STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075240	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Glendale LLC	4 Hazel Ave Naugatuck, CT 06770

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 15802 Based on review of facility documentation and policy for 1 of 5 personnel files reviewed, the facility failed to conduct a required background for an LPN, according to policy, prior to hire. The findings include: LPN #2's hire date was 1/17/22. Review of LPN #2's personnel file identified that LPN #2 consented to a background check on 1/6/22, however, the file did not contain the state required ABCMS background check, including fingerprinting. Interview with the Director of HR on 1/26/24 at 1:00 PM identified LPN #2 did not have the required background check prior to hire. The Director of HR identified that she did not know why the background check was not done as it was prior to her employment at the facility. Review of the facility policy on background checks identified all offers of employment are contingent upon clear results of a thorough background check. Background checks will include social security verification, prior employment verification, personal and professional references, criminal history and state specific background checks, i.e. facilities operating in states that require state specific background check processes shall be adhered to per state guidelines.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 9 residents (Resident #40) reviewed for PASSAR, the facility failed to submit a PASSAR when a resident received a new diagnosis. The findings include: 1. Resident #40 was admitted to the facility initially on 5/12/14 with a diagnosis that included mild or situational depression, myocardial infarction, and urinary tract infection. A PASARR Level 1 dated 5/1/14 identified Resident #40 had a diagnosis of mild or situational depression with no major mental illness and no diagnosis of dementia. The outcome from the assessment indicated a 120 day short term approval. Resident #40 was readmitted to the facility on [DATE] with diagnoses that included anxiety disorder, congestive heart disease, depression, and cerebral infarction. The care plan dated 3/25/23 identified Resident #40 was at risk for distressed and fluctuating mood symptoms related to diagnosis of depression. Interventions included to monitor for signs and symptoms of worsening sadness and depression. The annual MDS dated [DATE] identified Resident #40 had severely impaired cognition, a diagnosis of dementia, anxiety disorder, depression other than bipolar, and psychotic disorder other than schizophrenia, and received antidepressants 7 days a week. The social worker annual assessment dated [DATE] identified Resident #40 was not considered by the state level 2 PASARR process to have a serios mental illness and/or intellectual disability or a related condition. Interview with the MDS Coordinator, (RN #5) on 1/24/24 at 9:49 AM identified Resident #40 had an MDS dated [DATE] that indicated no for a diagnosis for PASSAR. RN #5 indicated Resident #40 was admitted without a diagnosis of dementia but in October of 2022 was given a diagnosis of dementia. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with SW #1 on 1/24/24 at 10:15 AM indicated social services was responsible to update the PASSAR when there was a new psychiatric diagnosis or if someone came in as a Level 2 and needed updates based on how many days the resident was approved for. SW #1 indicated after the surveyor requested the PASSAR for Resident #40, SW #1 indicated she reviewed the medical record and had noticed Resident #40 had a diagnosis of major depression after admitted d 5/12/14, but that diagnosis was not on the admission PASSAR. SW #1 indicated at that time a new PASSAR should have been done with the new diagnosis and it wasn't done. SW #1 indicated Resident #40 had a 120 day approval and there was not another PASARR completed at that time. SW #1 indicated it also did not get picked up when the prior social worker, SW #2, had done an audit of all PASSAR's for all residents that were in the facility in beginning of 2022. SW #1 indicated when she started in early 2022, the SW #2 had completed an audit of all PASSAR's in the facility a couple of months before she left and informed her that all the PASSAR's were up to date and were all set. SW #1 indicated she assumed, moving forward, she only had to review the PASSAR's on admission and when psychiatry identified a new psychiatric new diagnosis. SW #1 indicated it was missed and was an oversight. SW #1 indicated that she submitted a new PASSAR on 1/23/24 and today she received the outcome of the PASSAR as a Level 1 exempt due to the new diagnosis of dementia in 2022. SW #1 indicated she and the other social workers at the facility had started an audit yesterday of all PASSAR's in the facility to make sure the diagnosis on the PASSAR matches the diagnosis list in the medical record and would update PASARR if needed. Review of the facility preadmission screening for mental illness and/or intellectual development disability policy identified facility staff will ensure that appropriate pre-admission screening for mental illness and intellectual disability was conducted per federal and state regulations. Individuals identified with mental illness, or intellectual or developmental disability will be provided with appropriate services. The facility staff will ensure upon admission the pre-admission screening and resident PASARR has been completed. If a PASSAR is incomplete or incorrect, social services will coordinate with appropriate needs and services and any recommendations with be incorporated into the plan of care. Completed PASSAR's will be kept in the medical record. Social Services will coordinate any updates as needed and per the federal and state regulations. 46040

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility policy, and interviews for the only sampled resident (Resident #83) reviewed for psychiatric medication side effects, the facility failed to ensure a status change Level 1 PASRR screen was completed. The findings include: Resident #83 was admitted to the facility on [DATE] with diagnoses that included neoplasm of the brain, anxiety, and major depressive disorder. Review of the Notice of PASRR Level 1 Outcome report dated 5/27/21 identified Resident #83 had situational low level behavioral health symptoms, a diagnosis of major depression with no indicators identified that would signify the need for further evaluation, at that time. The report further identified that if Resident #83's symptoms/behaviors did not improve or resolve within 30 - 60 days of the screen, then the nursing facility must submit an updated status change Level 1 screen to reevaluate the need for a PASSR Level 2 behavioral health evaluation. The annual MDS dated [DATE] identified Resident #83 had intact cognition, had an active diagnosis