STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075402	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mansfield Center for Nursing and Rehabilitation	100 Warren Circle Storrs Mansfield, CT 06268

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility documentation, review of facility policy, and interviews, for two of six sampled residents (Residents #13 and #47) reviewed for accidents, the facility failed to ensure the required staff assistance was utilized during the use of the mechanical lift, and for one of six sampled residents (Resident #33) the facility failed to ensure the required staff assistance was in place during a mechanical lift transfer and failed to ensure the resident was attached to the lift correctly, which resulted in an accident and injury. The findings include: 1. Resident #13 was admitted to the facility in January 2025 with diagnoses that included metabolic encephalopathy, dementia, and renal failure. The admission MDS assessment dated [DATE] identified Resident #13 had intact cognition, functional limitation in range of motion of the bilateral upper extremities, utilized a wheelchair for mobility, was dependent on staff for toileting hygiene, toileting and transfers from the bed to the wheelchair, and was always incontinent of bowel and bladder. The physician's order dated 3/17/25 directed Resident #13 be transferred with the assistance of two staff members. The care plan dated 1/31/25 identified Resident #13 had a deficit in Self Care Function with interventions that direct 2 staff for bathing/showering, 2 staff for dressing, and 2 staff for toileting. Observation on 4/9/25 at 9:40 AM identified NA#7 and NA#6 utilizing the mechanical lift to transfer Resident #13 from the bed (a seated position) to the bathroom, to be seated on the toilet. Both NA#6 and NA#7 completed the transfer. Resident #13 was seated on the toilet and disconnected from the lift. NA#7 directed NA#6 to call him when she was finished with care and left the room. NA#6 completed care and dressed the resident in the bathroom with the door closed. Observation on 4/9/25 at 9:55 AM identified NA#6 operating the mechanical lift independently without assistance to transfer Resident #13 out of the bathroom and into the wheelchair which was located in the room next to the bed. (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 4/9/25 at 10:04 AM with NA#6 identified she has worked at the facility since 9/2024 and identified she is a full-time employee. NA#6 further identified that she looks at the care card to identify what type of care the resident needs and indicated that all residents required two staff members when utilizing the sit to stand mechanical lift. Interview on 4/9/25 at 10:24 AM with RN#1 identified that all of the staff is aware that mechanical lift transfers require the assistance of two staff members. Interview on 4/9/25 at 12:39 PM with the ADNS identified that NA competencies are done annually and as needed and that all nurses' aides are aware that two staff members are required when utilizing the mechanical lift. Interview on 4/9/25 at 2:15 PM with the Administrator and RN#4 identified that the facility policy identifies that mechanical lift transfers require the assistance of 2 staff members. The policy on use of the mechanical lifts identified that two staff members must be involved in the transfer of a resident with the mechanical lift. 2. Resident #33's diagnoses included Alzheimer's disease, aphasia, muscle weakness and chronic kidney disease. The annual MDS assessment dated [DATE] identified Resident #33 had intact cognition (BIMS of 13), required maximal assistance with bed mobility, and upper body dressing, required total assistance with lower body dressing and toileting hygiene. The assessment further identified Resident #33 did not ambulate, utilized a wheelchair and was dependent on staff for mobility. The care plan dated 8/21/24 identified Resident #33 had an activities of daily living (ADL) self-care performance deficit due to Alzheimer's/dementia. The care plan interventions directed: transfer status of [NAME] (which is a sit to stand mechanical lift) or Hoyer lift (which is a total mechanical lift) with assist of two (staff), back to bed with Hoyer at night, and toilet transfer status of Sara lift assist of two if able otherwise back to bed with the Hoyer lift. The care plan also identified Resident #33 had limited physical mobility related to Alzheimer's dementia and osteoarthritis. Review of the Nurse Aide care card instructions in effect for the month of October 2024 identified the need for two staff with the use of the Sara lift and the Hoyer lift. The physician's orders for the month of October 2024 directed Acetaminophen (Tylenol) tablet 650 milligrams (mg), administer two tablets orally in the morning for pain. Review of the medication administration record identified that on 10/8/24, the resident was administered Tylenol 650 mg at 10:07 AM for complaint of discomfort in addition to his/her regularly scheduled Tylenol. The nurse's note dated 10/8/24 at 10:46 AM written by RN #5 identified Resident #33 had pain in the left knee, tibia and fibula area with some increased warmth and swelling. The note further identified that APRN #1 was notified, and an x-ray was ordered. