STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056242	A. Building B. Wing	06/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westlake Convalescent Hospital	316 S Westlake Avenue Los Angeles, CA 90057

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 43851 Based on observation, interview, and record review the facility failed to ensure the call light was within reach for one of five sampled residents (Resident 22). This deficient practice had the potential to result in the resident not being able to call nursing staff for assistance when needed. Findings: A review of the Admission Record indicated the facility admitted Resident 22 on 5/25/2016, with diagnoses including hemiplegia (paralysis of one side of the body), blindness of the left eye, dependence on the wheelchair, type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). A review of Resident 22's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 6/9/2024, indicated the resident had moderately impaired cognition (a person's ability to think, learn, remember, use judgement, and make decisions) skills for daily decision making. The MDS indicated Resident 22 required supervision or touching assistance with eating. The MDS indicated Resident 22 required substantial/maximal assistance for oral hygiene, was dependent on help for toileting hygiene, showering/bathing self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. A review of Resident 22's Care Plan revised 6/20/2024, indicated the resident had a self-care deficit for toileting related to physical mobility, weakness, contractures and needed extensive assistance. The care plan indicated a goal for Resident 22 to maintain their current level of function if possible, and for the resident to be clean and dry after each episode of incontinence (inability to control the bladder or bowel). The care further indicated interventions that included answering the call light properly and keeping the call light close and within reach. During a concurrent observation and interview on 6/21/2024 at 7:29 PM, Resident 22 was observed sitting up in bed. Resident 22 was observed with their call light hanging off the bed on the floor, not within the resident's reach. Resident 22 was observed looking around his bed. Resident 22 indicated he knew how to call for help from staff. Resident was observed looking for the call light and unable to locate the call light. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/21/2024 at 7:31 PM, Certified Nursing Assistant (CNA) 3 confirmed Resident 22's call light was hanging off the bed not within the resident's reach. CNA 3 stated the call light should be on the bed within the resident's reach. CNA 3 stated there was a potential for Resident 22 to not be able to call staff when needed. During an interview on 6/23/2024 at 1:58 PM, the Director of Nursing (DON) stated the call light should be within the reach of the resident at all times. The DON stated there was a potential for residents to not be able to call out for help when needed if call lights were not available for the resident. A review of the facility's policy and procedure reviewed 1/19/2024, indicated when the resident was in bed or confined to a chair be sure the call light was within easy reach of the resident.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 47883 Based on interview and record review, the facility failed to ensure a current copy of the resident's advance directive (AD, a written instruction, recognized under State law, relating to the provision of health care when the individual is unable to make decisions for themselves) was in the resident's medical chart for one of three sampled residents (Resident 40). This deficient practice had the potential for the facility to not honor the resident's medical decisions regarding end-of-life treatment. Findings: A review of Resident 40's Admission Record indicated the facility admitted the resident on 12/15/2023, with diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), end stage of renal disease (final , permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own), and dementia (decline in mental ability severe enough to interfere with daily functioning/life). A review of Resident 40's physician History and Physical (H&P) dated 12/16/2023, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 40's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 12/20/2023, indicated the resident had moderately impaired cognition (moderately damaged mental abilities, including remembering things, making decisions, concentrating, or learning) The MDS also indicated the resident was dependent on two or more helpers for assistance with bed mobility, transfer, locomotion, dressing, eating, toilet use and personal hygiene. During an interview with the Director of Social Services (SSD), on 6/21/2024 at 8:43 PM, and a concurrent review of Resident 40's clinical record, the SSD stated the resident's Advance Directive acknowledgement form indicated that Resident 40 had an advance directive. The advance directive was not found in Resident 40's clinical record. The SSD stated the advance directive was not in the chart, and she would check in her office. During an interview with SSD on 6/22/2024 at 11:53 AM, the SSD stated that she was not able to find Resident 40's advance directive in her office. The SSD stated a copy of Resident 40's advance directive should have been kept in the resident's chart to provide guidance to the facility staff about the resident's wishes. During an interview with the Director of Nursing (DON) on 6/23/2024 at 11:53 AM, the DON stated that a copy of Resident 40's advance directive should have been kept in the resident's chart to ensure the resident's wishes would be carried out, and to provide guidance to the facility staff about the resident's wishes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policies and procedures titled, Advance Directives, revised 1/19/2024, indicated to comply with state and federal law regarding the development and implementation of a resident's advance directives. If there was an advanced directive, then this information shall be placed in the clinical record when provided by the resident or their representative.