was observed to have long fingernails. During an interview on 05/29/2024 at 9:05 AM, Licensed Vocational Nurse (LVN) #18 stated nurses trimmed the nails of those resident with diabetes during the resident's shower. During an interview on 05/29/2024 at 9:29 AM, Certified Nurse Aide (CNA) #23 stated nail trimming was a part of a resident's bath/shower and the nurses trimmed the nails of those resident with diabetes. CNA #23 stated Resident #20 and Resident #93 did not refuse their baths/showers and their nails should have been trimmed during their bath/shower and as needed. During an interview on 05/29/2024 at 11:14 AM, CNA #24 stated Resident #20 or Resident #93 did not refuse their baths/showers so they would not refuse nail care. CNA #24 stated their nails should have been trimmed on their baths/shower days. During an interview on 05/29/2024 at 2:04 PM, LVN #2 stated Resident #20's fingernails were long and needed to be trimmed. LVN #2stated the CNAs should have trimmed Resident #20's fingernails on the resident's bath/shower days. LVN #2 confirmed Resident #93 had fingernails that needed to be trimmed and should be trimmed by a nurse. During an interview on 05/31/2024 at 1:54 PM, the Director of Nursing stated she expected the staff to check and trim the resident's nails. During an interview on 05/31/2024 at 2:12 PM, the Administrator stated he expected the staff to trim the resident's fingernails on shower/bath days and as needed.

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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. 46258 Based on interview, record review, and facility policy review, the facility failed to ensure a root cause was determined for a fall for 1 (Resident #62) of 3 sampled residents reviewed for accidents. Findings included: A facility policy titled, Fall Management Program, revised on 03/13/2021, specified Purpose To provide residents a safe environment that minimizes complications associated with falls, The policy specified, The IDT [Interdisciplinary team] will review the circumstance surrounding the fall then summarize their conclusions on an IDT note. An Admission Record revealed the facility admitted Resident #62 on 10/19/2023. According to the Admission Record, the resident had a medical history that included diagnoses of adult failure to thrive, dementia, altered mental status, abnormalities of gait and mobility, and weakness. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/27/2024, revealed Resident #62 had a Staff Assessment for Mental Status (SAMS), which indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS indicated the resident was dependent on staff for activities of daily living (ADLs). Resident #62's care plan revised 05/10/2024, revealed the resident was a high risk for falls due to deconditioning, gait and balance problems, incontinence, psychoactive drug use, and generalized weakness. Resident #62's Progress Notes, dated 05/14/2024, revealed Resident #62 had an unwitnessed fall, was sent to the hospital for a head injury, and returned with eight staples on the back of their head. Resident #62's Post Fall Evaluation, dated 05/14/2024, revealed the reason for the resident's fall was not evident. During an interview on 05/29/2024 at 3:25 PM, the Director of Nursing acknowledged there were a lot of blanks on the fall incident report for Resident #62. The DON acknowledged it was something the facility needed to work on as the fall incident report should paint a picture of what happened. During an interview on 05/30/2024 at 9:47 AM, Licensed Vocational Nurse (LVN) #21 stated she was called to Resident #62's room by Certified Nurse Aide (CNA) #22, who had found the resident on the floor. LVN #21 stated Resident #62 had not fallen before, and she thought the resident leaned forward and toppled over. During an interview on 05/30/2024 at 2:22 PM, CNA #22 stated when he went to check on Resident #62, he found the resident on the floor on their back, with blood on their head. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator and the DON on 05/31/2024 at 1:05 PM, the Administrator stated he would expect the staff to find a root cause of a resident's fall and for the entire story to be documented. The DON acknowledged the whole picture of Resident #62's fall was ot listed and it should have been.