of depression, and had taken an antidepressant during the last 7 days. The care plan dated 12/15/23 identified Resident #83 exhibited or was at risk for distressed fluctuating mood symptoms related to anxiety or fear. Interventions included observing for signs of delirium, including delusions and hallucinations; notifying the physician as needed, and referencing the delirium care plan for additional interventions. The care plan further identified Resident # 83 was at risk for complications related to the antidepressant, needed daily, to manage his/her mood. Interventions included observation of Lexapro side effects, completion of the behavior monitoring flow sheet, monitoring for changes in mental status and functional level, and reporting changes to the physician, as indicated. Interview with SW #3 on 1/26/24 at 10:52 AM identified that since Resident #83's admission on 4/22/21, 4 Level of Care evaluations had been completed, but an updated status change Level 1 screen, per the recommendation on the 5/26/21 PASAR Level 1 Outcome report, had not been submitted. SW #3 indicated that since Resident #83's behavioral health symptoms/behaviors did not improve or resolved within 30 - 60 days of the initial screen, the facility should have submitted another Level 1 PASRR screen. Interview with the Director of Social Service (SW #1) on 1/26/24 at 11:00 AM identified that another Level 1 PASRR screen should have been submitted for Resident #83. SW #1 further identified that another Level 1 PASRR screen will be submitted for Resident #83 and that an audit of all facility PASRR outcome reports will be conducted to ensure there are no additional residents that had missed a screening or evaluation. The facility's Pre-Admission Screening for Mental Illness and/or Intellectual/Developmental Disability policy directs facility staff to ensure that appropriate pre-admission screening for mental illness and/or intellectual/developmental disability is conducted per the federal/state regulations. Social Services will review the PASRR to determine appropriate needs/services and any recommendations will be incorporated into the plan of care.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #74) reviewed for positioning, the facility failed to ensure positioning in wheelchair per policy. The findings include: Resident #74 was admitted to the facility with diagnoses that included muscle weakness, difficulty in walking and dementia. An Occupational Therapy note dated 12/7/23 identified Resident #74 was a fall risk and dependent on staff to put on and take off footwear. Resident #74 utilized a wheelchair and could sit unsupported for 30 seconds with his/her feet flat on floor but was unable to stand unsupported with an assistive device. The quarterly MDS dated [DATE] identified Resident #74 had severely impaired cognition, was always incontinent of bowel and bladder and required maximum assistance for transfers from bed to chair and toilet transfers. Resident #74 was independent with self-propelling in a standard wheelchair at least 150 feet in hallway and 50 feet when making 2 turns. Resident #74 was non ambulatory. A physician's order dated 1/10/24 directed a pressure redistribution cushion to chair. The care plan dated 1/18/24 identified the resident was at risk for skin breakdown due to limited mobility. Interventions included applying pressure redistribution surfaces to chair as per guidelines. Resident #74 uses a sit to stand lift for transfers. Resident #74 self-propels in wheelchair so keep room free from clutter. Observation on 1/22/24 at 10:10 AM identified Resident #74 was self-propelling down the hallway in a standard wheelchair using only his/her arms. The resident's legs were unable to reach the floor and observed extended outward and dangling about 4-5 inches above the floor. The wheelchair was without the benefit of leg rests. Interview with Resident #74 on 1/22/24 at 10:11 AM indicated he/she does not have leg rests but was requesting if someone could get some. Resident #74 indicated he/she was not comfortable in the wheelchair because his/her legs did not reach the floor because of a new cushion. Interview with NA #1 on 1/22/24 at 10:12 AM indicated she provided morning care for Resident #74 and the resident required a stand pivot with one assist out of bed to the standard wheelchair. NA #1 indicated Resident #74 did not have leg rests in his/her room for the wheelchair. NA #1 searched the room and the closet and indicated no leg rests could be found and identified she did not know how long they have been missing. NA #1 indicated she did not inform anyone about the missing leg rests. Interview with NA #2 on 1/22/24 at 10:15 AM indicated that the central supply person had received several new wheelchair cushions, and the central supply person went around giving residents new cushions. NA #2 indicated the central supply person gave Resident #74 a new cushion last Friday, but the new cushion was higher than the last cushion Resident #74 had. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of the Rehabilitation Department (PT #1), on 1/22/24 at 10:18 AM indicated that everyone was responsible for assigning cushions to wheelchairs. PT #1 indicated that sometimes it is the rehab department, sometimes nursing and sometimes the central supply person. PT #1 indicated Resident #74 self-propels sometimes with his/her arms and sometimes with his/her legs. PT #1 indicated Resident #74 sometimes uses leg rests for going outside and Resident #74 sometimes attempts to stand independently and was a fall risk. PT #1 indicated if there were leg rests on Resident #74's wheelchair, it could be more dangerous if Resident #74 attempted to stand up with the leg rests on the wheelchair. In an observation of Resident #74 while in the wheelchair, PT #1 indicated that Resident #74's feet do not touch the floor and were about 4 inches from the floor. PT #1 indicated Resident #74 was sitting on a higher cushion than he remembers. PT #1 indicated he could lower the wheelchair to use the same cushion or change the cushion so Resident #74's feet would reach the floor. PT #1 indicated he could also add leg rests. In an interview with Resident #74 on 1/22/24 at 10:20 AM he/she informed PT #1 that he/she was not comfortable with the positioning in the wheelchair. Resident #74 indicated he/she would like to try changing the cushion and have leg rests. Interview with LPN #1 on 1/22/24 at 10:30 AM indicated Resident #74 only uses his/her arms to self-propel in the wheelchair and does not use his/her legs. Interview with PT #1 on 1/22/24 at 10:35 AM identified the measurement from Resident #74's feet to the floor was 4.5 inches and the new cushion on the wheelchair was 2.5 inches high. PT #1 indicated the old cushion was only about a half inch high. PT #1 indicated he could lower the wheelchair and change cushion and give Resident #74 leg rests. PT #1 with OT #1 searched