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	APRN 1's progress note/assessment via telehealth visit dated 10/8/24 identified Resident #33 reported left knee pain and the inability to help with Sara lift transfer as usual. The note further identified that per nursing the left knee had slight edema, a negative [NAME] sign, was warm to the touch without erythema and an x-ray of the knee was ordered. The x-ray results dated 10/8/24 identified the resident had a fracture of the left tibia and fibula. It further noted that the resident had mild degenerative changes and diffuse osseous demineralization. The nurse's note dated 10/9/24 at 12:30 AM identified the x-ray results were positive for fracture of the left tibia/fibula and that an order was obtained to send the resident to the hospital emergency department. Review of the hospital discharge paperwork dated 10/9/2024 identified bruising and tenderness in the left proximal tibia and an x-ray was performed in the emergency department which showed an oblique left proximal tibia fracture. The leg was splinted with instructions to follow up with orthopedic surgery. The facility's reportable event report and investigation dated 10/9/24 at 9:30 AM identified Resident #33 complained of having pain in the left leg, with increased warmth and swelling to the area. In addition, an order was received to have an x-ray performed which indicated a left lower leg fracture involving the proximal tibia and fibula with minimal callus and mild displacement, and an order was received to send the resident to the emergency department for further evaluation. The report further identified the hospital identified a fracture of the left tibia, placed a long leg splint, and noted the resident a status of non-weight bearing until follow-up with orthopedic surgery. The facility submitted the report to the state survey agency with the classification as an injury of unknown origin, the reportable event report did not acknowledge the incident with the Sara lift that occurred on 10/7/25. The reportable event report identified a written statement by NA #2 dated 10/9/24 that identified she washed and got Resident #33 prepared for the transfer to his/her wheelchair, she placed the straps around the resident's torso, and attached the straps to the lift, placed the resident's feet on the lift platform, The statement further identified that during the transfer from the bed to the wheelchair, she noticed one of the resident's feet fell off the lift, and the resident told her that his/her leg was weak. The documentation further noted NA #2 lowered the resident down and went to get the nurse. The reportable event report investigation further identified that on 10/15/24 The DNS (former) spoke to NA #2 who identified that Resident #33's left foot slipped off the lift platform, causing the resident to kneel on the left knee. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with NA #2 on 4/3/25 at 2:20 PM identified that in the morning she assisted Resident #33 to sit on the edge of the bed to transfer him/her using the Sara lift to the wheelchair. She further identified that while the resident was attached to the Sara lift via the straps and in the process of transferring the resident she noticed that the resident's left foot slipped off the Sara lift platform. She noted that she locked the Sara lift and went in the hallway to get the nurse (LPN #2). LPN #2 came and asked the resident if she had any pain and assisted NA #2 in transferring the resident to the bed with the Sara lift. She further noted that they used the Hoyer lift to transfer the resident from the bed to the wheelchair. NA #2 identified that she was aware that Resident #33 required assistance from two staff to use the Sara lift, however, she transferred the resident by herself because there was nobody available to assist with the transfer. LPN #2's written statement dated 10/9/24 identified on 10/7/24 around 9:30 AM she was called by NA #2 to Resident #33's room. She noted that on arrival to the room she observed Resident #33 hooked up on the Sara lift and noted the left leg was bent behind the resident and was not on the lift platform (where the feet should be placed). She further identified that immediately the resident was safely transferred back to bed with assistance of two and noted Resident #33 appeared calm, denied pain or discomfort, had no visible bruises, lacerations or swelling and was able to move extremities without pain. Interview with the Charge Nurse (LPN #2) on 4/3/25 at 2:35 PM identified she was the nurse on duty