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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. 40141 Based on observation, interview, record review, and facility policy review, the facility failed to ensure an enteral gastrostomy tube feeding was administered as ordered for 1 (Resident #113) of 1 sampled resident reviewed for tube feeding. Findings included: A facility policy titled, Enteral Feeding, revised on 01/01/2012, specified, Enteral feeding will be administered via pump as ordered by the Attending Physician. An Admission Record indicated the facility admitted Resident #113 on 04/09/2024. According to the Admission Record, the resident had a medical history that included diagnoses of gastrostomy status and adult failure to thrive. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/16/2024, revealed Resident #113 had a Staff Assessment for Mental Status (SAMS), which indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS revealed the resident had a feeding tube and received 51% or more of their total calories by way of a tube feeding. Resident #113's care plan, initiated on 04/10/2024 and revised on 05/16/2024, revealed the resident required a tube feeding related to swallowing problems. Interventions directed staff to provide the resident's diet as ordered. Resident #113's Medication Administration Record for the timeframe 05/01/2024-05/31/2024, revealed the transcription of an order dated 05/2/12024 to provide the resident with Nepro 1.8 40 milliliters per hour (ml/hr) for 20 hours, on at 2:00 PM ad off at 10:00 PM. During a concurrent observation and interview on 05/29/2024 at 3:58 PM, Resident #113 was observed in bed and Jevity 1.2 enteral tube feeding formula infused at 40 ml/hr. Licensed Vocational Nurse (LVN) #9 stated the resident received Nepro through their feeding tube. LVN #9 confirmed Jevity 1.2 enteral tube feeding formula was currently infusing. LVN #9 reviewed the physician orders and stated the resident was ordered Nepro 1.8. LVN #9 stated the tube feeding that was hung should not be Jevity 1.2; it should have been Nepro 1.8. During an interview on 05/30/2024 at 10:43 AM, LVN #10 stated she started the Jevity 1.2 formula for Resident #113 on 05/29/2024 at 2:00 PM. LVN #10 stated she did not check the bottle of enteral feeding formula that was hung to ensure it was Nepro 1.8. During an interview on 05/31/2024 at 11:44 AM, the Medical Doctor (MD) stated she was notified on Wednesday, 05/29/2024, that Resident #113 had received the wrong tube feeding formula. The MD stated she was not worried about the wrong tube feeding being administered. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/31/2024 at 1:28 PM, the Administrator stated Resident #113 should not have received the incorrect tube feeding formula. The Administrator stated the nurse should have confirmed the physician order and the formula before the tube feeding was started. The Administrator indicated he expected for staff to follow the physician order, and if they had any questions, he expected the staff to contact the physician to clarify. During an interview on 05/31/2024 at 1:41 PM, the Director of Nursing (DON) stated the Jevity 1.2 enteral formula should not have been started for Resident #113. The DON indicated she expected the tube feeding rate and enteral formula to match the physician order.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 46194 Based on observation, record review, interview, and facility policy review, the facility failed to ensure a therapeutic diet were served to 1 (Resident #71) of 33 sampled residents as ordered by the physician. Findings included: A facility policy titled, Therapeutic Diets, revised on 06/01/2024, revealed, Therapeutic diets are diets that deviate from the regular diet and require a physician order. Procedure I. Therapeutic diets will not be given without a physician order. A. The nursing staff is responsible for communicating the physician's order for a therapeutic diet to the dietary department in writing. B. The therapeutic diet will be reflected on the resident's tray card. An Admission Record revealed the facility admitted Resident #71 on 01/25/2024. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and dysphagia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) 05/03/2024, revealed Resident #71 had a Staff Assessment for Mental Status (SAMS), which indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS indicated the resident required setup or clean up assistance with eating. Per the MDS, the resident was on a mechanically altered diet. Resident #71's care plan, initiated on 01/26/2024, revealed the resident had a potential nutritional problem related to diet restrictions as the resident was on a mechanically soft textured diet dur to their disease conditions. Interventions directed the staff to provide, serve diet as ordered. Resident #71's telephone physician order, dated 05/29/2024 at 9:00 AM, revealed an order for regular, pureed texture diet. The Dietary Communication form, revealed Resident #71's diet was downgraded to a pureed diet on 05/29/2024. During a concurrent observation and interview on 05/29/2024 at 1:17 PM, the surveyor observed Certified Nurse Aide (CNA) #1 set up a mechanical soft meal tray to feed Resident #71. The meal tray consisted of peas, potatoes, and ground meat. CNA #1 stated she was not aware the resident's diet had been changed to a pureed diet. During an interview on 05/29/2024 at 1:21 PM, Licensed Vocational Nurse (LVN) #3 stated she changed the resident's diet order that morning and gave the dietary communication form to the LVN #2 to give to the kitchen staff. communicated the change to the dietary staff. During an interview on 05/29/2024 at 1:59 PM, LVN #2 stated he gave the dietary communication form to downgrade Resident #71's diet to the Registered Dietician (RD) at 12:00 PM on 05/29/2024. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview n 05/29/2024 at 2:01 PM, the RD stated when a meal tray is dent out from the kitchen, the nurses should check to ensure the meal tray is correct. The RD stated she was not aware Resident #71's diet order was changed and had not received any communication from the nursing department to provide the resident a different diet.