Resident #74's room and indicated there were no leg rests in the room and did not know how long they were not available. In an interview on 1/22/24 at 10:45 AM, Resident #74 reported to PT #1 and OT #1 he/she wanted leg rests. After surveyor inquiry, a physician's order dated 1/22/24 directed occupational therapy evaluation and treatment as recommended. Observation on 1/24/24 at 8:36 AM identified Resident #74 was sitting in his/her wheelchair eating breakfast with a one-inch cushion and bilateral leg rests on the wheelchair with his/her legs resting on the leg rests. Interview with the Staff Development Nurse, (RN #1) on 1/24/24 at 8:45 AM indicated nursing staff are educated on a web-based system with paper posttest. RN #1 indicated the nursing staff must have competencies. RN #1 indicated if a resident cannot self-propel with their legs, then the wheelchair must have leg rests. Interview with LPN #1 on 1/24/24 at 9:00 AM indicated therapy was in with Resident #74 this morning and gave Resident #74 a smaller cushion which was not as high for the wheelchair and leg rests to make him/her more comfortable. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Director of Rehabilitation (PT #1), on 1/25/24 at 10:45 AM indicated on 1/22/24 he lowered Resident #74's wheelchair, added leg rests and changed the cushion. PT #1 indicated Resident #74 was picked up by OT for positioning and was now on case load. Review of the facility use of a wheelchair policy identified the purpose was to provide mobility for non-ambulatory residents with safety and comfort. A wheelchair should be the proper size: if too large the resident will not maintain good body alignment and if too small skin irritation will result due to pressure. Do not remove leg rests unless resident uses feet on floor to enable mobility. Pad seat of the chair with a pressure reducing cushion. Ensure cushion has a cover. Assist resident into wheelchair and lower leg rests and place resident's feet on the footrests. Position feet and legs in proper body alignment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident #29) reviewed for pressure ulcers, the facility failed to ensure that a low air loss mattress was applied timely for a resident admitted at risk of skin breakdown, and failed to ensure that an RN assessment was completed on a newly identified skin issue. The findings include: Review of the hospital discharge summary dated 11/23/23 identified Resident #29 was discharged from the hospital to the facility with a wound vac in place at the right hip due to an abscess requiring surgical intervention. Resident #29 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, osteomyelitis of the right femur, and insulin dependent diabetes. The care plan dated 11/23/23 identified Resident #29 was at risk for skin breakdown due to decreased mobility, incontinence, and actual skin breakdown related to a right hip pressure wound with wound vac. Interventions included completing weekly wound assessments to include measurements and description of the wound status. The Braden Scale (used to determine risk of pressure ulcer development) dated 11/23/23 identified that Resident #29 had a high risk of developing pressure ulcers. The admission MDS dated [DATE] identified Resident #29 had severely impaired cognition, was always incontinent of bowel, frequently incontinent of bladder and required maximum assistance with bathing, eating, and toileting. The MDS further identified Resident #29 was at risk for development of pressure ulcers. A physician's order dated 12/5/23 directed to apply a low air loss mattress with a setting of 160 lbs. The order further directed to check settings and function every shift. Review of the clinical record failed to identify that a low air loss mattress had been placed prior to 12/5/23, 12 days after admission. A nurse's note dated 12/17/23 at 2:43 AM by LPN #4 identified that Resident #29 had a change of condition evaluation due to newly identified skin issue. LPN #4 identified Resident #29 had a 2 cm x 3 cm pressure injury with blackened skin at the sacrum. The note further identified the APRN and Person #1, Resident #29's resident representative, were notified. Review of the clinical record failed to identify an RN assessment was completed following the development of the newly identified skin issue on 12/17/23. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A wound care physician's note dated 12/19/23 identified Resident #29 was seen for follow up evaluation of a right hip post-surgical wound, and an initial evaluation of an unstageable full thickness pressure injury to the sacrum. The sacral wound measured 4.5 cm x 5.5 cm and the depth of the wound was unstageable due to the presence of nonviable tissue and necrosis. The treatment plan included a daily dressing of calcium alginate with silver, gauze island, and border dressing daily. The care plan dated 1/22/24 identified Resident #29 was at risk for skin breakdown due to decreased mobility, incontinence, and actual skin breakdown related to a right hip pressure wound with wound vac and a newly developed sacral pressure ulcer. Interventions included the use of a low air loss mattress and to check the function and settings every shift. Interview with Person #1 on 1/22/24 at 10:24 AM identified that Resident #29 had a pressure ulcer that developed after admission to the facility. Person #1 identified that Resident #29 originally came to the facility for care of a right hip wound and developed an area on his/her back side a couple of weeks after admission. Person #1 identified that he/she was upset about the new pressure ulcer, as he/she felt the facility should have had interventions in place due to Resident #29's history with wounds. Interview with LPN #2 on 1/25/24 at 1:45 PM identified she was unsure when the low air loss mattress was placed, but there had been issues with the settings related to firmness that happened 'a few months ago' and that maintenance recommended the setting of 160 lbs. LPN #2 identified she reached out to maintenance about the mattress a couple of days after the mattress was placed, but by verbal request, and that the placement and documentation of maintenance assisting would not have any documentation. Interview and review of the clinical record with RN #3 on 1/26/24 at 11:13 AM identified that Resident #29 was admitted to the facility with a wound vac to the right hip. RN #3 identified that Resident #29 was initially scheduled to see an outside wound care physician, but at some point, that changed and subsequently the facility wound care physician saw Resident #29 for an initial evaluation on the morning of 12/5/23. RN #3 identified that during the initial evaluation, she saw that Resident #29 had a low air mattress in place, but the mattress felt too soft and so the weight was increased to 160 lbs. to increase the firmness. RN #3 identified she was unaware how long Resident #29 had the mattress in place, who placed it, or why it would have been placed without a physician's order prior to 12/5/23. RN #3 identified that the facility had a system to request low air loss mattresses and she would research to see if a request had been made for the mattress to determine when it was applied to Resident #29's bed. RN #3 also identified that Resident #29 should have had an RN assessment following the newly identified pressure ulcer on 12/17/23 by LPN #4. RN #3 further identified LPN #4 would not be able to make the determination if a wound was related to a pressure injury, and that an RN assessment would be necessary to determine this. RN #3 identified that she was typically notified of newly identified skin issues by the nursing staff via 'a sticky note on my desk', text, or 24-hour report sheets, and she would often complete an RN assessments of new wounds, but that a nursing supervisor could also assess any new skin issues. RN #3 also identified she did review charts of residents with newly identified skin issues. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 1/26/24 at 11:42 AM identified that for any newly identified skin issues, an RN assessment should be completed. The DNS identified an LPN would not be able to make an assessment if a skin issue was related to a possible pressure injury, and that would need to be determined by an RN. The DNS identified she did not complete an RN assessment of Resident #29's wound on 12/17/23 and she was unsure why a RN had not assessed Resident #29's wound until 12/19/23 as this was not the facility policy. Interview with the Regional Clinical Manager on 1/26/24 at 11:59 AM identified that the low air loss mattress for Resident #29 was not located in the facility system, and he was unable to determine when the mattress was applied. Although requested, the facility failed to provide a policy on Braden Scale assessments, a policy on newly identified skin issues or a policy on low air loss mattresses. The facility policy on nursing assessments directed that LPNs may assist an RN to collect data for nursing assessments, but assessments would be reviewed, coordinated, and certified as complete by RN within 24 hours of the assessment. The policy further directed that nursing assessments included a change of condition.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #102) reviewed for respiratory care, the facility failed to follow the manufacturer recommendations in the cleaning and storage of a CPAP (continuous positive airway pressure is a machine that uses mild air pressure to keep breathing airways open while you sleep.) The findings include: Resident #102 was admitted to the facility on [DATE] with diagnoses that included obstructive sleep apnea and dependance on others for enabling machines and devices. The care plan dated 8/31/23 identified Resident #102 was at risk for respiratory complications related to sleep apnea. Interventions included maintaining CPAP per order. The admission MDS dated [DATE] identified Resident #102 had intact cognition and required supervision or touching assistance for bathing, upper and lower body dressing and required non-invasive mechanical ventilators such as Bi-PAP or CPAP. A physician's order dated 1/10/24 directed to provide CPAP 5/15 back up rate 5/15 oxygen liter flow: apply at bedtime and remove in the morning. Interface type: full face mask. Humidification (if appropriate) heated or cool. Fill humidifier with sterile or distilled water. The physician orders did not direct how often and how much distilled water to use, when to change the CPAP filter, or when to clean and change the full face mask and tubing. Observation on 1/22/24 at 7:45 AM identified Resident #102 was lying flat in bed with eyes closed. Resident #102 had a CPAP machine on top of the nightstand with the CPAP mask without the benefit of being bagged, and the mask and tubing were not dated. Interview with Resident #102 on 1/22/24 at 7:45 AM indicated he/she had been at the facility since last summer (2023) and no one in the facility had ever changed the CPAP face mask or tubing. Resident #102 indicated he/she does not have a bag to put his/her face mask in to keep it clean. Interview with the DNS on 1/22/24 at 12:09 PM indicated the CPAP tubing was to be changed weekly, but she did not answer how often the mask needed to be changed and stated she would get the policy. The DNS indicated she would get a bag for the mask then indicated she would throw away the mask and tubing and get a new mask and tubing. The DNS also did not answer how often the filter on the CPAP machine should be changed or how often the tubing gets cleaned/changed. The DNS went into the medication room with LPN #1. The DNS discarded the CPAP masks because it was not bagged. The DNS indicated the nurse on Saturday 11:00 PM -7:00 AM was responsible to change the tubing and masks weekly. The nurse's note, written by the DNS, dated 1/22/24 at 1:35 PM identified that a request was sent to the oxygen company for replacement CPAP mask. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Glendale LLC	4 Hazel Ave Naugatuck, CT 06770

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility CPAP/BiPAP Cleaning Policy identified clean the CPAP frame when visibly soiled after use with soap and water. Dry well. After using cover with plastic bag or completely enclosed in machine storage when not in use. Follow manufacturer instructions for frequency of cleaning and repairing filters and servicing the machine. Replace the equipment routinely in accordance with manufacturer recommendations. General guidelines face mask and tubing change once every 3 to 6 months and headgear, non-disposable able filters, and humidifier chamber once every 6 months. Review of the manufacturer manual for the CPAP identified the filter screens out normal household dust and pollens and provides a more complete filtration of very fine particles. The blue pollen filter needs to be rinsed once at least every 2 weeks and replaced sooner if appears dirty or damaged. The disposable ultra fine filter needs to be replaced after 30 nights of use. Cleaning the tubing, hand wash the tubing and mask before first use and then daily. Wash with warm water and liquid dish soap, rinse thoroughly and air dry.