on 10/7/24 for the 7:00 AM to 3:PM shift. LPN #2 identified she was taking care of another resident in a nearby room when NA #2 called her to come to Resident #33's room. She identified that when she entered the room, Resident #33 had the lift pad around her upper torso with the straps attached to the lift, but the resident was hanging freely from the lift with the knees not touching the padding on the lift where the knees are supposed to touch to support the resident, her left leg was also bent back and was not on the lift platform. LPN #2 further noted that NA #2 was in the process of transferring the resident from the bed to the wheelchair. LPN #2 identified that the leg straps (supports) were not in place (as they should be) around the resident's lower legs. LPN #2 further identified that the resident required two staff to assistance with the transfer and that NA #2 had not requested assistance. Additionally, LPN #2 identified that she notified the nursing supervisor of the incident. Interview with LPN #2 on 4/8/25 at 1:44 PM identified that on 10/8/24 Resident #33 complained of pain in the left lower extremity. LPN #2 noted that the left lower extremity was noted with swelling and redness. She identified that she notified the nursing supervisor on duty and x-rays were ordered. LPN #2 further identified Resident #33 should absolutely have the lift leg support straps in place when using the Sara lift. The physical therapy (PT) note dated 10/9/24 at 2:44 PM by PT #2 identified Resident #33 was referred to PT due to significant decline in his/her transfer abilities that was noted on 10/8/24, and the resident was found to have a deformity of the left lower extremity with increased edema to the left lower extremity and was sent out for x-rays which revealed a fracture of the left fibula/tibia. Interview with MD #1 (Orthopedic Surgeon) on 4/9/25 at 9:26 AM identified Resident #33 was seen in the office due to a fracture and based on the x-ray results, and his examination of the resident, he identified Resident #33 had an acute fracture. He further noted that the accident with the Sara lift could definitely have caused the fracture, and because of the resident's dementia, the response to pain may be atypical and the resident may not remember what occurred. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the Physical Therapist (PT #1) on 4/8/25 at 8:33 AM identified that if the resident transfer status fluctuates between the use of a Sara lift and Hoyer lift then the leg straps should be utilized. PT #1 further identified if the leg straps on the Sara lift are not used as indicated and secured it can cause injuries to the resident. PT #1 further identified that if the leg straps on the Sara lift are used and secured properly, a resident's leg would not slip off the platform/foot support. PT #1 added that when using the Sara lift with Resident #33, two staff members are needed to prevent the resident from getting hurt and for safety. PT #1 added that two staff members are needed in Sara lift transfers as one staff would aid in positioning residents who are unable to position themselves in a seated position to be connected to the Sara lift and guide the resident during the transfer while the other staff manages the Sara lift. Interview with the Staff Development Nurse (RN #2) on 4/7/25 at 10:56 AM identified that two staff members are required when using the mechanical lift as one staff operates the machine/lift and the other staff guides the resident, and legs support straps are to be utilized during the transfers as it is a part of the training. Interview with the current DNS and the Administrator on 4/9/25 at 1:39 PM identified that NA #2 was an agency staff and was provided with education following the incident. Review of the [NAME] 3000 (Sara lift) instructions for use manual identified that the foot support is used for positioning before and supporting the resident's feet during raising and transferring. In addition, the lower leg straps accessory is used to ensure that the lower parts of the resident's legs stay close to the knee support as they pass around the knee supports, then around the resident's lower calves. Also to ensure that the straps are firm but comfortable for the resident. In addition, the manual further identified in the warning section that the residents' feet shall always remain in full contact with the foot support and when raising, check to ensure that the resident's feet do not lift from the foot support. Review of the policy and procedure for Sara lift (partial weight bearing/standing lift) identified a mechanical lifting device is utilized to safely move a patient/resident from bed to chair or to the commode/bathroom and two staff are utilized to perform the procedure unless it is specified by physical therapy that the transfer can be completed with one person assisting. The policy and procedure for using the Sara lift in part, identify to place the resident's feet onto the foot support, adjust the resident's leg so that they are in full contact with the knee support of the lift, attach sling to the lift at the designated spots and attach the support strap to the resident's legs for safety. 