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 43851 Based on observation, interview, and record review, the facility failed to accommodate communication needs for one of five sampled residents (Resident 59) by failing to keep a Korean communication board (a tool that includes pictures that help residents communicate their healthcare and every-day needs to facility staff) that help residents at bedside within the resident's reach. This deficient practice had the potential for Resident 59 to not be able to communicate their needs to the facility staff. Findings: A review of Resident 59's Admission Record indicated the facility admitted the resident on 7/20/2023, with diagnoses that included osteomyelitis (an infection in the bone), type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), hyperlipidemia (high levels of cholesterol in the blood), muscle weakness, and metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood). A review of Resident 59's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 4/30/2024, indicated the resident had modified independence (some difficulty in new situations only) cognitive skills for daily decision making. The MDS indicated Resident 59 required set up to clean up assistance for eating and oral hygiene. The MDS indicated Resident 59 required supervision or touching assistance for personal hygiene and required partial/moderate assistance for toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear. The MDS further indicated Resident 59 required substantial/moderate assistance for showering/bathing self. A review of Resident 59's Care Plan revised 4/19/2024, indicated the resident's primary language was Korean. The care plan indicated a goal for staff to anticipate Resident 59's needs and indicated the language barrier would not affect the resident's ability to communicate. The care plan intervention was to attempt to work out communication for yes/no answer, encourage the use of gestures as needed, provide an interpreter as needed, provide room visits, and provide a visual communication board. During an observation on 6/21/2024 at 7:13 PM, Resident 59 was observed sitting in bed. A Korean communication board was observed in a folder placed in a bin secured to the wall by the entrance of the resident's room. There was no communication board observed at bedside or near Resident 59's reach. During an interview on 6/21/2024 at 7:20 PM, Licensed Vocational Nurse (LVN) 5 stated Resident 59 spoke Korean. LVN 5 stated staff communicate with the resident though gestures and stated there was also a Korean speaking nurse. LVN 5 stated sometimes Resident 59 got upset when you talked to him because they could not understand you. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, interview, and record review, with Social Services Director (SSD), Resident 59's Korean communication board was observed in a folder placed in a bin secured to the wall by the entrance of the resident's room. The SSD stated there was no Korean communication board observed at Resident 59's bedside. Resident 59's care plan was reviewed with SSD. The SSD stated Resident 59's care plan indicated the resident's primary language was Korean and indicated to provide the resident with a visual communication board. The SSD stated the communication board was used to facilitate communication between Resident 59 and the staff, and it would be difficult for Resident 59 to communicate their needs if they did not have easy access to the communication board. The SSD stated it would be beneficial for Resident 59 to have a Korean communication board at bedside to facilitate easier communication with staff. During an interview using translation services on 6/22/2024 at 1:17 PM, Resident 59 stated sometimes they have difficulty speaking to staff. Resident 59 stated it's hard to talk to staff because they do not speak Korean. Resident 59 further stated they try to talk to staff using gestures and stated they were not sure if they understood but stated I think they understand. During an interview on 6/23/2024 at 1:58 PM, the Director of Nursing (DON) stated. Resident 59 had a communication board in their room on the wall and one with activities. The DON stated Resident 59 was Korean speaking and the communication board should be near the resident at bedside for easy access. The DON stated there was a potential for Resident 59 to not be able to relay their needs to staff and have difficulty communicating with staff if there was no communication board at bedside. A review of the facility's policy and procedure titled, Accommodation of Needs Related to Communication Deficits, reviewed 1/19/2024, indicated communication needs will be identified and appropriate interventions, including care planning, will be developed in order to accommodate the communication needs of the resident. Care plan will be developed, updated quarterly and as indicated to reflect accurate, current assessments related to communication needs.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on observation, interview, and record review, the facility failed to provide oral care for one of three sampled residents (Resident 2), who was totally dependent upon staff for all activities of daily living (ADLs - essential and routine activities include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet), was unable to breathe independently and was ventilator (a machine that helps one breathe) dependent. This deficient practice had the potential to place Resident 39 at risk for ventilator associated infection. Findings: A review of Resident 2's Admission Record indicated the facility admitted Resident 2 on 6/20/2018 and readmitted on [DATE], with diagnoses including epilepsy (a brain condition that causes recurring seizures[a sudden, uncontrolled burst of electrical activity in the brain]), and chronic respiratory failure (a condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide). A review of the Physician's Order dated 4/23/2024, indicated Resident 2 was to receive oral care every shift to prevent infection. A review of the Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 5/2/2024, indicated Resident 2's cognition was severely impaired (never/rarely made decisions). The MDS further indicated Resident 2 was totally dependent upon staff for all activities of daily living (ADLs -essential and routine activities include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet). The MDS also indicated Resident 2 was receiving oxygen therapy, required suctioning, tracheostomy care and required an invasive mechanical ventilator. A review of the humidity deficit care plan, initiated 5/1/2024, indicated Resident 2 was prone to humidity deficit due to the presence of a tracheostomy, and oxygen dependence. The review of the care plan also indicated the goal was for Resident 2 to remain free from respiratory infection. A further review of the care plan indicated the interventions included to provide oral care every shift, check the resident's oxygen saturation every shift, to titrate the resident's oxygen administration to maintain his oxygen saturation greater than 92 percent and to change oxygen devices such as the nasal cannula and mask every week. A review of the Dental Care care plan, initiated 4/23/2024, indicated Resident 2 was totally dependent upon staff for oral care and the goal was for Resident 2 to maintain oral hygiene daily. The care plan interventions included for staff to assist with oral hygiene as needed and to provide good oral hygiene every shift and as needed. A review of Resident 2's Order Summary Report, dated 6/22/2024, indicated on 4/23/2024, the physician ordered the facility was to change the oxygen device (nasal cannula (NC)/mask/T-bar/oxygen tubing) every Friday and as needed (prn). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/21/2024 at 6:05 PM, Resident 2 was observed lying in bed, with dry flaky lips and off-white crusty patches on his tongue. During an observation on 6/22/2024 at 10:44 AM, with Certified Nursing Assistant 1 (CNA 1) Resident 2's mouth was observed at the resident's bedside. During a concurrent interview, CNA 1 stated Resident 2's tongue was dry and crusty. CNA 1 stated it appeared it had been a while since staff had provided oral care to Resident 2. CNA 1 also stated the CNAs or Respiratory therapists provide oral care to the subacute residents. During a concurrent interview and observation on 6/22/2024 at 11:14 AM, at Resident 2's bedside, Respiratory Therapist 1 (RT 1) stated the respiratory therapists provide mouthcare using a sponge and mouthwash. RT 1 stated Resident 2 had white patches on his tongue and maybe RT 1 could suction it off. During an interview on 6/23/2024 at 9:28 AM, Director of Staff Development (DSD) stated CNAs, licensed nurses and respiratory therapist can all perform mouth care on subacute residents. The DSD stated Resident 2 required mouth care every shift. The DSD stated the white patchy crust on Resident 2's tongue indicated he had not received mouthcare in a while. The DSD stated it was important for residents to maintain a clean mouth in order to prevent infection as it can lead to ventilator associated pneumonia for residents on a ventilator. During an interview on 6/23/2024 at 2:05 PM, the Director of Nursing (DON) stated RTs, licensed nurses and CNAs can provide mouth care in subacute unit. Looks like it had been a minute. The DON stated for Resident 2 who has a tracheostomy and used a ventilator, good mouth care was important to prevent ventilator associated pneumonia. A review of the facility's policy and procedure titled, Mouth Care, dated 1/13/2023, indicated to provide mouth (oral) care, as the purposes of this procedure were to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth. A review of the facility's policy and procedure titled, Activities of Daily Living (ADLs) / Maintain Abilities, dated 1/13/2023, indicated a resident who was unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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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** 44253 Based on observation, interview, and record review, the facility failed to implement accident risk and hazard interventions for two of five sampled residents (Residents 2 and 20). These deficient practices had the potential to place Residents 2 and 20 at risk for injuries. Findings: a. A review of Resident 2's Admission Record (Face Sheet) indicated the facility admitted the resident on 6/20/2018, and readmitted on [DATE], with diagnoses including epilepsy (a brain condition that causes recurring seizures[a sudden, uncontrolled burst of electrical activity in the brain]), and chronic respiratory failure (a condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide). A review of the Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 5/2/2024, indicated Resident 2's cognition was severely impaired (never/rarely made decisions) and was totally dependent upon staff for all activities of daily living (ADLs -essential and routine activities include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet). The MDS also indicated Resident 2 had a seizure disorder or epilepsy. A review of Resident 2's Seizure Disorder care plan, initiated 4/23/2024, indicated at risk for injury due to epilepsy. The interventions included to provide a safe environment at all times and for facility staff to provide padded side rails. A review of Resident 2's Order Summary Report, dated 6/22/2024, indicated on 4/23/2024, the physician ordered the facility to apply pillows or wedge pillow and frequent visual checks every shift for seizure precautions for Resident 2. The order summary report further indicated to not leave the resident alone during a seizure activity, to protect from injury, if resident was out of bed, help to the floor to prevent injury, remove, or loosen tight clothing, and not to attempt to restrain resident during a seizure as this could make the convulsions more severe. During an observation on 6/22/2024 at 10:44 AM, Resident 2 was observed in bed. Resident 2's bedrails did not have any padding as a precaution for seizure. During a concurrent observation and interview on 6/22/2024 at 1:26 PM with Licensed Vocational Nurse 4 (LVN 4), Resident 2's bed rails were observed. LVN 4 stated Resident 2's side rails were not padded. LVN 4 stated Resident 2 was supposed to have padded side rails in place because Resident 2 was on seizure precautions. LVN 4 stated the side rails protect the resident from harm and to prevent injury. 44309 b. A review of Resident 20's Admission Record indicated the facility originally admitted the resident on 9/3/2015, and readmitted on [DATE], with diagnoses including epilepsy, and encephalopathy (a change in your brain function due to injury or disease). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 20's MDS dated [DATE], indicated the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 20 was dependent to staff (helper does all of the effort) for toileting hygiene, upper and lower body dressing, personal hygiene, and showering and bathing. The MDS further indicated Resident 20 required substantial / maximal assistance (helper does more than half the effort) for oral hygiene. A review of the Physician's Orders dated 6/18/2024, indicated to apply seizure precautions during every shift such as application of pillows or wedge pillow and to provide frequent visual checks. A review of the seizure care plan initiated on 6/19/2024, indicated to keep Resident 20's environment safe by padding the resident's siderails if permitted by the resident. During an observation on 6/22/2024 at 10:02 AM, Resident 20 was observed in his bed, the bedrails did not have any padding as a precaution for seizure. There were no pillows or wedge pillows placed next to Resident 20's bedrails. During a concurrent observation and interview on 6/22/2024 at 10:07 AM, with the Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 20's bedrails were not padded. LVN 1 stated Resident 20 had a diagnosis for seizure and it was required to pad and cover his bed side rails to protect him from injury caused by seizure. A review of Resident 20's Medication Administration Record (MAR) for June 2024, indicated that LVN 1 checked off the padded side rails for seizure precaution as in place for June 22, 2024, during 7 AM-3 PM shift. During an interview on 6/23/2024 at 2 PM with the facility's Director of Nursing (DON), the DON stated staff were required to follow physician's orders for seizure precautions. The DON stated Resident 20 had an order for padded sided rails and it was not implemented by the staff. The DON stated the potential outcome was injuries during seizure activity. A review of the facility's policy and procedure titled, Safety and Supervision of Residents, revised 1/19/2024, indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents were facility-wide priorities. The P&P also indicated the facility's Resident-Oriented Approach to Safety by Implementing interventions to reduce accident risks and hazards shall include implementing all interventions and ensuring that interventions are implemented correctly and consistently.