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #102) reviewed for respiratory care, the facility failed to have physicians' orders signed in a timely manner. The findings include: Resident #102 was admitted to the facility on [DATE] with diagnoses that included obstructive sleep apnea, stroke, heart disease, and epilepsy. The care plan dated 8/31/23 identified Resident #102 was at risk for seizures. Interventions included medicating resident per physician order and monitor effectiveness. Review of physician's orders dated 8/31/23 - 10/31/23 failed to reflect the physician/APRN had signed and dated the orders. The admission MDS dated [DATE] identified Resident #102 had intact cognition and required supervision or touching assistance for bathing, upper and lower body dressing. Additionally, required non-invasive mechanical ventilators such as Bi-pap or CPAP. Review of physician's orders dated 12/1/23 - 12/31/23 failed to reflect the physician/APRN had signed and dated the orders. Interview with RN #3 on 1/25/24 at 6:20 AM indicated the physician must sign the admission orders then sign monthly orders every month for 3 months and then monthly or every 60 days. RN #3 indicated MD #2 signs his orders electronically and does not let the APRN's sign his resident's orders. Interview with the Unit Manager (RN #4) on 1/25/24 at 8:30 AM indicated the physician must see the resident and sign admission orders within 24 hours, then monthly by the APRN or physician. RN #4 indicated the APRN's and physicians in facility can sign the orders electronically. RN #4 indicated MD #2 will usually sign the interim and monthly orders electronically. After clinical record review, RN #4 indicated MD #2 had only signed the monthly orders for November 2023 and January 2024 electronically. RN #4 indicated the admission orders for August 2023, monthly orders for September, October, and December 2023 were not signed electronically or in the paper chart. RN #4 indicated MD #2 prefers to sign his own orders. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Medical Records Person #1 on 1/25/24 at 9:00 AM indicated she and the DNS were responsible to make sure the physician orders and the admission history and physical were completed, signed and dated within 48 hours. Medical Records Person #1 indicated the physician was responsible to sign the monthly orders every 30 days for the first 3 months and then they can continue every 30 or 60 days. Medical Records Person #1 indicated the physicians usually don't do every 60 days, the physicians here usually sign orders every 30 days, unless there was a physician's order for the monthly orders to be renewed every 60 days if the resident was stable. Medical Records Person #1 indicated MD #2 only signs orders electronically, not on paper. After review of the paper clinical record, Medical Records Person #1 indicated the admissions, interim and monthly orders were not signed by a physician. Medical Records Person #1 indicated she did not know how to look in the electronic medical record to see if the physician had signed the monthly and interim orders electronically. Interview with the DNS on 1/25/24 at 9:05 AM indicated that the physicians have to sign admission orders within 48 hours of admission, then every 30 days for 3 months, and then every 60 days, but most physicians want to review, and sign orders every 30 days at this facility. After review of the medical record, the DNS indicated the physician orders were only signed electronically by the physician and were only signed on 11/8/23 and 1/10/24. The DNS indicated that MD #2 does not allow the APRN's to sign his physician's orders including Resident #102 electronically. Interview with MD #2 on 1/25/24 at 9:27 AM indicated he was responsible to sign the admission orders, monthly orders, and interim orders for his residents. MD #2 indicated he was responsible to see all new admissions within 48 hours and sign the admission orders. MD #2 indicated goes to the facility on ce a week and he tries to get to the facility within the 48 hours of a new admission. MD #2 indicated he signs all orders electronically in the computer and does not sign the orders in the charts. MD #2 indicated he believes the APRN's do not sign the physician's orders in the electronic medical record. After electronic clinical record review for Resident #102, MD #2 indicated he only signed the residents orders on 11/8/23 and 1/10/24 and were next to be reviewed and signed on 2/9/24. MD #2 indicated he does not know why he did not sign the admission orders for Resident #102 or the monthly orders for September, October, and December 2023. Review of the admission orders policy identified that a physician must personally approve, in writing, a recommendation that an individual be admitted to a facility. A physician, physician assistant, nurse practitioner or clinical nurse specialist must provide written and or verbal orders for the resident's immediate care and needs. The orders should allow facility staff to provide essential care to the resident consistent with the residents mental and physical status on admission. Although requested, a policy regarding the signing of physician's orders was not provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #65) reviewed for unnecessary medications, the facility failed to ensure the attending physician reviewed and responded to the pharmacy consultant's recommendations. The findings include: Resident #65 was admitted to the facility on [DATE] with diagnoses that included heart failure, bradycardia, and chronic atrial fibrillation. Review of the consultant pharmacist's medication regimen review dated 7/15/23 identified the resident is currently receiving Amiodarone 200mg twice daily. After initial dosing and steady state is achieved, the most recommended dose is 100mg once daily to minimize side effects. Please evaluate the current need for a higher dose. Consider tapering to standard maintenance dose of 100mg once daily, if appropriate. The facility responded as follows; (would defer to the consultant cardiologist to evaluate). A physician's order dated 9/29/23 directed to administer Amiodarone HCL 200mg by mouth two times daily, for arrythmia. Review of the consultant cardiologist's nursing facility subsequent visit documents dated 10/25/23 and 11/8/23 identified that Resident #65 was receiving Amiodarone 200 mg. The visit documents failed to identify if the consultant cardiologist had reviewed the pharmacist's 7/15/23 recommendation to re-evaluate the current need for a higher dose of Amiodarone. Review of the consultant pharmacist's medication regimen review dated 12/5/23 identified the resident is currently receiving Amiodarone 200mg twice daily. After initial dosing and steady state is achieved, the most recommended dose is 100mg once daily to minimize side effects. Please evaluate the current need for a higher dose. Consider tapering to standard maintenance dose of 100mg once daily, if appropriate. The facility responded as follows; (would defer to the consultant cardiologist to evaluate). The quarterly MDS dated [DATE] identified Resident #65 had intact cognition and during the last 7 days received medication from the following high-risk pharmacological classifications: antianxiety, anticoagulant, diuretic, and opioid. The care plan dated 1/5/24 identified Resident #65 was at risk for cardiovascular symptoms or complications related to his/her diagnoses of atrial fibrillation, congestive heart failure, bradycardia, and hyper/hypotension episodes. Interventions included administering cardiac medications as ordered, assessing and monitoring vital signs, monitoring labs, and reporting abnormal labs to the physician. The care plan further identified Resident #65 was receiving diuretic therapy related to edema and congestive heart failure. Interventions included monitoring the medication dose to achieve desired effects while minimizing adverse consequences, especially when multiple antihypertensives were prescribed simultaneously. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with the consultant cardiologist (MD #3) on 1/26/24 at 8:46 AM identified that he did not have access to his notes, and he was unable to recall if he had reviewed the consultant pharmacist's medication regimen review dated 7/15/23, to evaluate the Amiodarone dosing recommendation. MD #3 further identified that he would not have agreed to the Amiodarone reduction to 100mg once daily as Resident #65 was not appropriate for such a big dose reduction. MD #3 indicated however he would add Resident #65 to his list to evaluate during his next visit to the facility and review the Amiodarone dosing. Interview with the Unit Manager (RN #5) identified that she oversees cardiac rounds when the consultant cardiologist visits the facility, and her responsibilities include prepping the resident's medication list, x-rays, recent labs, etc. that will need to be reviewed by the cardiologist, accompanying the physician during rounds, discussing recommendations for testing, labs, medication, or treatment changes with the cardiologist, and lastly communicating updates to the medical APRN. RN #5 indicated that the cardiologist documents his notes, including a medication review, on the consultation sheet; a copy of the consultation is placed in the resident's medical record. RN #5 identified that she did not have a direct answer as to why the medication regimen reviews dated 7/15/23 and 12/5/23, deferring to a cardiology evaluation, lacked documentation that the review was completed. Interview with APRN #1 on 1/26/24 at 11:37 AM identified that she did not have access to her computer and without her documentation in front of her would not be able to answer specific questions. APRN #1 further identified that for a recommendation related to Amiodarone dosing she would defer to the consulting cardiologist. APRN #1 indicated that the process for the monthly medication regimen review is that she would indicate if a recommendation needed to be reviewed by one of the consultants and document as such. APRN #1 would make a copy of the medication regimen review and provide copies to the DNS and unit manager. After the resident was seen by the consultant, APRN #1 indicated that she would review the consultant's documentation, including the medication review, for updates or order changes. Interview with the Regional Clinical Manager and the DNS on 1/26/24 at 12:03 PM identified that RN #5 oversees cardiac rounds, and she is responsible for relaying recommendations and information. The DNS further indicated that RN #5 is not able to control what the consultant cardiologist documented once the information is relayed. The Regional Clinical Manager identified that going forward the nurse who passes along the information to the consultant can write a confirmation note indicating that there are no changes to the resident's medication regimen based on the consultant pharmacist's recommendations. Review of the Pharmacist Provider Requirements policy directs a consultant pharmacist will establish a system whereby the consultant pharmacist's observations and recommendations regarding customer's drug therapy are communicated to those with authority and/or responsibility to implement and/or respond to the recommendations in an appropriate and timely fashion. Although requested, documentation to indicate the medication regimen reviews dated 7/15/23 and 12/5/23 had been reviewed and responded to by the attending physician was not provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews, the facility failed to ensure that medication storage refrigerator temperatures were monitored in accordance with facility policy. The findings include: Observation of the facility medication storage areas on 1/26/24 at 9:15 AM with RN #1 identified the medication refrigerator temperature logs for the L/M unit identified multiple missing daily temperatures. The observation further identified the medication refrigerators on the L/M and the SR units contained Insulin. A further review of the medication refrigerator temperature logs for the 2 medication refrigerators for the facility was completed for 11/2023 - 1/2024 (3 months). Review of the 11/2023 medication refrigerator temperature logs identified that for M/L unit refrigerator, no temperatures were recorded on 11/5 and 11/26/23. The review also identified 21 of 30 days only one temperature was recorded. Review of the 11/2023 refrigerator logs for the S/R unit identified that for 24 of 30 days, only one temperature was recorded. Review of the 12/2023 medication refrigerator temperature logs for the M/L unit refrigerator identified no temperatures were recorded on 12/9, 12/12, 12/30, and 12/31/23. The review also identified for 17 of 31 days, only one temperature was recorded. Review of the 12/2023 temperature logs for the S/R unit refrigerator identified that no temperatures were documented on 12/15/23, and for 24 of 31 days, only one temperature was recorded. Review of the 1/2024 medication refrigerator temperature logs for the M/L unit refrigerator identified no temperatures were recorded on 1/12, 1/14, and 1/26/24. The review also identified for 15 of 26 days, only one temperature was recorded. Review of the 1/2024 temperature logs for the S/R unit refrigerator identified that no temperatures were documented on 1/2, 1/7, 1/8, 1/12, and 1/22/24. The review also identified that for 18 of 26 days, only one temperature was recorded. Review of the S/R unit temperature log on 1/26/24 also identified a documented temperature of 39 F at 1:00 AM on 1/27/24, (a date in the future). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #3 on 1/26/24 at 9:55 AM identified that she was responsible for collecting and reviewing the medication refrigerator logs for the facility. RN #3 identified she was unsure if the logs were required to be completed once or twice daily, but that they were typically done on the 11:00 PM - 7:00 AM shift, and again on the 7:00 AM - 3:00 PM shift. RN #3 identified she was aware of the missing temperatures on the logs and was working with the nursing supervisors of the facility to ensure they were completed. The Temperature Log for Refrigerator instructions directed temperatures were to be recorded twice each workday. The facility policy on daily monitoring of medication refrigerator temperatures directed that medication refrigerators would be monitored daily to ensure temperatures were within proper range for prescribed medications. The policy further directed that medication refrigerator temperatures would be checked twice daily by licensed staff, and the temperatures would be logged on the Refrigerator Temperature Log.