3. Resident #47's diagnoses included dementia, type 2 diabetes, anemia and hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. The quarterly MDS assessment dated [DATE] identified Resident #47 had severe cognitive impairment, had no behaviors, was dependent for hygiene, lower body dressing, and bed mobility. The assessment further identified Resident #47 did not ambulate, utilized a wheelchair and was dependent on staff for mobility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The care plan dated 2/9/25 identified Resident #47 had an ADL self-care performance deficit related to cognitive impairment /history of CVA with left sided hemiplegia. Care plan interventions included transfer with two staff assist using the Sara lift (sit to stand lift). The Nurse Aide care card instruction for April 2025 identified Resident #47 required the assistance of two 2 staff members when using the Sara lift. Observation on 4/2/25 at 12:19 PM identified Resident #47 seated in his/her adaptive wheelchair located on the right-side of the resident's bed. NA #5 wheeled the resident to the end of the bed facing the entrance door of the room. NA #5 positioned the Sara lift in front of the resident, then applied the sling to Resident #47 followed by attaching the sling to the Sara lift followed by applying the leg support straps and she ensured the resident placed his/hand on the support grips. NA #5 then utilized the control to raise the resident up, then transferred the resident to the bathroom and lowered the resident to the toilet seat. Interview with NA #5 on 4/2/25 at 1:06 PM identified the care card indicated Resident #47 required two staff members for transfers with the Sara lift. NA #5 further identified that she should have had a second staff member with her during the transfer, but she transferred the resident by herself. She added that when she first started orientation on the unit, she was trained and told by staff that Resident #47 only needed one person to use the Sara lift for transfers. Interview with the DNS on 4/2/25 at 3:10 PM identified that two staff members are required to use the Sara lift. The DNS reviewed Resident #47's care plan and indicated that he/she required two people when utilizing the Sara lift. Interview with the Staff Development Nurse (RN #2) on 4/7/25 at 10:56 AM identified that staff are trained to use two staff members when using the Sara lift. RN #2 further identified she provided education and/competency to the nurses' aides including NA #5 in December of 2024. She noted that during the transfer, one staff member operates the lift, and one staff member provides hands on guidance to the resident. Interview with the Physical Therapist (PT #1) on 4/8/25 at 8:25 AM identified Resident #47 requires two staff members for transfers using the Sara lift. PT #1 noted that when using the Sara lift for this resident that two staff members are needed to prevent the resident from getting hurt and for safety, as one staff member operates the Sara lift, and the other staff member guides the resident and ensures the resident is positioned properly. The Mechanical Lift policy identified two staff members must be involved in the transfer of a resident with the Mechanical Lift.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 755 Based on review of facility documentation, review of facility policy/procedures and interviews, the facility failed to establish a complete system of records of receipt and disposition of all controlled medications in sufficient detail to enable an accurate reconciliation. The findings include: Review of the bi-monthly narcotic drug audit form dated [DATE] identified the facility was auditing to ensure that medication carts were locked, all controlled drugs have a proof of use sheet, the narcotic count was correct, all change of shift narcotic count sheets were signed, all narcotic medications were labeled correctly, and no expired narcotic medication was stored in the medication cart. Review of the narcotic reconciliation with the ADNS on [DATE] at 1:40 PM identified that there were four binders in the ADNS office that contained the yellow Controlled Substance Disposition Records (CSDR), the CSDR sheets were organized by nursing unit and arranged in alphabetical order. Additionally, the oldest yellow CSDR sheet was dated [DATE] and had not yet been reconciled with the white CSDR nor were the medications identified as having been destructed. The book did not contain any audit sheets. Interview with the ADNS on [DATE] at 2:00 PM identified that she was responsible for conducting the controlled drug medication auditing and she also identified that she completed her audit