STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065401	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Stonegate	15720 Garden Plaza Dr Parker, CO 80134

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on record review and interviews, the facility failed to honor resident choices for four (#71, #130, #183, and #186) of eight residents reviewed for self-determination out of 35 sample residents. Specifically, the facility failed to provide bathing for Resident #71, #130, #183 and #186 per their preferences. Findings include: I. Facility policy and procedure The Activities of Daily Living (ADL) policy, reviewed 9/10/24, was provided by the nursing home administrator (NHA) on 10/9/24 at 4:13 p.m. It read in pertinent part, The resident will receive assistance as needed to complete activities of daily living (ADLs). The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: bathing, dressing, grooming, and oral care. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. II. Resident #71 A. Resident status Resident #71, age greater than 65, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included fracture of left lower tibia and fibula (leg bone), chronic embolism and thrombosis of deep veins of lower extremities (blood clots), type 2 diabetes mellitus, chronic kidney disease stage 4, depression and anxiety disorder. The 9/9/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required substantial/maximal assistance with shower/bathe, upper/lower body dressing, putting on/taking off footwear, sit to stand and toilet transfers. The MDS assessment indicated the resident did not have behaviors or rejection of care during the review period. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident interview Resident #71 was interviewed on 10/3/24 at 4:03 p.m. Resident #71 said she felt good, fresh, cozy and clean when she got her regular showers. She said when she got her showers her hair felt good. Resident #71 said she did not feel as clean and comfortable when she did not get her regular showers. Resident #71 said she refused a shower one time. She said because there was a new certified nurse aide (CNA), her therapy had run late, it was after 4:00 pm and approaching dinner so she told the CNA she did not want her shower but unfortunately the shower did not get rescheduled. Resident #71 said she preferred a shower two times per week. C. Record review A review of Resident #71's ADL care plan, initiated 9/2/24, revealed it did not address the resident's specific shower/bathing preferences or needs. The care plan revealed to assist with mobility and ADLs as needed and therapy services as ordered. The Kardex (a tool utilized by staff to provide consistent care for residents) report, dated 10/3/24, revealed no specific references to the residents shower/bathing preferences or needs. Resident #71's bathing task records were reviewed from 9/2/24 to 10/3/24. The records revealed the resident preferred to receive a shower twice per week on Tuesdays and Fridays. The bathing task records further revealed the following: According to review of Resident #71's bathing task records from 9/2/24 to 10/3/24 the resident received a shower on 9/10/24, 9/13/24, 9/24/24 and 10/1/24. The resident received a sponge bath on 9/27/24. The resident received a shower four out of nine opportunities. From 9/2/24 to 9/9/24 (eight days) there were no showers documented for Resident #71. The documentation revealed the resident refused a shower on 9/17/24, however there was not a progress note to document why or the circumstances. III. Resident #130 A. Resident status Resident #130, age greater than 65, was admitted on [DATE] and discharged on [DATE]. According to the August 2024 CPO, diagnoses included metabolic encephalopathy (brain dysfunction), urinary catheter infection, congestive heart failure and dementia. The 7/30/24 MDS assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of five out of 15. He was dependent on staff assistance with eating, hygiene, shower/bath and upper/lower body dressing. He required substantial/maximal assistance with bed mobility, sit to stand and transfers. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS assessment indicated the resident did not have behaviors or rejection of care during the review period. B. Record review A review of Resident #130's ADL care plan, initiated 7/24/24, revealed it did not address the resident's specific shower/bathing preferences or needs. The care plan revealed to assist with mobility and ADLs as needed and therapy services as ordered. Resident #130's bathing task records were reviewed from 7/23/24 to 8/2/24. The records revealed the resident preferred a shower twice per week on Tuesdays and Fridays. From 7/23/24 to 8/1/24 (ten days) there was no documentation indicating the resident had received or been offered a shower. Documentation revealed the resident had one shower on 8/2/24 the day of his discharge. IV. Staff interviews Licensed practical nurse (LPN) #5 was interviewed on 10/3/24 at 1:52 p.m. LPN #5 said it was important for the residents to have regular showers to prevent infections, it felt good, it promoted a good mood and it was good for the skin. LPN #5 said she would also do a skin check during a shower if the CNA would tell her there was something she needed to look at. LPN #5 said if a resident refused a shower she would give them time and offer again many times. She said she also talked to a supervisor if the resident did refuse and charted in the progress notes. CNA #4 was interviewed on 10/3/24 at 2:01 p.m. CNA #4 said it was important for the residents to have regular showers because it promoted good hygiene, so they would feel good and it gave them energy. CNA #4 said if a resident refused a shower she tried to encourage them. She said if they continued to refuse the resident would sign a paper and she would sign a paper and put it in the bath book. CNA #4 said she documented the refusal in the task section of the medical record and she would tell the nurse who would chart the refusal reason in the progress notes. 47151 V. Resident #183 A. Resident status Resident #183, age greater than 65, was admitted on [DATE]. According to the September 2024 CPO, the diagnoses included paraplegia (paralysis of the lower body), high blood pressure, pressure ulcer, muscle weakness and a complication of an internal fixation device (surgical implant) of the vertebrae. The 10/2/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. He was dependent on staff for assistance with toileting hygiene, lower body dressing and transfers; he needed substantial/maximum assistance for bed mobility (movement back and forth in bed, sitting to lying/lying to sitting) and set-up help only with eating. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS assessment documented the resident's shower/bathing had not occurred due to a medical condition or safety concerns. B. Resident interview Resident #183 was interviewed on 10/1/24 at 9:12 a.m. Resident #183 said he had not been offered a shower since he was admitted to the facility on [DATE]. The resident said he needed assistance bathing because he was unable to use his legs and was unsure of his scheduled shower days. C. Record review Resident #183's comprehensive care plan, initiated 9/25/24, included focus areas for falls, pain medication, nutrition, skin integrity, and urinary incontinence. The care plan failed to address the resident's preferred or scheduled shower days as well as his needed level of assistance. Resident #183's bathing task sheet in his electronic medical record (EMR) failed to specify the resident's bathing schedule or his preferred bathing days,. -Review of the resident's EMR did not reveal documentation indicating the resident had been offered or provided a shower from 9/25/24 to 10/1/24 Resident #183's Kardex as of 10/2/24 documented to assist the resident with ADL's as needed and did not include his bathing schedule, preferences or level of assistance needed. On 10/2/24 the residents bathing records stored in a binder at the nurses were reviewed and there was no record Resident #183 was offered a shower or bath since his admission on 9/25/24. VI. Resident #186 A. Resident status Resident #186, age greater than 65, was admitted on [DATE] and discharged on [DATE]. According to the December 2023 CPO, the diagnoses included encephalopathy (brain dysfunction), high blood pressure, dementia, dysphagia and weakness. The 12/15/23 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of two out of 15. She was dependent on maximum assistance for toileting hygiene, and needed substantial to maximum assistance with bathing, lower body dressing, transfers and all bed mobility, and supervision only with eating and oral hygiene. B. Record review Resient #186's ADL care plan documented she had self-care performance deficit due to a recent hospitalization , a recent urinary tract infection, weakness, decreased mobility, dementia and incontinence. -However, the resident's comprehensive care plan and ADL care plan focus failed to include Resident #186's staff level of assistance required for bathing or her preferred or scheduled bathing days. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #186's ADL task report was provided by the divisional director of clinical services (DDCS) on 10/2/24 at 11:00 a.m. The task report revealed the resident's bathing schedule was Tuesday and Friday. -However, the task sheet did not include if the showers were provided and a review of the resident's electronic medical record revealed the facility did not document the resident refusing any showers or baths offered. VII. Staff interviews CNA #2 was interviewed on 10/2/24 at 11:30 a.m. CNA #2 said she provided Resident #183 a shower on 10/1/24 six days after his admission and documented the shower in the resident's EMR. -However, CNA #2 was unable to show where Resident #183's shower was documented. CNA #2 said if a resident refused a shower the staff will ask the resident again if they would like a shower, and if the resident continued to refuse a nurse was then notified of the resident's refusal. CNA #2 said if a could also be offered a bed bath if they did not want to take a shower or bath, and if the resident refused altogether the resigned signed the paper copy of their daily bathing record. LPN #1 said she assisted transferring Resident #183 out of his bed on either 9/30/24 or 10/1/24 so he could have a shower. LPN #1 said the staff should record in the residents EMR if they received any kind of shower or bath, and a bathing record should also be stored in the binder. LPN #1 said she was unable to see where Resident #183's shower was recorded. The director of nursing (DON) and the DDCS were interviewed together on 10/3/24 at 3:08 p.m. The DON said the shower schedule for residents was set according to the room numbers of the residents, so specific rooms numbers were scheduled for specific days, and the schedule was on the binder at the nurses station containing the residents bathing records. The DON said she had not yet identified any gaps that residents had not received their showers as scheduled. She said some residents preferred different bathing days of the week than their scheduled days and the facility could accommodate that, and residents could bathe more frequently if they preferred. The DDCS said once the resident was admitted the facility should immediately have the resident on the bathing schedule. The DDCS said the facility did audits and pulled shower reports out of the EMRs for all residents in the facility to ensure residents were getting showers as scheduled. The DDCS said the facility had previous shower documentation issues and have had to retrain staff on bathing documentation. The DDCS said the facility did not have a record of Resident #186's shower schedule as offered by the facility or documentation Resident #186 was provided a shower or bath as scheduled.