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on observation, review of facility documentation, facility policy, and interviews, the facility failed to maintain nourishment refrigerators in a clean and sanitary manner including labeling, dating and discarding food items as per the policy. The findings include: A tour of the resident's nourishment refrigerators with the Director of Dietary on [DATE] at 7:40 AM identified the following. Nourishment refrigerator #1. Brown liquid on the bottom in the freezer and the refrigerator had dried liquid on the bottom shelf and splatter marks on the inside walls. Ice cream partially eaten not labeled or dated in the freezer. Minestrone soup dated [DATE], not labeled with a name. Small container with sausage cubes and toothpicks in each piece of meat dated [DATE] not labeled with a name. A sandwich baggy with 4 cheese cubes dated [DATE] not labeled with a name. A chicken sandwich on a plate with saran wrap not labeled with a name or dated. A peanut butter and jelly sandwich in saran wrap with hard bread dated [DATE]. A sandwich baggy with 5 cubes of cheese dated [DATE] not labeled with a name. A sandwich baggy with 13 cubes of cheese dated [DATE] not labeled with a name. A sandwich baggy with 16 cubes of cheese dated [DATE] not labeled with a name. Brown pudding in a bowl with a lid not labeled with a name or dated. A cup of applesauce with a lid not labeled with a name or dated. Inside the bottom drawer was a brown paper bag dated [DATE] with a small round cheesecake with no date, and cheese sticks, 2 expired on [DATE], 1 expired on [DATE], and 1 expired on [DATE]. In the bottom drawer was a bag of 8 tangerines not labeled with a name or dated. Nourishment refrigerator #2. Crumbs on the shelves in the refrigerator and liquid spots in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The freezer had a reddish-brown liquid frozen on the bottom. The seal of the freezer was torn and missing pieces. In the freezer was a frozen yogurt labeled with a name but not dated. In the freezer was a reusable metal 40 ml water bottle not labeled with a name or dated. In the freezer was a red liquid in an Arizona bottle half full not labeled with a name or dated. In the freezer was a half-eaten ice cream caramel cookie crunch not labeled with a name or dated. In the refrigerator was a pitcher of liquid not labeled with a name or dated. There was a ,d+[DATE] sandwich that was wrapped in paper towels and was hard to touch, not labeled with a name or dated. Soup in a bowl with lid dated [DATE] not labeled. An interview with the Director of Dietary on [DATE] at 8:20 AM indicated that it was the kitchen and housekeeping's responsibility to keep the nourishment refrigerators and freezers clean. The Director of Dietary indicated she usually cleans them daily, but she was off on Friday, Saturday, and Sunday and identified that it was the cook's responsibility when she was off. The Director of Dietary did not know why the freezers and refrigerators were not kept clean and indicated all items in the nourishment refrigerator were to get discarded after 3 days. The Director of Dietary indicated all staff and visitors know that all items must be labeled and dated before placing them in the refrigerator or freezer and there was a sign on the front of both refrigerators to remind the staff and visitors. The Director of Dietary indicated in refrigerator #1 that she did not know how she missed the brown paper bag in the bottom drawer with the expired cheese sticks. The Director of Dietary indicated in refrigerator #2 in the freezer the yogurt and water bottle belonged to staff and staff are aware they are not allowed to use the resident's nourishment refrigerator. The Director of Dietary indicated the water pitcher with juice was from the nourishment cart and nursing should have dated it before placing it in the refrigerator. Review of the policy on resident refrigerators identified items not labeled and dated will be discarded. Items older than 3 days will also be discarded. Review of the facility food brought in for residents identified food brought into resident's by family or visitors will be handled and stored in a safe and sanitary manner to ensure the safe consumption of food brought in. Storing food brought in that requires refrigeration shall be labeled with the resident's name and date that the food was brought in. Food must be stored in a closed container to prevent contamination. Food with be held in the refrigerator for 3 days following the date on the label and will be discarded by staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident # 29) reviewed for pressure ulcers, the facility failed to ensure that facility staff maintained proper infection control technique and hand hygiene during a dressing change. The findings include: Review of the hospital discharge summary dated 11/23/23 identified Resident #29 was discharged from the hospital to the facility with a wound vac in place at the right hip due to an abscess requiring surgical intervention. Resident #29 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, osteomyelitis of the right femur, and insulin dependent diabetes. The care plan dated 11/23/23 identified Resident #29 was at risk for skin breakdown due to decreased mobility, incontinence, and actual skin breakdown related to a right hip pressure wound with wound vac. Interventions included completing weekly wound assessments to include measurements and description of the wound status. The Braden Scale (used to determine risk of pressure ulcer development) dated 11/23/23 identified that Resident #29 had a high risk of developing pressure ulcers. The admission MDS dated [DATE] identified Resident #29 had severely impaired cognition, was always incontinent of bowel, frequently incontinent of bladder and required maximum assistance with bathing, eating, and toileting and was at risk for development of pressure ulcers. A nurse's note dated 12/17/23 at 2:43 AM by LPN #4 identified that Resident #29 had a change of condition evaluation due to a newly identified skin issue. LPN #4 identified Resident #29 had a 2 cm x 3 cm pressure injury with blackened skin at the sacrum. The note further identified the APRN and Person #1, Resident #29's resident representative, were notified. A physician's order dated 12/17/23 directed wound care by cleansing with normal saline and applying calcium alginate and bordered foam dressing daily. A wound care physician's note dated 12/19/23 identified Resident #29 was seen for follow up evaluation of a right hip post-surgical wound and an initial evaluation of an unstageable full thickness pressure injury to the sacrum. The sacral wound measured 4.5 cm x 5.5 cm and the depth of