twice a month. She identified that her narcotic audit consisted of ensuring the narcotic medications were locked when not in use, the narcotic count was correct, the shift change count were sign by the nurse, and no expired narcotic medication kept in the cart; however, she identified that she was waiting to receive the white CSDR sheet from the nurse and she will then reconcile to ensure that white CSDR match to the yellow CSDR to ensure the count were accurate. She further identified that she was not auditing the yellow CSDR in her binder until the nurse gave her the white CSDR from the nursing units. The facility Controlled Substance Handling policy identified that all controlled drugs will be subject to special receipt, handling, storage, disposal, and record keeping. The facility failed to ensure there was an adequate medication reconciliation practice to ensure medications are not diverted.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of facility policy/procedures and interviews, the facility failed to ensure that food stored in the refrigerator and freezer was labeled with an expiration and open date, and the staff failed to wear beard restraints. The findings include: During the initial brief tour of the kitchen on 4/2/25 at 9:41 AM with the Dietary Manager identified cooler #2 contained eight waffles in an open package stored with no expiration date and no open date as well as a Starbucks mocha drink that was 2/3 full. Interview on 4/2/25 at 9:42 AM with the Dietary Manager identified the waffles should be labeled with the open date and the expiration date. Observation on 4/2/25 at 9:46 AM identified the walk-in refrigerator contained shredded cabbage that was opened with no open date label and no expiration date and Parmesan cheese wrapped with saran wrap with no open date and no expiration date. Interview on 4/2/25 at 9:48 AM with the Dietary Manager identified the cabbage was recently opened to make coleslaw and that it should have been labeled with the date opened and date it needed to be discarded. He further identified that the Parmesan cheese should be labeled with the same information. Observation on 4/2/25 at 9:50 AM identified the walk-in freezer contained a box of pizza slices that was ¾ full and open to air. It was not labeled with date of expiration or date it was opened. A beef patty package of twelve patties with no expiration date, there was an opened package of hot dogs with no expiration, and oatmeal raisin cookie dough in saran wrap with no expiration date. Interview on 4/2/25 at 9:55 AM with the Dietary Manager identified that food items should not be left open to air, and they should have an expiration date. Observation on 4/3/25 at 11:52 AM of the tray line identified the Dietary Manager was plating food, and did not have a beard restraint in place. Additionally, Dietary Aide #1 had a full beard and mustache and was also plating food without a beard restraint in place. Interview with the Dietary Manger on 4/7/25 at 11:30 AM indicated that there should have been facial coverings worn by himself and the Dietary Aide #1 on 4/3/25 when plating food for the lunch meal. The Storage of Food and Supplies policy identified that food from non-approved sources should not be stored in the kitchen, ie. staff food. Food products that are open and not completely used and/or food transferred from their original package to another storage container; or prepared at the facility and stored should be labeled with the contents and the use by date. The Personal Hygiene for Food Handlers identified hair restraints such as hats, hair coverings or nets, and beard restraints are worn at all times when in the kitchen. Hair is to be fully contained inside the covering. Facial hair should be neatly trimmed and covered by a mask or beard guard.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, review of facility policy/procedures and interviews for 1 of 3 residents (Resident #57) reviewed for pressure injuries, the facility failed to ensure facility staff used appropriate PPE when providing care to a resident on Enhanced Barrier Precautions (EBP) and failed to ensure infection control surveillance data collection reports were complete and compiled on a monthly basis. The findings include: 1. Review of the infection control program for the period of April 2023 to January 2024 with the Regional Director of Clinical Operations (RN #7) and the Infection Preventionist (IP) Nurse (RN #4) on 4/7/25 at 12:57 PM failed to identify that monthly surveillance infection reports and analysis of infection trends were completed from April of 2023 through January 2024 within the monthly Antibiotic Report as well as the quarterly reports provided for April 2023, July 2023, and October 2023. The Antibiotic Report was provided by RN #7, which indicated that this was what the facility was apparently using during those periods for their infection surveillance, however the