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for three (#181, #177 and #240) of nine residents reviewed out of 35 sample residents. Specifically, the facility failed to: -Ensure Resident #181 and Resident #177 received skin care as ordered by the physician; and, -Ensure Resident #240's provider was notified timely of a delay in starting antibiotics and ensure the resident's vital signs were monitored during a change in condition. Findings include: I. Failure to ensure Resident #181 and Resident #177 received skin care as ordered by the physician A. Facility policy and procedure The Skin Integrity and Pressure Ulcer/Injury Prevention and Management policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 5:00 p.m. It revealed in pertinent part, The policy provides associates and licensed nurses with procedures to manage skin integrity, prevent pressure ulcer/injury, complete wound assessment/documentation, and provide treatment and care of skin and wounds utilizing professional standards of the NPIAP (National Pressure Injury Advisory Panel) and (WOCN) Wound, Ostomy, Continent Nurses Society. Measures to maintain and improve the resident's tissue tolerance to pressure are implemented in the plan of care. All residents upon admission are considered to be at risk for pressure injury development due to medical issues requiring nursing care related to disease process and illness or need for rehabilitation services. Upon admission and throughout stay at a minimum pressure redistribution surface is in use with turning and repositioning with ADL care/assistance, incontinent care if needed to include skin barriers application as needed, and preventative wheelchair cushion if indicated. When skin breakdown occurs, it requires attention and a change in the plan of care may be indicated to treat the resident. B. Resident #181 1. Resident status Resident #181, age greater than 65, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included congestive heart failure, acute respiratory failure and osteoarthritis. The [DATE] hospice assessment and care plan revealed the resident was bed bound due to weakness and her inability to get out of bed and bear weight. She needed assistance for all ADLs including bathing, dressing, feeding, transfers, and toileting (incontinence of bowel and bladder). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review The [DATE] nursing admission collection tool for skin condition documented Resident #181 had a skin alteration of blanchable redness on her coccyx (base of the spine). Resident #181's hospice care plan revealed a physician's order for the hospice nurse to provide instructions related to the prevention and management of skin breakdown. Barrier cream was initiated for redness on the resident's coccyx on [DATE]. A review of Resident #181's [DATE] CPO revealed a physician's order to apply barrier cream to the resident's buttocks twice a day and as needed for moisture associated skin damage (MASD), ordered on [DATE]. -However, a review of Resident #181's [DATE] treatment administration record (TAR) revealed the barrier cream was documented as administered only once a day instead of twice a day on [DATE], [DATE], [DATE] and [DATE]. C. Resident #177 1. Resident status Resident #177, age less than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included lower left limb cellulitis (skin infection), major depressive disorder, pruritus (itching), bullous disorder (skin disorder causing blisters), benign prostatic hyperplasia (enlarged prostate) and anxiety. Resident #177's minimum data set assessment (MDS) was still in progress at the time of the survey. The [DATE] progress notes in the resident's electronic medical record (EMR) documented the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 11 out of 15. 2. Record review The [DATE] nursing admission collection tool for skin condition documented Resident #177 had a skin alteration of an open area on his buttocks. Resident #177's EMR revealed documentation on [DATE] that the resident likely would need a follow up appointment with an infectious disease specialist and the resident was at high risk for readmission to the hospital due to his significant wounds. A review of Resident #177's physician orders revealed an order on [DATE] to cleanse the area with normal saline (NS), pat dry, and apply triad cream (sterile coating for broken skin) three times a day and additionally as needed for MASD. -However, a review of Resident #177's [DATE] TAR revealed treatments were not documented as provided on the evening shift of [DATE] and [DATE] and only administered two times each day instead of three. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 11:30 a.m. LPN #1 said she was unsure why Resident #177 and #181 had missing documentation in their TARs and she would have to follow up as to why the physician's orders were not documented as completed on those dates (see dates above). The director of nursing (DON) and the divisional director of clinical services (DDCS) were interviewed together on [DATE] at 3:08 p.m. The DON said Resident #177 refused some of his care and wound dressing changes which the nursing staff reported to her. The DON said the residents did have the right to decline any treatment and she spoke to the Resident #177 about his refusal of care because she wanted to address the refusals as soon as possible. -However, a review of Resident #177's EMR revealed the first documented refusal of triad cream applied to his buttocks was on [DATE]. There were no refusals of the treatment documented on [DATE] and [DATE]. The DON said the nurse should have documented a refusal of care or treatment administration in the TAR on [DATE] and [DATE]. The DON said refusals of wound care or dressing changes could negatively impact a resident's healing. The DDCS said, for any treatment listed in the TAR, the staff should have documented if the treatment was administered or not, including if a resident refused, and the TAR should not have blank spaces left on it. 47350 II. Failure to ensure Resident #240's provider was notified timely of a delay in starting antibiotics and ensure the resident's vital signs were monitored during a change in condition A. Professional references According to Kizior, R. J., [NAME], K. J. (2023). Ampicillin. [NAME] Nursing Drug Handbook. Elsevier. PpXXX,d+[DATE], Continue antibiotics for the full length of treatment. Space doses evenly. According to [NAME], I. J., et al. (2019). The value of vital sign trends in predicting and monitoring clinical deterioration: A systematic review. National Institute of Health (NIH), National Library of Medicine (NLM), retrieved on [DATE] from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6333367/, Changes in vital signs prior to clinical deterioration are well documented and early detection of preventable outcomes is key to timely intervention. B. Facility policy and procedure The Changes in Resident's Condition or Status policy and procedure, reviewed [DATE], was provided by the NHA on [DATE] at 5:55 p.m. It read in pertinent part, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility must immediately inform the resident, consult with the resident's physician and notify, consistent with his or her authority, the resident representative when there is a significant change in the resident's physical, mental or psychosocial status in either life threatening conditions or clinical complications. When making notification, the facility must ensure that all pertinent information is available and provided upon request to the physician. C. Resident #240 1. Resident status Resident #240, age 86, was admitted on [DATE] and expired at the facility on [DATE]. According to the [DATE] CPO, diagnoses included infection of right hip prosthesis and thrombosis (blood clot) of right femoral and popliteal vein. The [DATE] MDS assessment revealed the resident's short and long term memory were intact and he was independent in his daily decision making. The resident was dependent with mobility and transfers. 2. Delayed antibiotic administration a. Record review Review of Resident #240's [DATE] hospital records documented active medications on discharge from the hospital included Ampicillin sodium (antibiotic) 2 grams (gms) intravenously (IV) every four hours. The [DATE] CPO documented a physician's order for Ampicillin sodium 2 gms IV every four hours for hip infection and abscess, ordered [DATE]. Resident #240's [DATE] medication administration record (MAR) documented the following: -On [DATE] at 8:00 p.m. Ampicillin was unavailable for administration; -On [DATE] at 12:00 a.m. Ampicillin was unavailable for administration; -On [DATE] at 4:00 a.m. Ampicillin was unavailable for administration; and, -On [DATE] at 8:00 a.m. Ampicillin was unavailable for administration. A comprehensive review of Resident #240's EMR failed to reveal documentation that indicated the provider was notified that four doses of Ampicillin were missed after Resident #240 was admitted to the facility. b. Staff interviews (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Registered nurse (RN) #1 was interviewed on [DATE] at 11:40 a.m. RN #1 said the facility had some antibiotics in the automated manual medication dispensing system (a system used for emergency medications). She said if antibiotics were not in the automated manual medication dispensing system, they were ordered from the pharmacy and were received the same day with the last delivery occurring around 9:00 p.m. She said if there was a delay in receiving an antibiotic from the pharmacy, the provider should be notified. She said residents on antibiotic therapy should receive their doses of medications on time so that their infections did not come back. The DON and the DDCS were interviewed on [DATE] at 3:39 p.m. The DDCS said antibiotics for newly admitted residents should be received on the same day the resident was admitted from the pharmacy. She said the pharmacy's last delivery every day was at approximately 9:00 p.m. She said if there was any delay in a resident's antibiotic therapy, the provider should be notified. She said she did not know why Resident #240's antibiotic therapy was not started timely. The DON said report should have been received by the facility's admitting nurse from the hospital regarding what antibiotics the resident was on and when the next dose of antibiotic was due. 3. Vital sign monitoring a. Record review A nursing progress note, dated [DATE] at 4:00 p.m., documented Resident #240 was more somnolent (drowsy, sleepy) and sitting up in a wheelchair. He was still speaking with the nurse and waiting to be put back in bed. His dose of pain medication was held (due to his somnolence) and his IV (intravenous) was started. The nurse called the provider regarding his current condition and orders were received for laboratory (lab) blood work to be done stat (immediately). If the lab work could not be done immediately, staff was to give a Fleet enema one time, monitor the resident and await a rounding provider to evaluate the resident in the morning. Staff was in the room putting the resident back into bed and the nurse returned to the family to explain what the provider wanted. The family, who were at the bedside, called the resident's name and said to the nursing staff they needed to call 911. The nurse supervisor was asked to call 911 because that was what the family wanted. The nurse then entered the room and the resident was lying flat and the nurse instructed the resident to breathe. The resident was able to grasp and squeeze the nurse's hand while they were waiting for paramedics to arrive. The paramedics arrived and as a report was being given to them by the facility nurse, the resident became unresponsive, despite paramedics calling his name. The paramedics started cardiopulmonary resuscitation (CPR) and the resident was pronounced deceased at 6:24 p.m. The [DATE] vital signs documentation revealed Resident #240's oxygen saturation levels (measure of oxygen in the blood) were as follows: -At 9:03 a.m. the resident's oxygen saturation level was 90% (percent) on room air; -At 9:57 a.m. the resident's oxygen saturation level was 90% via nasal cannula (no flow rate); -At 1:23 p.m. the resident's oxygen saturation level was 91% on room air; and, -At 4:30 p.m. the resident's oxygen saturation level was 95% on room air. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A comprehensive review of Resident #240's EMR failed to reveal documentation of any other vital signs (blood pressure, pulse, respirations) taken on [DATE]. -However, according to the [DATE] progress note, the resident was somnolent, the provider was notified of the resident's condition but the EMR failed to reveal documentation of a head to toe physical assessment conducted on the resident to assess his change of condition or of the resident's current vital signs prior to the provider being notified of the change of condition. Furthermore, the EMR failed to reveal any resident monitoring, documentation of vital signs or a physical assessment of the resident after the family requested 911 and before the paramedics arrived. b. Staff interviews RN #1 was interviewed on [DATE] at 11:40 a.m. RN #1 said when a resident was having a change or suspected change of condition, a head to toe physical assessment should be done and vital signs should be taken. She said the provider should be notified of the change of condition, the physical assessment and the vital signs. She said the change of condition, physical assessment and vital signs should all be documented in the EMR. The director of nursing (DON) and the DDCS were interviewed on [DATE] at 3:39. The DDCS said when a resident had a change of condition, nurses should complete a head to toe physical assessment with vital signs. She said the provider should be notified with the change of condition, the results of the physical assessment and the vital signs. She said this all should be documented in the resident's EMR.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on observations, record review and interviews the facility failed to ensure eight (#239, #59, #232, #231, #183, #23, #36, #21) of 12 residents out of 35 sample residents received the necessary treatment and services according to professional standards of practice to prevent or heal pressure injuries. Specifically, the facility failed to: -Ensure timely and accurate skin assessments were conducted and interventions were in place to prevent Resident #239 from developing a facility-acquired unstageable coccyx wound; -Ensure Resident #59, who was at risk for developing pressure wounds, had effective personalized preventative measures in place, accurately documented a pressure wound and was provided pressure ulcer treatment per physician orders; -Ensure Resident #232, who was admitted with an unstageable coccyx pressure wound, had timely effective personalized preventative measures in place and accurately documented skin assessments; -Ensure Resident #231, who had a right heel deep tissue injury (DTI) had an accurate admission nursing skin assessment and had personalized skin prevention interventions in place; -Ensure Resident #183, who had a stage 3 pressure wound, was provided pressure ulcer treatments per physician orders; -Ensure Resident #23, who had a stage 3 coccyx wound, had his air mattress consistently checked; -Ensure Resident #36, who had a stage 2 pressure wound performed a skin assessment; and, -Ensure Resident #21, who was admitted with a stage 3 pressure wound, had a timely skin assessment. Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA: 2019, retrieved from https://www.internationalguideline.com/guideline on 10/8/24, Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) Intact skin with non blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individual with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Category/Stage 2: Partial Thickness Skin Loss. Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. The Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss. Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss. Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage 4 ulcer can extend into muscle and/or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. Unstageable: Depth Unknown. Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar tan, brown or black) on the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth,and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural (biological) cover and should not be removed. Suspected Deep Tissue Injury: Depth Unknown. Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. II. Facility policy and procedure The Skin Integrity and Pressure Ulcer/Injury Prevention and Management policy and procedure, revised 7/9/24, was provided by the nursing home administrator (NHA) on 10/2/24 at 5:55 p.m. It read in pertinent part, A comprehensive skin inspection/assessment is completed on admission and readmission to the facility. A skin assessment/inspection should be performed weekly by a licensed nurse. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Measures to maintain and improve the resident's tissue tolerance to pressure are implemented in the plan of care. All residents upon admission are considered to be at risk for pressure injury development due to medical issues requiring nursing care related to disease process and illness or need for rehabilitation services. Measures to protect the resident against the adverse effects of external mechanical forces, such as pressure, friction, and shear are implemented in the plan of care. III. Resident #239 A. Resident status Resident #239, age 79, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), rheumatoid arthritis (RA), dementia and an unstageable sacral pressure wound. The 9/30/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. She required substantial/maximal assistance with toileting and personal hygiene. She required supervision with bed mobility and transfers and setup assistance with eating. The assessment indicated the resident did not have any unhealed pressure wounds that were stage 1 or higher. The assessment indicated the resident was at risk for developing pressure wounds. B. Observations and resident interview On 10/3/24 at 10:15 a.m. Resident #239 was standing at her bedside with a piece of medipore tape dated 10/3/24 taped at the top of her sacrum. The resident had an air mattress on her bed. No dressing was observed over the sacral wound. The wound bed contained slough (yellow white material). No purulent drainage (drainage containing pus) or odor was noted. The wound nurse (WN) cleaned the area with clean gauze and sterile saline and packed the area with quarter strength Dakin's solution (an antibacterial solution) soaked gauze and placed a dated Mepilex dressing over the wound. Resident #239 said she was not sure why the dressing was not in place on her wound, but she said nursing staff did not always do the twice a day wound care. C. Record review (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The unstageable coccyx pressure wound care plan, initiated 9/25/24, documented the resident had actual impairment to skin integrity related to fragile skin and non-compliance with nursing and therapy education regarding not sitting in one position. Interventions included administering treatments as ordered, assessing wound healing and documenting the status of the wound perimeter, wound bed and healing progress, reporting improvements and declines to the provider, educating the resident/caregiver on the causes of skin breakdown, including transfering/positioning requirements good nutrition, frequent repositioning, enhanced barrier precautions, if the resident refused treatment, staff was to confer with the resident, interdisciplinary team (IDT) and family to determine alternative methods, providing the resident with pressure relieving devices on her chair and cleaning and drying the resident's skin after each incontinence episode. The skin integrity care plan, initiated on 9/27/24 and revised on 9/30/24, indicated the resident was at risk for skin breakdown. Interventions included cleaning and drying the resident's skin after each incontinence episode, providing a pressure reducing mattress, performing treatments as ordered, weekly skin checks and providing a wheelchair cushion. -The unstageable coccyx wound care plan was not initiated until 9/25/24, two days after the wound was initially identified (see progress notes below). -The skin care plan was not initiated until 9/27/24, four days after the wound was identified (see progress notes below). The 9/14/24 admission nursing skin assessment documented the resident had blanchable redness over her sacrum. The 9/14/24 Braden Scale assessment (an assessment tool used to predict pressure ulcers) indicated Resident #239 was not at risk for developing pressure ulcers. The 9/17/24 nursing skin/wound progress note documented the resident complained of discomfort to her lower back and she had redness to her lower back. The note documented the resident was educated to reposition herself often and call for assistance when needed. The 9/23/24 nursing skin/wound progress note documented the resident was seen by the wound nurse with complaints of an open area to her lower mid-back. The wound presented with moderate serosanguinous drainage (blood tinged yellow fluid). Its measurements were 3.6 centimeters (cm) by 4 cm by 0 cm. An air mattress was ordered for resident. The 9/23/24 physician order documented to cleanse the wound with normal saline, pat dry and apply medihoney using a cotton swab and cover with foam dressing. The order was discontinued on 9/25/24. A 9/23/24 physician order documented to check that the air mattress was on and functioning every shift. -The order to check for air mattress function was not initiated until after the unstageable coccyx wound was identified. A 9/25/24 nursing weekly skin assessment documented Resident #239 had an open area to her coccyx that contained slough and a large amount of drainage. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 9/25/24 nursing wound assessment documented Resident #239 had an acquired unstageable coccyx pressure wound. It had 100% slough on the wound bed with serosanguinous (blood tinged yellow) drainage. Measurements were 4.6 cm by 5 cm. It documented the provider and family were notified on 9/25/24. The 9/25/24 nurse practitioner progress notes documented an unstageable pressure ulcer to Resident #239's sacral area. The 9/25/24 wound care physician's (WCP) progress note revealed an unstageable coccyx pressure wound with measurement of 4.6 cm by 5 cm. A debridement (a surgical procedure that removes dead or damaged tissue from a wound) was conducted and final measurements were 4.6 cm by 5 cm by 0.3 cm. The 9/25/24 physician orders documented to cleanse the area with normal saline, pat dry and apply quarter strength Dakin's solution gauze and cover with ABD (abdominal) pad and secure with tape twice a day. -The comprehensive nursing weekly skin assessment and the nursing wound observation tool were not completed until 11 days after the initial admission skin assessment was done on 9/14/24 and two days after the wound was identified on 9/23/24. The 9/26/24 nurse practitioner progress note documented the sacral wound bed had thick yellow slough with moderate serosanguinous drainage and tenderness present. The 9/27/24 treatment administration record (TAR) revealed no documentation of wound care being provided at bedtime. The 9/28/24 Braden Scale assessment indicated the resident was not at risk for developing a pressure ulcer. -However, Resident #239 was identified as having an unstageable coccyx wound on 9/25/24. -The 10/2/24 TAR revealed there was no documentation of wound care being provided to Resident #239's wound in the morning. The 10/3/24 nursing wound assessment documented an unstageable coccyx pressure wound with 90% slough with serosanguinous drainage. Its measurements were 4.4 cm by 5 cm by 3.7 cm. -A comprehensive review of the electronic medical record (EMR) failed to reveal documentation of an interdisciplinary team (IDT) risk management assessment of Resident #239's wound. IV. Resident #59 A. Resident status Resident #59, age 77, was admitted on [DATE] and readmitted on [DATE]. According to the October 2024 CPO, the diagnoses included metabolic encephalopathy, protein calorie malnutrition and non Hodgkin's lymphoma. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 9/5/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of three out of 15. She was dependent on staff for toileting, personal hygiene and bed mobility. Transfers were not attempted due to medical/safety concerns and the resident was dependent with eating due to being on tube feedings. The assessment indicated the resident did not have any unhealed pressure wounds that were stage 1 or higher and did not document that the resident had moisture associated skin damage (MASD). The assessment indicated the resident was at risk for developing pressure ulcers. B. Observations On 10/3/24 at 9:30 a.m. Resident #59 was lying on an air mattress with an incontinence brief and a urinary catheter in place. No dressings were in place after the incontinence brief was removed. Three small wounds were observed over the resident's sacrum. The wound beds were shallow and pink. The WN cleaned the wounds with normal saline soaked gauze and applied Triad cream over the sacral area. The measurements for the top coccyx wound were 1.2 cm by 0.3 cm by 0.1 cm. The left wound measurement was 0.1 cm by 0.1 cm and the right wound measurement was 0.5 cm by 0.4 cm by 0.1 cm. C. Record review The skin breakdown care plan, initiated 8/3/24, documented Resident #59 was at risk for skin breakdown. Interventions included cleaning and drying the resident's skin after each incontinence episode, providing pressure reducing mattress, performing treatment as ordered and weekly skin checks. The unstageable pressure ulcer to coccyx care plan, initiated 9/30/24, indicated Resident #59 had a pressure ulcer related to immobility. Interventions included administering medications and treatments as ordered, assessing wound healing and documenting the wound status and reporting improvements or decline, educating resident/family/caregivers regarding transferring/positioning requirements, good nutrition and frequent repositioning, enhanced barrier precautions and following facility policies and protocols. -The skin breakdown care plan failed to reveal personalized preventative interventions for skin breakdown. -The unstageable pressure ulcer to coccyx care plan was initiated on 9/30/24, during survey, without documentation of an unstageable coccyx wound and a month after MASD was first identified for Resident #59. The 8/3/24 admission nursing skin assessment documented the resident had a surgical incision over the left ear. -The admission skin assessment did not document pressure wounds. The 8/3/24 Braden Scale assessment documented indicated the resident was at mild risk for pressure wounds. -The 8/5/24 nursing weekly skin assessment did not document the presence of pressure wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 8/10/24 physician orders documented repositioning every four hours, ordered 8/10/24 and discontinued 8/15/24. The 8/10/24 physician orders documented barrier cream to be applied twice a day. The order was discontinued 8/15/24. -The 8/12/24 nursing weekly skin assessment did not document the presence of pressure wounds. The 8/29/24 Braden Scale assessment indicated the resident was at very high risk for pressure wounds. The 8/30/24 nursing skin/wound progress note documented the resident was seen by the wound nurse and she had skin breakdown to her bottom due to incontinence. She was on an air mattress as well as frequent brief checks and changes. The 9/3/24 physician order documented to check that the air mattress was on and functioning every shift. The order was discontinued on 9/17/24. The 9/3/24 physician orders documented Triad cream twice a day and as necessary for MASD. The order was discontinued on 9/17/24. The 9/5/24 nursing weekly skin assessment documented the presence of moisture associated skin damage (MASD) on Resident #59's coccyx. The 9/12/24 nursing weekly skin assessment documented the presence of MASD on her coccyx. The 9/26/24 nursing readmission skin assessment documented the resident's skin color was normal, temperature warm, moisture normal and turgor good. -However, It did not document the presence of MASD which had been identified on 8/30/24, 9/3/24, and 9/12/24 (see above). The 9/26/24 Braden Scale assessment indicated the resident was at very high risk for pressure wounds. The 9/27/24 physician orders documented an order to clean the resident's coccyx wounds with normal saline, pat dry and apply a dry dressing. The order was discontinued on 9/28/24. The 9/30/24 physician order documented an order to clean wounds on coccyx area with normal saline, pat dry and apply dry dressing for unstageable wound to coccyx. The 10/1/24 physician order documented to check the air mattress was on and functioning. The 10/1/24 physician order documented to clean Resident #59's unstageable coccyx wound with normal saline, pat dry and apply a foam dressing to unstageable coccyx wound at bedtime. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-However, during the wound observation on 10/3/24, a foam dressing was not observed over the coccyx and a foam dressing was not reapplied. An unstageable coccyx wound was not documented in the skin progress notes or in a nursing skin assessment. A comprehensive review of the certified nurse aides (CNA) bed mobility task record for Resident #59 from 9/2/24 to 9/30/24 revealed the resident was documented as being provided assistance with bed mobility as follows: -Three times on 9/11/24, 9/15/24 and 9/28/24; -Two times on 9/2/24, 9/3/24, 9/5/24, 9/6/24, 9/8/24, 9/10/24, 9/12/24, 9/13/24, 9/26/24, 9/27/24, 9/29/24, 9/30/24; and, -One time on 9/7/24. V. Resident #232 A. Resident status Resident #232, age less than 65, was admitted on [DATE]. According to the October 2024 CPO, diagnoses included viral pneumonia, chronic pain and an unstageable sacral pressure ulcer. The 10/7/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was dependent with toileting, bed mobility and transfers and required set up assistance with eating and personal hygiene. The assessment indicated the resident had one or more unhealed pressure wounds with one unstageable pressure wound with slough and/or eschar on the wound bed. B. Observation and resident interview Resident #232 was interviewed on 9/30/24 at 2:10 p.m. Resident #232 said her pressure wound started at the hospital. She said she was being followed by a wound nurse at the facility but she was not sure if a wound physician had seen her. During the interview, Resident #232 was observed to be on an air mattress. Resident #232 was interviewed again on 10/3/24 at 10:00. Resident #232 said she was having too much pain and did not want to have her wound assessed. C. Record review The skin integrity care plan, initiated 9/30/24 (during the survey), revealed the resident had actual skin impairment related to fragile skin. Interventions included cleaning and drying the resident's skin after each incontinence episode, educating resident/family/caregivers of causative factors and measures to prevent skin injury, following facility protocols, identifying and documenting potential causative factors and providing weekly treatment documentation, including measurements. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The unstageable coccyx wound care plan, initiated 9/30/24 (during the survey), indicated Resident #232 was admitted with the pressure wound. Interventions included administering medications and treatments as ordered, assessing wound healing with measurements, reporting improvements and declines and providing the resident with pressure relieving devices on bed/chair. -The skin integrity and unstageable coccyx wound care plans were not initiated until 9/30/24, during the survey and ten days after Resident #232 was admitted with an unstageable pressure wound. The 9/20/24 nursing admission skin assessment documented Resident #232 had a stage 3 coccyx pressure wound. The 9/20/24 Braden Scale assessment indicated the resident was a moderate risk for developing pressure wounds. The 9/23/24 physician order documented to cleanse the coccyx wound with normal saline, apply medihoney and cover with foam dressing every day. The order was discontinued on 10/1/24. The 9/24/24 nursing wound assessment documented a stage 4 coccyx pressure wound with 90% slough tissue present and with serosanguineous drainage. -However, the 9/20/24 nursing admission skin assessment documented the wound as a stage 3 coccyx pressure wound. The 9/25/24 nursing wound assessment documented an unstageable coccyx wound that had slough material in the wound bed and serosanguineous drainage. Measurements were 4.6 cm by 5 cm. The 9/25/24 wound physician progress note documented an unstageable coccyx pressure wound with exposed muscle. The wound bed had 100% slough. Wound measurements were 4.6 cm by 5 cm by 0 cm. The wound required debridement and post debridement measurements were 4.6 cm by 5 cm by 0.3 cm. The 9/30/24 nursing weekly skin assessment documented a stage 3 coccyx pressure wound. -The 9/30/24 weekly nursing skin assessment documented a stage 3 coccyx pressure wound after the wound physician staged it as an unstageable pressure wound on 9/25/24. The 10/1/24 physician order documented to cleanse the coccyx with normal saline, apply one quarter strength Dakin's solution and cover with ABD dressing twice a day and as necessary. VI. Resident #231 A. Resident status Resident #231, age 86, was admitted on [DATE]. According to the October 2024 CPO, diagnoses included acute osteomyelitis right ankle/foot, protein calorie malnutrition, peripheral vascular disease (PVD) and a right great toe amputation. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 10/7/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. He required substantial/maximal assistance with toileting, personal hygiene and transfers. He required partial/moderate assistance with bed mobility and set up assistance with eating. The assessment indicated the resident did not have unhealed pressure wounds that were stage 1 or higher. The resident had a surgical wound and had one venous/arterial wound present. B. Observation and resident interview On 10/2/24 at 10:00 a.m. Resident #231 was sitting up in a wheelchair with a dressing over his right foot and a postoperative shoe on. -An air mattress was not observed on the bed and protective heel boots were not observed in the room. Resident #231 said he was on a regular mattress and did not have protective boots that he wore while he was in bed. He said he wore a surgical shoe when he was up. On 10/3/24 at 10:30 a.m. Resident #231's right medial heel was observed to be calloused with thickened skin. C. Record review The skin integrity care plan, initiated 9/21/24, indicated Resident #231 was at risk for skin breakdown. Interventions included treatments as ordered and weekly skin checks. -A review of the comprehensive care plan failed to reveal personalized preventative measures put in place to prevent skin breakdown. The 9/20/24 admission nursing skin assessment documented a surgical incision on the right great toe. -There was no documentation on the admission skin assessment of a right heel deep tissue injury (DTI). The 9/20/24 Braden Scale assessment indicated Resident #231 had a mild risk of pressure wounds. The 9/25/24 nursing wound observation tool documented a right heel deep tissue injury pressure wound that the resident had on admission. Measurements were 1.4 cm by 0.8 cm by 0 cm. Interventions in place were a surgical shoe, weekly skin checks, wound team visits and protective boots. -However, the admission skin assessment did not document the right heel DTI was present on admission (see above) The 9/25/24 wound physician progress note documented Resident #231 had a right heel DTI with measurements of 1.4 cm by 0.8 cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 9/27/24 Braden Scale assessment indicated Resident #231 was at mild risk for pressure wounds. The 9/27/24 nursing weekly skin assessment documented a right great toe surgical incision. It documented a dressing change done to his right big and right second toe and applied betadine to right heel and right lateral vascular wound. -A comprehensive review of Resident #231's October 2024 CPO failed to reveal documentation of offloading, protective heel boots or an air mattress. 