the wound was unstageable due to the presence of nonviable tissue and necrosis. The treatment plan included a daily dressing of calcium alginate with silver, gauze island, and border dressing daily. A physician's order dated 1/24/24 directed Santyl Ointment to Resident #29's sacral wound daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 1/26/24 at 10:54 AM during a dressing change to Resident #29's sacral pressure ulcer by LPN #3, who performed the dressing change, while LPN #5 assisted identified the following. LPN #3 opened dressing supplies, which included 4 x 4 gauze and 2 border foam dressings, and placed them directly on top the dresser with no barrier to the left of Resident #29's bed. LPN #3 was not observed to wiped or clean off the dresser top prior to placing the dressing supplies. A closed package containing a 4 x 4 inch sheet of calcium alginate was also observed on the dresser. LPN #3 was observed to wash her hands an put on clean gloves on. LPN #3 then reached into her pockets, with the gloves, to retrieve an item, removed her hands, and then reached in her pockets a second time, retrieved a pair of bandage scissors, and placed them on the dresser. RN #3 (IP/Wound nurse) entered the room. LPN #3 placed her gloved hands in her pocket again to retrieve a black marker, to label the new dressing. RN #3 then directed LPN #3 that she should not place gloved hands into her pockets and that she should remove her gloves, wash her hands, and don new gloves, which LPN #3 then completed. RN #3 and LPN #5 then assisted LPN #3 with Resident #29 with repositioning and with removing Resident #29's brief, which was soiled with stool. At 10:57 AM, LPN #3 removed the sacral pressure ulcer dressing dated 1/25/24, cleansed the wound with normal saline on a 4 x 4 gauze, and placed the used gauze and old dressing inside of the soiled brief. LPN #3 removed her gloves, folded the brief into a ball and placed the brief at the foot of Resident #29's bed. At 11:00 AM, LPN #3 removed and disposed of the soiled brief from Resident #29's bed and washed her hands while LPN #5 and RN #3 stayed with Resident #29. LPN #3 then donned a new pair of gloves and opened the package containing the calcium alginate sheet and placed the sheet directly on the dresser top. LPN #3 then began cutting the calcium alginate sheet with bandage scissors. LPN #3 was not observed to clean the scissors prior to using them. During this process, LPN #3 then placed the calcium alginate sheet on the dresser top 2 additional times. RN #3 then identified that LPN #3 should not place the calcium alginate sheet directly on the dresser and would need to use a new sheet to apply to Resident #29's wound. LPN #5 then removed her PPE, washed her hands, and left the room to retrieve a new sheet of Calcium Alginate. LPN #5 then returned to the room with the package and handed LPN #3 the package to LPN #3, who was observed to have the same gloves on. LPN #3 opened the new package, this time leaving the calcium alginate sheet to rest on top of the internal portion of the package. After cutting the calcium alginate sheet, LPN #3, without any additional glove changes or hand hygiene, applied Santyl Ointment to Resident #29's open sacral with her gloved fingers. LPN #3 then changed her gloves but was not observed perform hand hygiene and applied the Calcium Alginate and border form dressings to Resident #29's sacral pressure ulcer. RN #3 and LPN #3 then placed a clean brief on Resident # 29 and LPN #3 collected all the open dressing packages from the dresser top and discarded them, doffed her gloves and washed her hands. Immediately following the conclusion of this observation at 11:08 AM, RN #3 and LPN #3 identified they had finished the dressing change, and no other interventions were needed and then exited Resident #29's room. Observations failed to identify that the dresser top was cleaned before or following the completion of the dressing change. Interview with LPN #3 on 1/26/24 at 11:10 AM identified she panicked while being watched during the dressing change. LPN #3 identified that RN #3 was in the room to assist, and they had reviewed the dressing change policy and protocol prior to the observation. LPN #3 identified that due to the number of the people in the room, and observation by this surveyor, she was nervous and that caused her to mess up. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075240	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Glendale LLC	4 Hazel Ave Naugatuck, CT 06770

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with RN #3 on 1/26/24 at 11:13 AM identified that she had reviewed both the dressing change policy, hand hygiene policy, use of PPE policy and the policy and procedures related to dressing changes with LPN #3 on 1/25/24 and 1/26/24 as she was aware that Resident #29 would likely have an observation of his/her dressing change due to the wound vac in place. RN #3 identified LPN #3 should not have had gloves on while reaching into her pockets, should have had dressing materials on a barrier and not directly on a dresser top, and should have had a trash collection bag set up to dispose of items including the soiled brief and used gloves. RN #3 also identified that LPN #3 should have wiped down the bandage scissors after removing them from her pocket, should have utilized a tongue depressor to apply the Santyl ointment to Resident #29's wound instead of using gloved fingers, and should have had gloves and hand sanitizer ready at the bedside for the dressing change. RN #3 identified it was not policy to leave a soiled brief on a resident's bed during a dressing change. Review of facility documentation related to LPN #3's competency evaluations identified LPN #3 completed annual competencies related to hand hygiene and PPE use on 11/29/23. The competencies included hand washing and gloving, including hand hygiene following donning and doffing of gloves, and removal of PPE, including glove removal following contamination. The facility policy on clean dressing changes directed that a clean field should be set up for wound cleansing and dressing application and should include a table wiped clean (if soiled) and a disposable cloth or linen liner then placed on the table. The policy also directed that only supplies to be used on the wound should be placed on the clean filed, and at one time, an area should be established for soiled items to be placed (chux or plastic bag). The facility policy on wound care directed to use a clean cloth (such as a paper towel) to establish a clean field, and all items to be used during the dressing change should be on the clean field. The policy further directed that reusable item, such as scissors, should be wiped with alcohol for wound care. The policy also directed that wound care should use a no-touch technique, and tongue applicators and blades should be used for creams and ointments from their containers.