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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. 46194 Based on observation, interview, and facility policy review, the facility failed to date open food items and properly store dry food in sealed containers. These deficient practices affected all residents who received food from the kitchen. Findings included: A policy titled Food Storage, revised on 07/25/2019, revealed, Purpose To establish guidelines for storing, thawing, and preparing food. Policy Food items will be stored thawed, and prepared in accordance with good sanitary practice. All items will be correctly labeled and dated. Per the policy, D. Label and date all food items. The policy specified, G. Any opened products should be placed in storage containers with tight fitting lids. During an observation on 05/27/2024 at 8:39 AM, the surveyor noted in the walk-in refrigerator plastic storage container dated 05/10/2024 through 05/17/2024, of bell peppers that had a black fuzzy substance on them and a fluid seeping out of the container and two undated bags of cheese. In the walk-in freezer, there was an undated bag of diced ham that was opened to air. In the dry storage area, there were containers of dry milk, lima beans, and rice that were opened to air. During an interview on 05/27/2024 at 8:41 AM, Dietary Aide (DA) #5 stated the bell peppers were bad and should have been disposed of ten days ago. DA #5 stated the cheese should have had an opened date and a use-by- date labeled on the package. During an interview on 05/27/2024 at 8:51 AM, the Registered Dietician stated no food should be exposed in the walk-in freezer and food in the dry storage area should be sealed. During an interview on 05/30/2024 at 8:35 AM, the Dietary Supervisor (DS) stated when food items were opened, staff should place an opened dated and a use-by-date on the item. The DS stated items in storage containers should be properly sealed and air tight. During an interview on 05/30/2024 at 4:05 PM, the Director of Nursing stated food items should be labeled with an opened date and discarded per the facility policy. During an interview on 05/31/2024 at 12:00 PM, the Administrator stated stored foods needed to have a label as to when the food was placed in the refrigerator and a use-by date. The Administrator stated he would expect if a dry food item was opened, it should be placed in a container that sealed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055407	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cupertino Healthcare & Wellness Center	22590 Voss Avenue Cupertino, CA 95014

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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. 46659 Based on observation, interview, record review, document review, and facility policy review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented during indwelling catheter care for 1 (Resident #12) of 1 sampled resident reviewed for urinary catheter. Findings included: The Centers for Medicare & Medicaid [CMS] Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, memorandum dated 03/20/2024 with an effective date of 04/01/2024, revealed CMS is issuing new guidance for State Survey Agencies and long term care (LTC) facilities on the use of enhanced barrier precautions to align with nationally accepted standards. EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. A facility policy titled, Enhanced Barrier Precautions, revised on 04/30/2024, revealed, 7. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities for those at risk of transmission or acquisition of MDROs: a. Dressing b. Bathing/showering c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator h. Wound care: any skin opening requiring a dressing. An Admission Record indicated the facility readmitted Resident #12 on 04/14/2024. According to the Admission Record, the resident had a medical history that included diagnoses of methicillin resistant staphylococcus aureus infection, need for assistance with personal care, and urinary tract infection. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/02/2024, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for toileting hygiene and had an indwelling catheter. Resident #12's care plan, initiated on 04/15/2024, revealed the resident had an indwelling catheter related to a diagnosis of neurogenic bladder. During an observation on 05/29/2024 at 9:59 AM, Certified Nurse Aide (CNA) #16 cleansed the urinary catheter of Resident #12, while CNA #15 and Licensed Vocational Nurse (LVN) #14 assisted. The staff wore gloves and a mask; no gown was worn during care. During an interview on 05/29/2024 at 10:57 AM, LVN #14 stated when catheter care was provided, staff wore gloves, a gown, and a mask. LVN #14 stated a gown was not worn during Resident #113's catheter care. During an interview on 05/29/2024 at 11:00 AM, CNA #16 stated that for residents with catheters, staff just wore gloves and mask. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055407	A. Building B. Wing	05/31/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/29/2024 at 11:03 AM, CNA #15 stated staff were required to wear gloves and a face mask when they performed catheter care. According to CNA #15, a gown was only needed when the resident had an infection. During an interview on 05/29/2024 at 1:22 PM, the Infection Control LVN stated she was not aware of the new enhanced barrier precautions that were in effect and thought it was still an optional precaution in nursing homes. During an interview on 05/31/2024 at 1:54 PM, the Director of Nursing stated she expected staff to wear personal protective equipment (PPE) when they performed care on the residents on enhanced barrier precautions. During an interview on 05/31/2024 at 2:12 PM, the Administrator stated he expected the staff to wear the PPE as required for enhanced barrier precautions.