47151 VII. Resident #183 A. Resident status Resident #183, age greater than 65, was admitted on [DATE]. According to the September 2024 CPO, diagnoses included paraplegia, high blood pressure, pressure ulcer, muscle weakness and a complication of an internal fixation device (surgical implant) of the vertebrae. The 10/2/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. He was totally dependent on assistance for toileting hygiene, lower body dressing and transfers. He needed substantial/maximum assistance for bed mobility (movement back and forth in bed, sitting to lying/lying to sitting) and set-up help only with eating. The MDS assessment documented the resident had a stage 3 pressure ulcer upon admission and was at risk for developing pressure injuries. The assessment documented the resident did not refuse care. B. Record review Resident #183's 9/25/24 wound observation documented preventative measures included wound dressing changes twice a day. Resident #183's skin care plan, initiated 9/25/24, documented he was admitted with a stage 3 sacral wound with an intervention to administer treatments as ordered. A review of Resident #183's physician orders revealed an order for wound care: Cleanse the area with normal saline (NS) and pat dry. Apply skin prep around the peri wound, using quarter strength soaked gauze, lightly pack the wound and leave a tail for removal, then apply foam dressing two times a day for a sacral wound stage 3, ordered 9/26/24. -However, a review of Resident #183's September 2024 treatment administration record (TAR) revealed on 9/27/24 and 9/29/24, within five days of his admission to the facility, his evening wound treatment was not documented as administered and there was no documentation Resident #183 refused his wound treatment. VIII. Resident #36 A. Resident status (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #36, age greater than 65, was admitted on [DATE]. According to the September 2024 CPO, diagnoses included acute respiratory failure, heart disease, heart failure, anxiety and stage 2 sacral (near the lower back) pressure ulcer. The 7/5/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. She was dependent and required total assistance with bathing, transfers, dressing, personal hygiene and rolling left to right/right to left in bed. She needed substantial assistance with eating and oral hygiene. The MDS assessment documented the resident had a stage 2 pressure ulcer upon admission and was at risk for developing pressure injuries. B. Record review Resident #36's skin care plan, initiated 6/30/24, documented she was admitted with a stage 2 sacral wound with an intervention to administer treatments as ordered and perform weekly skin checks. A review of Resident #36's physician orders revealed an order for weekly skin integrity and data collection, ordered 6/30/24. -However, a review of Resident #36's weekly skin assessments showed the facility failed to complete a skin integrity and data collection on 7/7/24, one week after Resident #36's admission. IX. Resident #23 A. Resident status Resident #23, age greater than 65, was admitted on [DATE] and readmitted [DATE]. According to the September 2024 CPO, diagnoses included end stage renal disease (decreased kidney function), dependence on renal dialysis, anemia in chronic kidney disease and protein-calorie malnutrition. The resident needed substantial assistance with transfers and partial/moderate assistance with bathing, lower body dressing and toileting hygiene. She was independent with eating and oral hygiene. The 9/14/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The MDS assessment documented the resident had a stage 3 pressure ulcer upon admission and was at risk for developing pressure injuries. The assessment documented the resident did not refuse care. B. Record review Resident #23's care plan, initiated 8/16/24, documented she was admitted with a stage 3 coccyx wound and she was seen by the wound team weekly. Pertinent interventions included a pressure reducing mattress and administering treatments as ordered. A review of Resident #23's physician orders revealed an order to check that Resident #23's air mattress was on and functioning every shift due to the presence of a coccyx wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-However, a review of Resident #23's September 2024 TAR revealed her pressure reducing mattress was not documented as having been checked on six of the evening shifts (9/3/24, 9/20/24, 9/25/24, 9/26/24, 9/27/24, 9/29/24) and two of the day shifts (9/5/24 and 9/8/24) in September 2024. 50690 X. Resident #21 A. Resident status Resident #21, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the September 2024 CPO, diagnoses included infection and inflammatory reaction due to an internal fixation device and a stage 3 pressure ulcer on the right upper back. The 8/31/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. He was independent with rolling in bed and required maximal assistance with transfers and dressing. The assessment revealed he was at risk of developing pressure ulcers and had no current, non-healed pressure ulcers. B. Resident #21 and resident representative interview Resident #21 and his representative were interviewed together on 9/30/24 at 3:27 p.m. Resident #21 and his representative said Resident #21 got the back wound at the hospital. They could not verify the date it was first noticed at the hospital. Resident #21 and his representative said the physician who treated the resident's elbow wound prescribed antibiotics that they thought were to treat the back wound as well. B. Observation On 10/2/24 at 3:40 p.m. Resident #21 was observed while LPN #2 performed wound care. Resident #21 sat in his wheelchair and leaned forward. LPN #2 removed the dressing on the resident's back. One wound was observed on Resident #21's middle back (on a part of his spine that protruded). The wound measured 2.0 cm by 0.6 cm by 0.2 [TRUNCATED]

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review and interviews, the facility failed to ensure one (#23) of two residents reviewed for dialysis care out of 35 sample residents received dialysis services consistent with professional standards of practice. Specifically, the facility failed to consistently complete the pre- and post-dialysis facility assessment section on dialysis communication forms for Resident #23. Findings include: I. Facility policy and procedure The Hemodialysis policy, reviewed 9/6/24, was received from the nursing home administrator (NHA) on 9/30/24 at 1:00 p.m. It revealed in pertinent part, The facility assures that each resident receives care and services for the provision of offsite hemodialysis consistent with the professional standards of practice. This includes ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility, and ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. Day of dialysis: follow physician orders regarding medication administration pre- and post-dialysis. Observe the vascular access site prior to dialysis and initiate the pre/post dialysis communication form to be sent to the dialysis clinic with the resident. Post-dialysis: obtain vital signs of the resident upon return from dialysis and complete the pre-post dialysis communication form. Maintain dialysis transfer forms in the resident's record-do not destroy. II. Resident #23 A. Resident status Resident #23, age greater than 65, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included end stage renal disease (decreased kidney function), dependence on renal dialysis, anemia in chronic kidney disease and protein-calorie malnutrition. The 9/14/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident needed substantial assistance with transfers, and partial/moderate assistance with bathing, lower body dressing, and toileting hygiene. She was independent with eating and oral hygiene. The MDS assessment documented the resident received dialysis care. B. Record review Review of Resident #23's September 2024 CPO revealed a physician's order for Resident #23 to receive dialysis on Tuesdays, Thursdays and Saturdays, ordered 8/17/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #23's pre- and post-dialysis communication forms located in the dialysis communication binder, revealed the communication forms had three sections which were to be filled out on dialysis days. The pre-dialysis section on the dialysis communication form was to be completed by the facility with the resident's vital signs, including temperature, pulse, respirations and blood pressure. The section included comments to identify any assessment concerns or medication changes which the facility wished to be communicated with the dialysis center, the condition of the access/site, and whether a meal was given to the resident to take to the dialysis center. A signature, staff title, date and time the assessment was completed were to be filled in by the facility staff. The second section on the dialysis communication form was to be completed by the dialysis center after the resident completed their dialysis session. The section included vital signs, pre-weight, post-weight, condition of the access site, whether any medications were given at the dialysis center and any recommendations or follow up from the dialysis center. A signature and date were to be filled in by the dialysis center nurse. The post-dialysis section on the dialysis communication form was to be completed by the facility with the resident's vital signs, including temperature, pulse, respirations and blood pressure and the condition of the access site. A signature, staff title, date and time the assessment was completed were to be filled in by the facility staff. Review of Resident #23's dialysis communication forms from 8/31/24 to 9/26/24 revealed the communication form was not completed appropriately on the following dates: -On 8/31/24 the facility did not complete the pre-dialysis or post-dialysis sections of the dialysis communication form. -On 9/3/24 the facility did not complete the pre-dialysis section of the dialysis communication form. -On 9/5/24 the facility did not complete the pre-dialysis section of the dialysis communication form. -On 9/14/24 the facility did not complete the vital signs information in the pre-dialysis section, sign the pre-dialysis section or complete the post-dialysis section of the dialysis communication form. -On 9/17/24 the facility did not complete the vital signs information in the pre-dialysis section, sign the pre-dialysis section or complete the post-dialysis section of the dialysis communication form. -On 9/19/24 the facility did not document the resident's pre-dialysis weight in the dialysis communication form or complete the post-dialysis section of the dialysis communication form. III. Staff interviews (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on 10/3/24 at 11:30 a.m. LPN #1 said Resident #23's vital signs should have been checked prior to the resident going to dialysis. LPN #1 said usually a certified nurse aide (CNA) checked vital signs but a nurse was also able to check vital signs. LPN #1 said staff should get the resident's vital signs the day of their dialysis appointment by 10:45 a.m. LPN #1 said she was not aware there was missing documentation on Resident #23's dialysis paperwork but she said, at times, Resident #23's blood pressure could get low and could explain some of the missing documentation in the dialysis binder if the resident did not attend the dialysis treatment. LPN #1 said the staff was supposed to weigh the resident at the facility prior to the resident going to dialysis. She said the vital signs and weights should be recorded on the dialysis communication forms in the binder prior to the resident going to dialysis. The director of nursing (DON) and the divisional director of clinical services (DDCS) were interviewed together on 10/3/24 at 3:08 p.m. The DDCS said the dialysis communication forms should be filled out consistently, including the pre-dialysis section, prior to the residents going to their dialysis appointments. The DON said when a resident returned to the facility from dialysis with the communication binder, the facility nurse should call the dialysis center to follow up and get a report for how much fluid was taken off the resident at dialysis and document the information in the resident's electronic medical record (EMR). The DON said the dialysis communication forms should include the necessary information because it could indicate the resident experienced a fluid volume loss that affected the resident's blood pressure and the physician might make further recommendations based on that information.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on record review and interviews, the facility failed to ensure one (#287) of five residents out of 35 sample residents was free from significant medication errors. Resident #287 was admitted to the facility on [DATE] for skilled nursing care after a failed left total knee revision. Secondary diagnoses included hypertension (high blood pressure), post-procedural pain and a history of heart failure. Resident #287's physician's orders for medications, upon his admission to the facility from the hospital on 6/20/24, included an order for carvedilol (a medication used to treat high blood pressure and heart failure) 6. 25 milligrams (mg) twice daily for heart rate and blood pressure (BP). The hospital's list of physician ordered medications was verified by the facility's physician. The medication orders were entered into Resident #287's electronic medical record (EMR) by licensed practical nurse (LPN) #2 on 6/20/24 at 3:55 p.m. and confirmed by LPN #3 on 6/20/24 at 4:51 pm. However, LPN #2 incorrectly entered the physician's order for carvedilol as 25 mg by mouth two times a day for hypertension, if systolic blood pressure was under 100 mm/hg (millimeters of mercury), notify the physician and document in a progress note. LPN #2 incorrectly entered the dose of the carvedilol as 25 mg instead of the physician ordered 6.25 mg, four times the dose the resident was ordered to receive. LPN #3 failed to catch the discrepancy when confirming the entered physician's orders one hour after they were entered into Resident #287's EMR. Resident #287 was administered the 25 mg dose of carvedilol on the evening of 6/20/24 and the morning of 6/21/24. As a result of LPN #2's and LPN #3's failure to accurately transcribe and confirm a physician's medication order, Resident #287 received two doses of the medication that were excessively high. He sustained hypotension (low blood pressure) and was transferred to the hospital intensive care unit on 6/21/24. He was treated for a medication overdose that required intravenous medications to support his blood pressure and circulation. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 9/30/24 to 10/3/24, resulting in the deficiency being cited as past noncompliance with a correction date of 6/28/24. I. Incident on 6/20/24 and 6/21/24 On 6/20/24 at 7:28 pm, Resident #287's BP was 112/59 mm/hg and the nurse administered the carvedilol medication to the resident. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-The resident was administered an incorrect dose of carvedilol 25 milligrams (mg) instead of the correct dose of 6.25 mg. On 6/21/24 at 7:05 am, Resident #287's BP was 102/52 mm/hg and the nurse administered the carvedilol medication to the resident. -The resident was administered an incorrect dose of carvedilol 25 mg instead of the correct dose of 6.25 mg. At 1:59 p.m., Resident #287's blood pressure was 73/94 [sic] mm/hg. -LPN #2 and LPN #3 failed to follow professional standards of nursing practice when entering and confirming physician's medication orders into the EMR. As a result of LPN #2 and LPN #3's failure to accurately transcribe and confirm a physician's medication order, Resident #287 received two doses of the medication that were excessively high. He sustained hypotension (low blood pressure) and was transferred to the hospital intensive care unit on 6/21/24. He was treated for a medication overdose that required intravenous medications to support his blood pressure and circulation. Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 9/30/24 to 10/3/24, resulting in the deficiency being cited as past noncompliance with a correction date of 6/28/24. II. Facility's plan of correction The corrective action plan implemented by the facility in response to Resident #287's medication administration failure on 6/20/24 and 6/21/24 was provided by the nursing home administrator (NHA) on 10/3/24 at 6:15 p.m. The plan revealed the following: A. Corrective action Resident #287 was assessed following the administration of the two larger doses of carvedilol. The physician was promptly notified and new orders for the correct dose were obtained. The resident was notified of the error and sent to the hospital for further evaluation. The resident's primary care physician at the facility reviewed the medical record and supplied the facility with his findings. Education was done with the two nurses who transcribed and verified the medication order upon admission. A root cause analysis was completed with the involved nurses, and corrective action was implemented based on the findings. B. Identification of others The facility reviewed hospital discharge medication orders and facility admission medication orders. Out of 41 admissions that were reviewed, there was one other error noted. That error had no adverse outcomes. The physician was notified and corrective action was implemented. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	C. Systemic changes Admission orders education was conducted from 6/25/24-6/28/24 and included the following: -All admission orders will have a second check completed by a nurse -The second check should consist of verifying the correct admission orders were entered by the first nurse -Orders should not be confirmed unless they meet the 10 rights of medication administration: right patient, medication, time, dose, route, right education/advice, right to refuse, right assessment, right evaluation/response and right documentation. -52 staff completed education on admission orders. -112 staff completed education regarding double checking blood pressures if abnormal results were obtained the first time. D. Monitoring -Review of medications will be done by the pharmacist upon admission and as needed. -Admission orders from the hospital are reviewed and entered by a nurse. A second nurse reviews the orders, comparing them to the transfer orders from the hospital. -If a medication error is identified, the process for medication variance will be followed, including prompt action to maintain safety for the resident, communicating with the physician, and implementing any provided orders. Additional education will be done with the nurses involved. This will be done within 24 hours of admission, and for two weeks or longer based on the level of compliance. The DON or designee, will conduct this review 3-5 (three to five) times per week for two weeks. -If significant abnormal vital signs are obtained, a second check will be completed using a manual cuff (for blood pressures). The DON will identify significantly abnormal vital signs and determine if re-checks have been completed. This will be done 3-5 (three to five) times per week for four weeks, and based on the results, additional training will be done with nurses. -The DON or designee will report audit findings and medication regimen review findings to the Facility quality assurance process improvement (QAPI) committee. The committee will review the findings and determine if the facility has achieved substantial compliance. The frequency of ongoing monitoring will be determined by the facility QAPI committee. -Education for nurses will be done upon hire and as needed regarding the facility process for transcribing and checking medication orders upon admission, rechecking abnormal vital signs, and the policy/procedure related to medication administration and errors. Date of correction was 6/28/24. III. Professional reference (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), Elsevier, St. Louis Missouri, pp. 606-607, retrieved on 10/7/24, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: the right medication, the right dose, the right patient, the right route, the right time, the right documentation and the right indication. IV. Resident #287 A. Resident status Resident #287, age 75, was admitted on [DATE] and transferred to the hospital on 6/21/24. According to the June 2024 computerized physician orders (CPO), diagnoses included a failed left total knee revision, post-procedural pain and hypertension. The minimum data set (MDS) assessment was not completed on the resident due to being in progress at the time of the resident's discharge. B. Record review A review of Resident #287's BP documentation revealed the following: -On 6/20/24 at 5:51 p.m. the resident's BP was 160/94; -On 6/20/24 at 7:28 p.m. the resident's BP was 112/59; -On 6/21/24 at 7:05 a.m. the resident's BP was 102/52; -On 6/21/24 at 8:56 a.m. the resident's BP was 112/60; and, -On 6/21/24 at 1:59 p.m. the resident's BP was 73/94 [sic]. A nursing progress note dated 6/21/24 at 10:55 a.m. documented that Resident #287 received two doses of carvedilol 25 mg per the admission order, which was transcribed incorrectly. There were no adverse effects noted. The nurses were educated, the order was corrected, the physician was notified, and a new order was received to monitor vital signs every four hours for 24 hours. The resident was informed of the error. The June 2024 CPO revealed a new physician's order for carvedilol oral tablet 6.25 mg was entered on 6/21/24 at 10:23 a.m. The June 2024 CPO revealed a physician's order for vital signs every four hours for one day, entered on 6/21/24 at 12:00 p.m. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A medical provider note dated 6/21/24 at 12:26 p.m. documented the medication error resulted in significant hypotension. The resident was seen laying in bed and was easily arousable, but lethargic and mildly dizzy. Staff was unable to establish an intravenous (IV) line to give him fluids, so the recommendation was to send him to the emergency room (ER). An order for a one time dose of Midodrine HCL (a medication used to treat low blood pressure) oral tablet 2.5 mg for hypotension, was entered on 6/21/24 at 1:15 p.m. A hospital transfer summary note, dated 6/21/24 at 3:15 p.m., documented that nursing gave Resident #287 Midodrine HCL 2.5 mg at 1:00 pm for hypotension as ordered by the physician. A nurse could not start an IV on Resident #287, so the resident was transferred to the hospital. The resident's wife and daughter, the DON, and the hospital emergency room were notified. An emergency room clinician note, dated 6/21/24 at 4:50 p.m., revealed Resident #287 received approximately 1400 milliliters (mls) of IV fluids. Given the resident's history of heart failure, the ER clinician started IV blood pressure medications, put in a central IV catheter, and admitted him to the intensive care unit. The medical director's investigation, not dated, was provided by the divisional director of clinical services (DDCS) on 10/3/24 at 5:38 p.m. The investigation revealed that the resident's prior hospital discharge summary showed he was on carvedilol (Coreg) 6.25 mg twice a day. The investigation documented the initial error was in the transcription of this order during admission to the facility of carvedilol as a 25 mg dose. The resident received two doses (an evening dose on 6/20/24 and morning dose on 6/21/24), with a first BP of 112/59 mm/hg and a second of 102/52 mm/hg. The investigation documented other medications that could have contributed to the low blood pressure were diazepam, furosemide, hydromorphone, loratadine, losartan, methocarbamol, mirtazapine, pramipexole and spironolactone. V. Staff interviews LPN #1 and LPN #4 were interviewed on 10/3/24 at 9:36 a.m. LPN #1 and LPN #4 said, when a resident was admitted from the hospital, the facility received the resident's discharge summary before they arrived. They said the admissions department entered the discharge summary information into the EMR, including the list of the resident's medications given by the hospital. LPN #1 and LPN #4 said the facility nurses looked at that information, the physician verified it, and then the nurses entered the orders into the computer. The director of nursing (DON) and the DDCS were interviewed together on 10/3/24 at 3:13 p.m. The DON said the new facility procedure for entering residents' admission medications was for the physician, the DON, and the unit manager to check orders for new residents. The DON said, previously, staff had not been doing adequate admissions for new residents and that staff should have triple checked new admission physician orders as part of the admission process. The DON revealed that now the facility had a nurse who audited resident charts and ensured all the assessments, plans, diagnoses and physician's orders were entered correctly. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The DDCS was interviewed again on 10/3/24 at 5:27 p.m. The DDCS said Resident #287 was at the facility for a very short time. She said there was a medication error that occurred which resulted in the resident receiving an incorrect dose of his blood pressure medication. She said the resident was admitted to the hospital's intensive care unit following the medication error. The DDCS said when the error occurred, the nurses responsible for entering the order, LPN #2 and LPN #3, admitted the error immediately. She said LPN #1, who administered the medication to the resident, took the resident's vital signs and then the resident was sent out for evaluation. The DDCS said she wrote a summary recommending the medical director review the resident's EMR, and if there were any concerns he should share them. She said the facility wrote a variance, reported the error, and called the doctor. She said the pharmacist reviewed the resident's medications and found the error. The DDCS said the physician and the resident were notified promptly that he got two doses of the 25 mg dose of the medication. She said vital signs equipment was checked to make sure it worked and the blood pressures were accurate. The DDCS said education was done with the two LPNs who were responsible for entering the physician's order and verifying it incorrectly and a plan of correction was done to ensure the error would not occur again.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on observations, interviews and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease on three of three units. Specifically, the facility failed to: -Ensure hand hygiene was consistently performed during wound care; -Ensure enhanced barrier precautions (EBP) were followed during wound care and for residents with an indwelling medical device (foley catheter) and/or a wound; -Ensure a suction canister containing oral secretions was handled in a sanitary manner; -Ensure blood glucose meters were cleaned in a sanitary manner after each use according to manufacturer recommendations; and, -Ensure vital sign machines were cleaned in a sanitary manner. Findings include: I. Facility policy and procedure The Infection Prevention and Control Program (IPCP) and Plan, revised 6/13/24, was provided by the nursing home administrator (NHA) on 9/30/24 at 1:30 p.m. It revealed in pertinent part, The facility has an ongoing infection prevention and control program (IPCP) to prevent, recognize, and control the onset and spread of infection to the extent possible and reviews and updates the IPCP annually and as necessary. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment and following accepted national standards; written standards, policies, and procedures for the program, which must include, but are not limited to: standard and transmission-based precautions to be followed to prevent spread of infections; and the hand hygiene procedures to be followed by staff involved in direct resident contact. General procedures included to ensure staff followed the IPCP's standards, policies and procedures (hand hygiene and appropriate use of PPE). II. Hand hygiene and EBP failures during wound care. A. Professional references (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Centers for Disease Control and Prevention (CDC) Hand Hygiene for Healthcare Workers, updated 2/27/24, retrieved on 10/10/24 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, Know when to clean your hands: immediately before touching a patient, before performing an aseptic task such as placing an indwelling device or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or patient's surroundings, after contact with blood, body fluids, or contaminated surfaces and immediately after glove removal. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings, always clean your hands after removing gloves, remember to remove gloves carefully to prevent hand contamination as dirty gloves can soil your hands. According to the CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDRO)'s, updated 4/2/24, retrieved on 10/10/24 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ target gown and glove use during high contact resident activities. EBP may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status and infection or colonization with an MDRO. Examples of high contact resident are activities requiring gown and glove use for EBP include: dressing, bathing/showering, transferring, providing hygiene, changing linens changing briefs or assisting with toileting, device care or use (central line urinary catheter, feeding tube, tracheostomy/ventilator), wound care (any skin opening requiring a dressing). B. Observations On 10/2/24 at 3:10 p.m. infection preventionist, who was also the facility's wound nurse, (IP) and the director of nursing (DON) entered Resident #38's room to perform wound care for the resident. The following observations were made: The IP performed hand hygiene and put on a gown and gloves before entering the resident's room. The DON performed hand hygiene and donned (put on) a pair of gloves. The DON proceeded to assist the IP with positioning Resident #38 onto his side and held him in place during the wound care. -The DON did not don a gown prior to entering the resident's room and assisting with the resident's wound care. The IP cleansed the resident's upper back wound with normal saline soaked gauze, then removed her gloves and disposed of them in trash. She immediately put on a pair of new gloves and placed medi-honey (a wound treatment) with a cotton swab into the wound bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The IP did not perform hand hygiene after the removal and disposal of her old gloves and before donning new gloves. On 10/2/24 at 3:20 p.m. the IP and the DON entered Resident #36's room to perform wound care for the resident.was The following observations were made: The IP performed hand hygiene and put on a gown and gloves before entering the resident's room. The DON performed hand hygiene and donned (put on) a pair of gloves. The DON proceeded to assist the IP with positioning Resident #36 onto his side and held him in place during the wound care. -The DON did not don a gown prior to entering the resident's room and assisting with the resident's wound care. The IP measured Resident #36's coccyx wound and removed her gloves. She immediately donned new gloves and cleaned the wound with normal saline soaked gauze. -The IP did not perform hand hygiene after removal of her old gloves and before donning new gloves. C. Staff interviews The DON and the IP were interviewed on 10/2/24 at 3:30 p.m. The DON said she was not the one who usually assisted the IP with wound care. She said she was not aware that she still needed to don a gown when coming into close contact with Resident #38 and Resident #36 during wound care, even if she was not directly providing the wound care. The DON said now that it had been brought to her attention, she would put on a gown, per EBP guidelines, when assisting with wound care. The IP said hand hygiene should be performed before and after resident contact with hand sanitizer. She said hands should be washed with soap and water if they were visibly soiled. She said hand hygiene should be performed after the removal of gloves and before putting on a new pair of gloves to help prevent the contamination of hands by the soiled gloves. III. Suction canister failure A. Observations On 9/30/24 at 1:39 p.m. room [ROOM NUMBER]-A was observed to have a used suction canister at the bedside. The suction canister was less than half full of yellow tinged clear to white liquid. The suction canister was undated. A suction tubing and an uncovered yankauer suction device were connected to the suction canister and hanging off the edge of the resident's bedside table. On 10/1/24 at 12:00 p.m. the used suction canister in room [ROOM NUMBER]-A was observed in the same position on the resident's bedside table as it was the day prior. The suction canister contained the to have the same level of oral secretions in it. The suction canister continued to be undated and the suction tubing and yankauer suction device continued to hang off the edge of the bedside table. B. Staff interviews (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed practical nurse (LPN) #6 was interviewed on 10/2/24 at 12:20 p.m. LPN #6 said she did not know how long the suction canister had been sitting on the resident's bedside table. She said therapy had been working with the resident for approximately one week prior to suctioning out her oral secretions. She said, once a suction canister was used, it should be disposed of at the end of the shift. She said the yankauer suction device should have a cover on it to keep it clean. She said the oral secretions in the suction canister contained microorganisms which could be a medium for growth of other infectious microorganisms. The DON was interviewed on 10/2/24 at 1:00 p.m. The DON said the resident in room [ROOM NUMBER]A did not have a current physician's order to be suctioned. She said it was difficult to determine how long the suction canister had been sitting at the bedside. She said the soiled suction canister should have been disposed of as it was a source of microorganisms. 