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on observation, interview and record review, the facility failed to ensure that a resident with an indwelling catheter (a flexible plastic tube inserted into the bladder that remains there to provide continuous urinary drainage) received proper care and services for three of five sampled residents (Resident 20, 57, and 64) as evidenced by: -For Resident 20 the facility staff did not empty the indwelling catheter urinary collection bag (designed to collect urine drained from the bladder via a catheter) as ordered by the physician. -For Resident 57 the facility failed to maintain the resident's urinary catheter bag below the level of the bladder. -Fore Resident 64, there was no assessment for indwelling catheter removal. These deficient practices had the potential to result in urinary tract infection (UTI-an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney) and had a potential to lead to urosepsis (a potentially life-threatening complication of urinary tract infection). Findings: a. A review of Resident 20's Admission Record indicated the facility originally admitted the resident on 9/3/2015, and readmitted on [DATE], with diagnoses including epilepsy (a brain condition that causes recurring seizures[a sudden, uncontrolled burst of electrical activity in the brain]), encephalopathy (a change in your brain function due to injury or disease), and urinary tract infection (an infection in any part of the urinary system). A review of Resident 20's Minimum Data Set (MDS, an assessment and care screening tool) dated 6/3/2024, indicated the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 20 was dependent to staff (helper does all of the effort) for toileting hygiene, upper and lower body dressing, personal hygiene, and showering and bathing. The MDS further indicated Resident 20 had indwelling catheter. A review of Resident 20's Physician's Orders dated 6/18/2024, indicated to empty indwelling catheter drainage bag during every shift or when 3/4th full. A review of the History and Physical (H&P) dated 6/19/2024, indicated the resident had the capacity to understand and make decisions. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 20's Care Plan initiated on 6/19/2024, indicated the resident had an indwelling catheter due to urine retention (a condition in which you are unable to empty all the urine from your bladder). Resident 20 was readmitted to the facility with an indwelling catheter for urinary retention as diagnosed in acute hospital. The care plan interventions indicated to empty indwelling catheter drainage bag every shift or when 3/4th full. During a concurrent observation and interview on 6/22/2024 at 9:30 AM, inside Resident 20's room, the resident was observed in his bed watching TV. An indwelling catheter was observed with the urinary collection bag inside a privacy bag secured to the resident's bed. Resident 20 stated that his urinary collection bag had not been emptied since yesterday. During a concurrent observation and interview on 6/22/2024 at 9:37 AM with the Certified Nursing Assistant (CNA 2), Resident 20's urinary collection bag was observed. CNA 2 stated This bag is full and seems like night shift staff did not empty the bag. CNA 2 further stated that she started her shift today at 7 AM and she had not checked or emptied Resident 20's urinary collection bag. During an interview on 6/22/2024 at 10 AM, Licensed Vocational Nurse 1 (LVN 1) stated urinary collection bag of an indwelling catheter was required to be emptied during every shift or when its half full. LVN 1 stated the potential outcome of not emptying the collection bag when its full was infection. During an interview on 6/22/2024 at 10:15 AM, the facility's Director of Nursing (DON) stated staff were required to empty urinary collection bag during every shift or when it was 3/4th full as ordered by the physician. The DON stated Resident 20's urinary collection bag was full, and it was a deficient practice. The DON stated the potential outcome was infection. 43851 b. A review of Resident 57's Admission Record indicated the facility admitted the resident on 1/26/2024 with diagnoses that included adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability), retention of urine (difficulty urinating and completely emptying the bladder), and other disorders of the urinary system. A review of Resident 57's MDS dated [DATE] severely impaired cognitive skills for daily decision making. The MDS indicated Resident 57 was dependent on help for eating, oral hygiene, toileting hygiene, showering/bathing self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 57 was always incontinent of bowel and urine. The MDS further indicated Resident 57 had an indwelling catheter. A review of Resident 57's Physician's Orders dated 1/26/2024, indicated the resident had a Foley catheter (a type of indwelling catheter) attached to bedside drainage bag due to urinary retention; and was to receive Foley catheter care every shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 57's care plan revised on 4/3/2024, indicated the resident had an alteration in urinary elimination (difficulty urinating) as manifested by actual Foley catheter use for the purpose of urinary retention. The care plan indicated goals for Resident 57's bladder to be adequately emptied without any complications as evidenced by no bladder distention, no pain, and no fever daily for 90 days; to prevent the occurrence/recurrence of urinary tract infection daily for 90 days; and for the resident to not have any further skin breakdown and complications daily for 90 days. The care plan indicated interventions that included to maintain proper alignment of the Foley catheter to promote proper drainage. During an observation on 6/21/2024 at 6:24 PM, Resident 57 was observed lying in bed. Hanging on Resident 57's bedframe a urinary drainage bag was observed connected to a clear tube that led from the resident. The urinary drainage bag was observed hanging above the level of the bladder slightly above Resident 57's waist covered in a privacy bag. During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 5, on 6/22/2023, Resident 57's urinary drainage bag was observed. LVN 5 stated Resident 57 had a Foley catheter and verified that the resident's catheter was placed on the resident's bedframe at waist level. LVN 5 stated the catheter bag should be hanging below Resident 57's waist and should not be touching the ground. LVN 5 stated placing the urinary drainage bag for the Foley catheter at Resident 57's waist has the potential for the resident to have UTI. During an interview on 6/23/2024 at 1:58 PM, the Director of Nursing (DON) stated Foley catheters should be placed below level of bladder. The DON stated if the Foley catheter drainage bag was hung at the waist level above the level of the bladder there was a potential for infection control, due to backflow of urine which could cause a UTI. 44253 c. A review of the Admission Record indicated the facility admitted Resident 64 on 12/15/2023 and readmitted on [DATE] with diagnoses including pressure induced deep tissue damage of sacral region, acute kidney failure (kidneys are damaged and cannot filter blood as well as they should) and chronic respiratory failure (a condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide). A review of the Minimum Data Set, dated dated dated [DATE], indicated Resident 64's cognition was severely impaired (never/rarely made decisions) and was totally dependent upon staff for all activities of daily living (ADLs -essential and routine activities include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet). The MDS also indicated Resident 64 did not have an indwelling urinary catheter, was always incontinent of bladder and did not have any pressure injuries. A review of Resident 64's History and Physical, dated 6/6/2024, indicated the resident did not have the capacity to understand and make decisions. A review of the Wound evaluation flow sheet for the resident's Sacro-coccyx (tailbone) wound indicated on 6/20/2024, Resident 64's Sacro-coccyx was intact. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 64's Order Summary Report, dated 6/22/2024, indicated on 6/6/2024, the physician ordered the facility to place a urinary catheter attached to bedside drainage due to wound management. A review of Resident 64's urinary incontinence / indwelling catheter care plan, initiated 6/6/2024, indicated the goal was for Resident 64 to not have signs or symptoms of urinary tract infection. The interventions included for the facility staff to perform a bladder assessment initially on admission then quarterly thereafter and to provide catheter care per protocol. During an observation on 6/21/2024 at 5:50 PM, Resident 64 was observed lying in bed with a Foley catheter draining clear yellow urine. During an interview on 6/22/2024 at 1:33 PM, Licensed Vocational Nurse (LVN) 4 stated Resident 64 was admitted with pressure sores on her bottom and on 6/6/2024, the physician ordered Resident 64 to receive a urinary catheter for wound management. LVN 4 stated the urinary catheter was used so that urine would not go into Resident 64's wounds. During an interview on 6/22/2024 at 2:20 PM, Licensed Vocational Nurse (LVN) 2 stated Resident 64 was admitted with a stage 3 pressure sore on her Sacro-coccyx. LVN 2 stated Resident 64's stage 3 (skin injury due to pressure that extend through the skin into deeper tissue and fat but do not reach muscle, tendon, or bone) Sacro-coccyx wound had been resolved and Resident 64 now had a stage 1 (a reddened, discolored, or darkened area where Skin is not broken due to pressure) redness on her sacrum. LVN 2 stated Resident 64's urinary catheter was placed for wound management and now the catheter was no longer appropriate. LVN 2 stated urinary catheters were to be used for wound management for stage 3 and above pressure ulcers. LVN 2 stated keeping the catheter in leaves Resident 64 at risk for an infection. During an interview on 6/23/2024 at 2:10 PM, the Director of Nursing (DON) stated once Resident 64's stage 3 pressure injury was resolved, the resident should have been assessed for Foley catheter removal. The DON stated we should have attempted to remove the catheter because it was an unnecessary device, and its presence could lead to a urinary tract infection (UTI). A review of the facility's policy and procedure titled,Indwelling Catheter Care, reviewed 1/19/2024, indicated the purpose was to ensure the care of urinary catheter was carried out in a manner that minimizes trauma and infection risks. The maintenance includes keep drainage bag below the level of bladder at all times. Be sure tubing was not kinked, twisted, obstructed, or caught on side rails, keep drainage bag off the floor. Tubing should be secured with a securement device. Empty bag at the end of each shift. Change catheter and drainage as needed for any signs of infection and obstructions. The policy indicated to ensure Foley catheter insertion will be performed by the Licensed Nurse only when ordered by a physician with appropriate diagnosis, such as stage 3 & 4 decubitus ulcer, neurogenic bladder, urinary retention and monitoring of intake and output.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on observation, interview, and record review, the facility failed to change Resident 2's oxygen tubing every seven days per the residents care plan and physician order for one of three sampled residents (Resident 2). This deficient practice had the potential to cause complications associated with oxygen and mechanical ventilation therapy including infection or respiratory distress. Findings: A review of the Admission Record indicated the facility admitted Resident 2 on 6/20/2018, and readmitted on [DATE], with diagnoses including epilepsy (a brain condition that causes recurring seizures [a sudden, uncontrolled burst of electrical activity in the brain]), and chronic respiratory failure (a condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide). A review of the Minimum Data Set (MDS - a standardized assessment and screening tool) dated 5/2/2024, indicated Resident 2's cognition was severely impaired (never/rarely made decisions) and was totally dependent upon staff for all activities of daily living (ADLs -essential and routine activities include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet). The MDS also indicated Resident 2 was receiving oxygen therapy, required suctioning, tracheostomy care and required an invasive mechanical ventilator. A review of the Humidity Deficit care plan, initiated 5/1/2024, indicated Resident 2 was prone to humidity deficit due to the presence of a tracheostomy, and oxygen dependence. The review of the care plan also indicated the goal was for Resident 2 to remain free from respiratory infection. The interventions included to check the resident's oxygen saturation every shift, to titrate the resident's oxygen administration to maintain his oxygen saturation greater than 92 percent and to change oxygen devices such as the nasal cannula and mask every week. A review of Resident 2's Order Summary Report, dated 6/22/2024, indicated on 4/23/2024, the physician ordered the facility was to change the oxygen device (nasal cannula (NC)/mask/T-bar/oxygen tubing) every Friday and as needed (prn). During an observation on 6/21/2024 at 6:05 PM, Resident 2 was observed lying in bed with oxygen tubing attached from an oxygen concentrator (medical device used for delivering oxygen) to the resident's tracheostomy tube infusing at 3 liters per minute (PM). The oxygen tubing was dated 6/14/2024. During an observation inside Resident 2's room on 6/22/2024 at 11:14 AM, Resident 2's ventilator/oxygen tubing was observed with Respiratory Therapist 1 (RT 1). During a concurrent interview RT 1 stated Resident 2's oxygen tubing was dated 6/14/2024. RT 1 stated the oxygen was to be changed once a week on Friday. RT 1 stated Resident 2's oxygen tubing should have been changed yesterday. RT 1 stated the oxygen tubing was changed weekly to ensure the tubing remains clean and for infection control purposes. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/23/2024 at 2:07 PM, the Director of Nursing (DON) stated the respiratory therapist change the residents' oxygen tubing weekly. The DON stated there was a potential for developing an infection when the tubing was not changed weekly. A review of the facility's Policy and Procedure (P&P) titled, Care Plan - Comprehensive, dated 1/19/2024, indicated our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. A review of the facility policy and procedure titled, Physician Medication Orders, dated 1/19/2024, indicated Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview and record review, the facility failed to ensure the physician completed in person visits in a timely manner for one of three sampled residents (Resident 3), by failing to: -Ensure the physician initial face-to-face visit was made by a physician within 30 days after Resident 3s admission. -Ensure Physician visits were alternated with a Nurse Practitioner visits (NP- a nurse who is qualified to treat certain medical conditions without the direct supervision of a doctor) every 60 days after the first 90 days of Resident 3`s admission. These deficient practices had the potential to result in an undetected decline in medical, health, or psychosocial condition and can lead to a delay in necessary care, treatment, and services. Findings: A review of Resident 3's Admission Record (Face Sheet) indicated the facility originally admitted the resident on 5/16/2023, and readmitted on [DATE], with diagnoses including epilepsy (a brain condition that causes recurring seizures [a sudden, uncontrolled burst of electrical activity in the brain]), and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). A review of Resident 3's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 2/27/2024, indicated the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 3 was dependent to staff (helper does all of the effort) for toileting hygiene, upper and lower body dressing, personal hygiene, oral hygiene, and showering and bathing. A review of Resident 3's physician History and Physical (H&P) dated 3/24/2024, after Resident 3's readmission to the facility, indicated Resident 3 was able to make his needs known, but cannot make medical decisions. Further review of the H&P indicated it was completed by an NP. During a concurrent interview and record review on 6/22/2024 at 6:40 PM, with the Director of Nursing (DON) Resident 3's physical chart was reviewed. The DON stated the admission H&P dated 3/24/2024 was completed by an NP and not Resident 3's attending physician (PHY 1). The DON stated resident's attending physician was required to conduct an initial comprehensive visit personally within the first 30 days after resident's admission to the facility. The DON stated Resident 3's physician did not visit him personally after his readmission, instead PHY 1's Nurse Practitioner visited the resident and completed the H&P. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/23/2024 at 1 PM, with the DON, Resident 3's physician progress notes were reviewed. The DON stated Resident 3's physician progress notes dated 11/1/2023, 12/3/2023, 1/6/2024, 2/10/2024, and 3/3/2024 were written, signed, and dated by an NP. The DON stated resident's attending physician was required to alternate monthly visits with the NP after the first 90 days of admission. The DON stated, Seems like PHY 1 has not visited Resident 3 since November 2023. The DON stated the potential outcome was incomplete care of the resident. The surveyor attempted to call and interview PHY 1 on 6/23/2024 at 10:30 AM and 2:18 PM. However, the calls were not answered, and no return call was received by the surveyor. A review of the facility's policy and procedure titled, Physician Visits, dated 1/19/2024, indicated the attending physician must make visits in accordance with applicable state and federal regulations. The attending physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. After the first ninety day, if the attending physician determines that a resident need not be seen by him/her every thirty days, an alternate schedule of visits may be established, but not to exceed every sixty days. A physician assistant or nurse practitioner may make alternate visits after the initial ninety days following admission, unless restricted by law or regulation.

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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. 47883 Based on observation and interview, the facility failed to store Tuberculin purified protein derivative (Tuberculin PPD- used in skin test to help diagnose tuberculosis [infection caused by bacteria Mycobacterium tuberculosis]), according to manufacturer's recommendation. -Label Latanoprost (eye drops used to increase the outflow of fluid from the eye) with an open date. -Discard multi-dose of Clearlax (a medication used to treat occasional constipation) and Reguloid (a medication used to treat constipation) after 60 days of opening. This deficient practice had a potential for the residents to receive medications with improper efficacy due to improper storage condition of medications. Findings: During medication storage observation and concurrent interview on 6/21/2024 at 12:29 PM, with Registered Nurse (RN) 2, one open vial of Tuberculin PPD with expiration date 12/2025, and open date 5/29/2024, was observed in the medication refrigerator. RN 2 stated the label on the vial indicated to refrigerate until opened. RN 2 stated Tuberculin PPD medication had to be stored in the refrigerator only until vial was opened. RN 2 stated the vial was opened on 5/29/2024, and had to be stored under room temperature according to the manufacturer's recommendation. During medication storage observation and concurrent interview, with Licensed Nurse (LVN) 5 on 6/22/2024 at 4:51 PM, the following were observed in medication cart 3: -One open vial of Latanoprost with expiration date of 1/2026 and no open date. -One open plastic container of multidose Clearlax with expiration date of 2/2026, and open date of 3/29/2024. LVN 5 stated Latanoprost had to be labeled with the date when it was opened to ensure that the medication would be used according to the facility's policy. LVN 5 stated multidose medications like Clearlax had to be used in 60 days after the opening date. During medication storage observation and concurrent interview with LVN 6, on 6/23/2024 at 8:30 AM, one open container of multidose Reguloid with expiration date of 6/2026 and open date of 4/2/2024 was observed in medication cart 3. LVN 6 stated multidose medications had to be used 60 days after the opened date. During an interview on 6/23/2024 at 4:30 PM, the Director of Nursing (DON) stated all medication had to be stored according to the facility policy and manufacturer's recommendations. The DON stated the container or vial should be dated after opening, multi-dose packing had to be discarded within 60 days of opening, and Tuberculin had to be stored at room temperature after opening to ensure the effectiveness of the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Medication Storage in the Facility, last revised on 1/2018, indicated medication in multi - dose packaging will have beyond-use dating 60 days or manufacturer's expiration date if less than 60 days. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The nurse shall place a date open sticker on the medication and enter the new date of expiration.

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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. 38740 Based on observation, interview and record review, the facility failed to ensure staff followed food production recipes and fortified diet (diet to increase caloric intake) guidelines during lunch service when: -Fortified diets (diet enriched to increase caloric content) were not prepared and were not served to 10 residents who were on fortified diet. -Six residents on pureed diet (foods that do not require chewing and are easily swallowed. All foods should be smooth and pureed to the consistency of pudding) did not receive the pureed lettuce, tomato, and pickles with their meal per the menu. This deficient practice had the potential to result in meal dissatisfaction for residents on puree diet, decrease caloric intake and unintentional weight loss for residents who were on fortified diet. Findings: a. During the tray line observation on 6/22/2024 at 11:35 AM, residents who were on fortified diet the Dietary Aide (DA) 1 communicated the fortified diet orders during lunch service but [NAME] 1 who was serving the food did not add any additional food items per fortified menu. During a concurrent interview with [NAME] 1 and DA 1 on 6/22/2024 at 12:20 PM, [NAME] 1 stated residents on fortified diet receive extra gravy or butter on vegetables and starch during lunch. [NAME] 1 stated he did not add gravy or butter on the hamburger sandwich for lunch. [NAME] 1 stated fortified foods was for residents who were losing weight and fortified diet would help to increase the weight with more calories. During the same interview DA 1 stated residents on fortified diet get extra butter and gravy. DA 1 stated today there was no gravy or butter on the food. During an interview on 6/22/2024 at 12:30 PM, the Dietary Supervisor (DS) stated facility did not have a written fortified diet menu, he stated extra butter or gravy was not added to the food today. A review of facility policy titled, Fortified Diet, dated 2023, indicated fortified diet was designed for residents who cannot consume adequate amount of calories and or protein to maintain their weight or nutritional status. The goal was to increase calorie density of the food. Example of adding calories may include extra mayonnaise added to sandwich. b. According to the facility lunch menu for regular and pureed diet on 6/22/2024, the following items would be served on the Regular Diet: Hamburger on a Hamburger Bun and Mayonnaise; Lettuce, Pickle and tomato, Ketchup; Corn on the cob; Potato salad; Frozen peach Pie and Milk. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the facility lunch menu on 6/22/2024, the following items would be served on the Puree Diet: Hamburger pureed 1/2 cup; bun pureed, Lettuce, pickle and tomato pureed, creamed corn pureed and pureed potato salad 1/2 cup. During the tray line observation for lunch service on 6/22/2024 at 11:35 AM, resident who were on pureed diet the [NAME] 1 served pureed hamburger, pureed bread, and pureed corn. The residents on puree diet did not receive pureed lettuce, tomato, and pickles per menu. During an interview on 6/22/2024 at 12:20 PM, [NAME] 1 stated the resident on puree diet did not receive pureed pickles, lettuce, and tomato. During a concurrent review of the menu and interview with DS and [NAME] 1, the DS stated there was a mistake and we forgot to prepare the pureed pickles, lettuce, and tomato for the resident on the pureed diet per menu. [NAME] 1 stated residents can become unhappy with food when they did not receive the food on the menu. The DS stated that cooks should always review the menu and follow the menu when preparing and serving food.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38740 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage practices when: -Two previously cooked and frozen roast pork was thawing in the walk-in refrigerator with no pull out or thaw date. -One large turkey thawing in the walk-in refrigerator labeled with the wrong thaw date. -The walk-in freezer had ice buildup on the freezer ceiling, condenser, and pipes. Icicles hanging from the ceiling above food. There was a large deep pan in the freezer filled with solid ice and water leaking from above. These deficiencies had the potential to result in harmful bacteria growth, cross contamination (transfer of harmful bacteria form one place to another) and inappropriate storage of food and had the potential to affect 30 out 63 residents who eat food from facility kitchen. Findings: During an observation in the kitchen on 6/21/2024 at 5:15 PM, there was one previously cooked and frozen roast pork wrapped in foil with date of 6/13/2024 stored in the walk-in refrigerator. There was another previously cooked and frozen roast pork with dates 6/9/2024 and use by date of 7/9/2024 stored in the walk-in refrigerator. During a concurrent observation and interview with Dietary Supervisor (DS), he stated the roast pork was previously cooked and frozen, and the roast pork was removed from the freezer to thaw. The DS stated staff forgot to date the roast pork with the pull out of the freezer date and all food was thawed for 3 days and then cooked or used. During the same observation in the kitchen there was a large turkey thawing in the Walk-in refrigerator with a date of 6/21/2024, the turkey was soft to the touch and completely thawed. During a concurrent observation and interview with the DS, the DS verified the turkey was removed from the freezer yesterday and stated that the turkey was mislabeled and had the wrong thawing date. A review of facility policy titled, Food Receiving and Storage, dated 1/19/2024, indicated All foods stored in the refrigerator or freezer will be covered, labeled and dated. b. During an observation in the kitchen on 6/21/2024 at 5:30 PM, there was large amount of ice buildup inside the walk-in freezer ceiling, on the condenser and the pipes above the food. there was a large deep pan filled with solid ice and water dripping from the ceiling above. The floor of the walk-in freezer was slippery with ice. During a concurrent interview with DS, he stated the freezer recently had started to leak water and he is waiting for outside company to come in to fix it. (continued on next page)

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	056242	A. Building B. Wing	06/23/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Maintenance Supervisor (MS) on 6/22/2024 at 1 PM, he stated when there was something broken in the kitchen the Dietary Supervisor would let him know so he can either fix it or call the outside company for repairs. The MS stated he was informed yesterday about the freezer and the water leaking from the ceiling or compressor can contaminate the food in the freezer. The MS stated he was going to fix it today. A review of facility policy titled, Sanitation, dated 2023, indicated the FNS Director will report any equipment needing repair to the maintenance and the maintenance department will assist food and nutrition services as necessary in maintaining equipment. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on interview and record review, the facility failed to enforce its own policy related to a safe, sanitary environment and infection control for two of five sampled residents (Resident 10 and 29) by failing to: -Ensure staff members perform hand hygiene between glove changes for Resident 29. -Ensure to label Resident 10's Intravenous catheter (a thin plastic tube inserted into a vein using a needle) and to lock the needleless system after completion of antibiotic infusion. These deficient practices had the potential to transmit infectious microorganisms and increase the risk of infection for Residents 10 and 29. Findings: a. A review of the Admission Record indicated the facility admitted Resident 29 on 2/23/2024, and readmitted the resident on 3/28/2024, with diagnoses including sepsis (a life-threatening condition in which the body responds improperly to an infection. The infection-fighting processes turns on the body, causing the organs to work poorly), chronic kidney disease (kidneys are damaged and cannot filter blood as well as they should), and chronic respiratory failure (a condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide). A review of Resident 29's Contact Isolation Care plan initiated 3/29/2024, indicated the resident required contact isolation due to Candida auris (C. auris, an emerging multi-drug resistant organism [MDRO] that presents a serious global health threat due to its resistance to multiple antifungal drugs). The care plan interventions indicated staff were to encourage all staff and visitors to wash hands before entering and upon leaving the isolated area, inform resident, family and visitors about infection control precautions and procedures and staff were to use aseptic technique for all procedures and storage of all equipment. A review of Resident 29's Moisture Associated Skin Damage (MASD, inflammation of the skin caused by sources of moisture such as urine, perspiration, stool or mucus) care plan initiated on 3/29/2024, indicated the goal was for the resident's skin to be free from further development of skin excoriation. The interventions included to monitor for signs of infection, monitor effectiveness of treatment and to notify the physician as needed. A review of Resident 29's Minimum Data Set (MDS-comprehensive assessment and care screening tool) dated 5/31/2024, indicated Resident 29's cognition was severely impaired (never/rarely made decisions) and was totally dependent upon staff for all activities of daily living (ADLs -essential and routine activities include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet). The MDS indicated Resident 29 had a MASD and the facility applied ointments/medications for skin treatments. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 29's Order Summary Report, dated 6/22/2024, indicated on the physician ordered Resident 29 to be placed in contact isolation (steps that healthcare facility staff and visitors need to follow before going into a patient's room in order to stop germ from spreading) for C. auris on 4/4/2024. The order summary report also indicated the physician ordered the facility to administer the following treatments to Resident 29: - Apply A & D ointment to right heel resolved pressure injury daily for skin maintenance on 5/9/2024. - Apply A & D ointment to left heel resolved pressure injury daily for skin maintenance on 5/10/2024. -Apply A & D ointment to sacrococcyx resolved pressure injury daily for skin maintenance on 5/23/2024. - To perineal extending to bilateral groin MASD, cleanse with normal saline, pat dry, apply zinc oxide daily for 30 days on 5/29/2024. - Apply A and D ointment (skin protectant) to peri wound resolved fungal rash every day for skin maintenance on 6/15/2024. During an observation at Resident 29's bedside on 6/22/2024 at 10:13 AM, Licensed Vocational Nurse 2 (LVN 2) performance of Resident 29's skin maintenance treatment was observed. During the care, LVN 2 was observed applying with A and D (skin protectant) ointment with gloved hands to Resident 29's buttock area. LVN 2 then changed gloves without performing hand hygiene and applied zinc oxide to Resident 29's genital area in the front. LVN 2 then changed gloves for a third time without performing hand hygiene and applied A & D ointment to both of Resident 29's heels. During an interview on 6/22/2024 at 10:39 AM, LVN 2 stated she did not perform hand hygiene between glove changes during Resident 29's skin care. LVN 2 stated hand hygiene should be performed when gloves were changed for infection control and to not spread organisms from one area to the other. During an interview on 6/23/2024 at 11:32 AM, the Infection Preventionist (IP) stated hand hygiene was performed between glove changes and that hygiene between glove changes was done to prevent infection and control contamination. During an interview on 6/23/2024 at 2:08 PM, the Director of Nursing (DON) stated staff were to complete hand washing or hand hygiene between glove changes. The DON stated hand hygiene between glove changes ensured one did not contaminate other parts of the resident's body. 47883 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. A review of Resident 10's Admission Record indicated the facility admitted the resident on 2/22/2024, and readmitted on [DATE], with diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck), and end stage of renal disease (the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own). A review of Resident 10's History and Physical dated 4/30/2024, indicated Resident 10 had the capacity to understand and make decisions. A review of Resident 10's MDS dated [DATE], indicated the resident had intact cognition (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning) and required 1-2-person assistance with eating, toileting and personal hygiene, showering, and dressing. A review of the Care Plan initiated on 6/17/2024, indicated Resident 10 was on an Intravenous (IV- a thin plastic tube inserted into a vein using a needle) Catheter antibiotic. The care plan interventions indicated to manage an IV catheter per policy and procedure. A review of a Progress note dated 6/19/2024, indicated a peripheral IV line was started on 6/19/2024, to the left hand and covered with a transparent dressing. A review of Resident 10's Order Summary Report, dated 6/22/2024, indicated an order to: -Insert a peripheral Intravenous Catheter and connect to a needless lock system (a device that does not use needles for administration of medication or fluid) and document per facility protocol. -Check the IV site every 8 hours. -Vancomycin intravenous solution 500 milligram/100 milliliter (mg/ ml- unit of measurements) given at bedtime on 5/21/2024 and 5/24/2024. During a concurrent observation and interview, on 6/21/2024 at 7:30 PM, Registered Nurse 1 (RN 1) verified Resident 10's needleless lock system was not clamped and there was no label to indicate the date of insertion for the IV. RN 1 stated the needless lock system should be clamped when not in use because an open needless lock system increases the chances of cross contamination. RN 1 stated the licensed nurses should label the needless lock system with the date and time when it was inserted. During an interview on 6/23/2024 at 4:30 PM, the Director of Nursing (DON) stated that after IV insertion the registered nurses were required to attach a label to indicate the date and time of insertion. The DON stated the needless lock system should be clamped when not in use, otherwise microorganisms could go into the IV line, and the line could be contaminated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, dated 1/19/2024, indicated this facility's Infection prevention and control policies and practices were intended to facilitate maintaining a safe, sanitary environment and to help prevent and manage transmission of infections. The facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The P&P also indicated the use of gloves did not replace handwashing/hand hygiene and in most situations, the preferred method of hand hygiene was with an alcohol-based hand rub. If hands were not visibly soiled, use an alcohol-based hand rub: -before moving from a contaminated body site to a clean body site during resident care. -After contact with a resident's intact skin. -After handling used dressings, contaminated equipment, etc. -After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; and -After removing gloves.