47151 IV. Additional EBP failures A. Observations On 9/30/24 at 2:13 p.m. an unidentified staff member knocked on the door to Resident #177's room. Resident #177 had an indwelling foley catheter. Prior to entering the resident's room, the staff member donned a surgical mask, opened the door, entered Resident #177's room and told the resident he was going to have wound care. A second unidentified staff member then entered room Resident #177's room. At 2:23 p.m. the two unidentified staff members exited Resident #177's room. One staff member exited with a clear trash bag of disposable items. At 2:25 p.m. another unidentified staff member knocked on Resident #177's door, entered the resident's room holding a stack of clean, folded bedding and told the resident they were there to change the resident's bedding. A second staff member, certified nurse aide (CNA) #3, donned a yellow gown, a surgical mask and gloves and entered Resident #177's room. At 2:30 p.m. the unidentified staff member exited Resident #177's room with crumpled bedding in a clear trash bag. At 2:44 p.m. CNA #3 exited Resident #177's room. CNA #3 was no longer wearing PPE and was carrying two full clear trash bags, one of which contained a crumpled yellow gown. At 4:45 p.m. an EBP sign was observed posted outside Resident #177's door. The sign revealed in pertinent part, Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high contact activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at 9:26 a.m. an EBP sign was posted next to Resident #183's door to his room. The sign revealed in pertinent part, Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high contact activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use. On 10/2/24 at 10:21 a.m. an unidentified staff member knocked on the door to Resident #183's room and entered. At 10:22 a.m. CNA #1 entered Resident #183's room. Neither staff member donned a gown or surgical face mask prior to entering Resident #183's room. While in Resident #183's room, one of the staff members told Resident #183 he was going to be transferred into his chair. At 10:29 a.m. CNA #1 exited the resident's room. At 10:31 a.m. the unidentified staff member exited the room. B. Staff interviews CNA #3 was interviewed on 9/30/24 at 2:26 p.m., prior to entering Resident #177's room. CNA #3 said there were no gowns in Resident #177's room and gloves were the only PPE in his room. CNA #3 said the PPE was outside the door for residents who received wound care. CNA #1 was interviewed on 10/2/24 at 10:29 a.m., immediately after she exited Resident #183's room. CNA #1 said she and another CNA transferred the resident from his bed to a chair. CNA #1 said the resident was unable to use his legs, so both CNAs held the resident under his arms while they transferred him from his bed to the chair. CNA #1 said she was not aware the EBP sign posted outside Resident #183's room provided instructions to don a gown to transfer a resident with EBP. CNA #1 said she knew staff had to don a gown, gloves and mask to change a resident's bedding using EBP. -However, observation revealed CNA #1 did not don the appropriate PPE prior to transferring Resident #183 to his chair (see observations above). LPN #1 was interviewed on 10/3/24 at 11:30 a.m. LPN #1 said staff should don a gown and PPE according to the EBP sign and when doing wound care, bathing or transferring the residents with EBP. The DON) was interviewed on 10/3/24 at 3:08 p.m. The DON said the IP provided staff training on EBP, and followed up to ensure that all residents who required EBP had signs posted correctly. The DON said staff should don a gown for resident contact during transfers or lifting and changing residents bedding. 50690 V. Glucometer and vital signs machine disinfecting failures A. Professional reference (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Centers for Disease Control and Prevention (CDC) Guidelines for Environmental Infection Control in Healthcare Facilities (2019), was retrieved on 10/10/24 from https://www.cdc.gov/infection-control/hcp/environmental-control/index.html. It read in pertinent part, Careful cleaning of patient rooms and medical equipment contributes substantially to the overall control of Methicillin-resistant Staphylococcus aureus (MRSA), Vancomycin-intermediate Staphylococcus aureus (VISA) and Vancomycin-resistant Enterococci (VRE) transmission. Direct patient-care items (blood pressure cuffs) should be disposable whenever possible when used in contact isolation settings for patients with multiply resistant microorganisms. Non-critical items (those that come in contact with intact skin but not mucous membranes), are divided into noncritical resident care items (blood pressure cuffs, stethoscopes, wheelchairs, therapy equipment) and noncritical environmental surfaces (bed rails, bedside tables). They require cleaning followed by either low or intermediate level disinfection following manufacturers' instructions. Disinfection should be performed with an Environmental Protection Agency (EPA)-registered disinfectant labeled for use in healthcare settings. All applicable label instructions on EPA-registered disinfectant products must be followed (use-dilution, shelf life, storage, material compatibility, safe use and disposal). B. Facility policy and procedure The Cleaning and Disinfecting The Glucometer policy, revised 9/23/24, was provided by the nursing home administrator (NHA) on 10/2/24 at 5:34 p.m. It read in pertinent part, To prevent the spread of infection, specifically blood borne pathogens through the use of point of care blood glucose monitoring, by cleaning and disinfecting glucometers after each resident use. C. Observations During a continuous observation on 10/2/24, beginning at 8:54 a.m. and ending at 10:51 a.m., the following was observed: One glucometer was observed in the top drawer of the medication cart. RN #2 took the glucometer into room [ROOM NUMBER]. -At 9:24 a.m., after using the glucometer for the resident in room [ROOM NUMBER], RN #2 placed the glucometer on top of the medication cart and did not disinfect it. -At 9:28 a.m. she took the glucometer back into the same resident's room to do another blood sugar check. Upon returning to her cart, RN #2 placed the glucometer on top of the medication cart and did not disinfect it. -10:51 a.m., after another blood sugar check on the same resident in room [ROOM NUMBER], RN #2 put the glucometer in her pocket and left the area. She did not disinfect the glucometer. At 10:07 a.m. RN #2 took a vital signs machine into room [ROOM NUMBER]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 10:08 a.m. RN #2 brought the machine out of room [ROOM NUMBER]. At 10:09 a.m. RN #2 took the vital signs machine into room [ROOM NUMBER]. -RN #2 did not disinfect the vital signs machine in between residents At 10:13 a.m., an unidentified male CNA brought the vital signs machine out of room [ROOM NUMBER] and placed it in the hall near the [NAME] Creek nurses' station. -The unidentified CNA did not disinfect the vital signs after removing it from room [ROOM NUMBER]. At 10:16 a.m., the same unidentified male CNA took another vital signs machine, which had also been in room [ROOM NUMBER], out of the room and placed it in the hallway near room [ROOM NUMBER]. -The unidentified CNA did not disinfect the vital signs after removing it from room [ROOM NUMBER]. At 10:40 a.m., the same male CNA took the vital signs machine from near room [ROOM NUMBER] and brought it around the corner to sit next to the other vital signs machine near the [NAME] Creek nurses' station. One of the blood pressure (BP) cuffs fell on the floor and the CNA picked it up and placed it back in the basket attached to the machine. -The BP cuff and the vital signs machine were not cleaned. C. Staff interviews RN #2 was interviewed on 10/2/24 at 2:04 p.m. RN #2 said she was not taught the facility's policy for cleaning glucometers. RN #2 said there was only one resident who used the glucometer for blood sugar checks. She said she should have disinfected the vital signs machine in between residents but she forgot. The DON and divisional director clinical services (DDCS) were interviewed together on 10/3/24 at 3:13 p.m. The DDCS said the facility's policy was to use the glucometers for one patient and disinfect it according to the manufacturer's guidance, ideally as soon as it was used for the resident. The DON said that vital signs machines should be cleaned after each use on a resident to prevent the spread of any infection.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 47350 Based on record review and interviews, the facility failed to develop, implement and maintain an effective training program for all staff, including contract agency staff, based on the facility assessment and resident population. Specifically, the facility failed to complete orientation skills checklists and receipt of orientation packets, which included information for general orientation of the facility, medication administration, electronic medical record access, laundry procedures, resident transfers, gait belt usage and information on nursing documentation and admission of residents, for agency nursing staff. Findings include: I. Record review Review of agency nurse and certified nurse aide (CNA) records who were working in the facility revealed the following: Registered nurse (RN) #3 had an orientation packet receipt, signed 4/24/23. -RN #3 did not have an orientation skills checklist. CNA #7 had an orientation packet receipt, signed 2/10/23. -CNA #7 did not have an orientation skills checklist. -CNA #8 did not have an orientation packet receipt or a completed orientation skills checklist. CNA #9 had a skills orientation checklist, completed 8/15/23. -CNA #9 did not have an orientation packet receipt. -RN #4 did not have an orientation packet receipt or a skills orientation checklist. -Licensed practical nurse (LPN) #7 did not have an orientation packet receipt or a skills orientation checklist. RN #2 had an orientation packet receipt, signed in February 2023. -RN #2 did not have a completed skills orientation checklist. II. Staff interviews (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN #2 was interviewed on 10/2/24 at 1:00 p.m. She said she had been working at the facility for a year and did not recall any formal orientation to the facility. She said she did not receive a packet or an orientation skills checklist. She said she figured out what she needed to do or know on her own. RN #2 said she was not formally assigned to a mentor or preceptor but she asked other staff members and management if she had any questions. -However, a signed receipt of the orientation packet was provided by the staffing coordinator (SC) (see above). The director of nursing (DON) was interviewed on 10/2/24 at 1:09 p.m. The DON said she was new to the facility in the last two weeks and she did not know the process to orient outside agency nursing staff to the facility. She said the SC was in charge of ensuring agency staff received orientation. The SC and the DON were interviewed together on 10/2/24 at 1:20 p.m. The SC said she had taken over the role of orienting agency staff members in the last week due to an abrupt resignation of another staff member that had previously been in charge of orienting agency staff to the facility. She said agency staff should be given an orientation packet and assigned to a mentor. The SC said agency staff were given an orientation skills checklist to complete. She said the orientation skills checklist was not started until May of 2023. The SC said the facility had not used any outside agency staff again until recently within the last two weeks. She said if the facility had any changes to their existing policies, agency staff would be given a refresher of the information. The SC said she did not know why agency staff that currently worked at the facility, and had worked at the facility a year prior, did not have completed orientation packet receipts and orientation skills checklists.