reports were incomplete. Review of the monthly Antibiotic Reports (RN #7 indicate was used for surveillance) provided by the facility identified incomplete information in various columns such as: the Healthcare Associated infection (H) or Community Acquired Infection (C), met or did not meet (McGeer's), and new prophylactic for the period of April 2023 through January 2024. Interview with RN #4 on 4/7/25 at 12:57 PM identified that she was not working at the facility in 2023 and had only started working at the facility in February 2024. She identified that she currently completes her infection surveillance on a monthly basis, and she analyses the data to identify any trends or clusters and provides education to staff as needed based on the data. Interview with RN #7 on 4/8/25 at 3:15 PM identified the infection control surveillance reports were incomplete. She further identified that the facility had an IP at the time, and it was his/her responsibility to complete the surveillance reports and to analyze infection rates with the facility. Review of the Infection Control Program policy directed to maintain a separate record of infection for each resident who has an infection, analyze clusters of infection, changes in prevalent organisms, and any increase in the rate of infection in a timely manner. The policy further identifies the infection control program will be monitored quarterly or as indicated at the quality improvement meeting. 2. Resident #57 was admitted to the facility October 2023. Diagnoses include neurocognitive disorder with Lewy bodies dementia, trigeminal neuralgia, and pressure ulcer of sacral region Stage 3. The annual MDS assessment dated [DATE] identified Resident #57 had severely impaired cognition, was dependent for oral care, toileting, and personal hygiene, and dependent for transfers and mobility in a manual wheelchair. The MDS indicated the resident was at risk for developing pressure ulcers and had one unhealed Stage 4 pressure ulcer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The care plan dated 3/11/25 identified Resident #57 required Enhanced Barrier Precautions due to chronic wound pressure ulcer with interventions that included don gown and gloves when performing high contact care activities including dressing, bathing, transferring, changing linens, assisting with toileting or changing brief, care or use of indwelling medical device and providing wound care, evaluate EBP upon resolution of wound or discontinuation of indwelling medical device that places them at risk. The physician's orders dated 4/1/2025 directed to cleanse wound with a quarter (¼) strength Dakins, pat dry, pack with gauze loosely and apply dry clean dressing daily and as needed. The order was updated on 4/9/25 to cleanse wound with wound cleanser, pat dry and pack wound with ½ Dakins and apply 4x4 gauze daily and as needed. Additional orders included to monitor sacral wound for signs and symptoms of infection and ensure dressing is in place every shift and limit in chair time to 1 hour daily. Observation on 4/7/25 at 10:38 AM identified Resident #57 in bed positioned on the right side and appeared to be asleep. The name plaque on the outside of the room had a round blue sticker next to the resident's name. Interview on 4/7/25 at 11:49 AM with LPN#6 identified that rooms with a blue sticker next to a resident's name indicated that resident was on enhanced barrier precautions and noted that all residents on contact precautions have signage on the door frame indicating what type of precautions are required. Interview on 4/7/25 at 12:00 PM with NA#5 identified that the blue dots on the name plaques next to resident names are for the long-term care for those residents who have some issue and require PPE with care. The nursing progress note dated 4/8/25 at 3:34 PM identified the nurse was asked to view the resident's wound by the NA. The LPN indicated that above the present wound, there was an open area that was leaking large amounts of brown fluid. Observation on 4/9/25 at 10:35 of NA#7 at the bedside of Resident #57 finishing incontinent care and situating resident in bed identified NA#7 did not have any PPE in place and verbalized providing a brief change for the resident. Observation on 4/9/25 at 10:38 AM of LPN #7 identified LPN #7 entered Resident #57's room to provide wound care. LPN #7 was assisted by NA #7 who stayed in the room to help with resident positioning. LPN#7 placed a towel over the bedside table and placed the bottle of Dakin's solution, sterile gauze unopened, an opened multipack of non-sterile cotton tipped applicators on the towel. NA #7 had gloves in place, but no gown or mask, and held the resident up on the resident's left side so LPN #7 could access the sacral wound dressing. LPN #7, wearing only gloves, took down the dressing and as she removed the wound covering, an area close to the border of the dressing, up the back from the packing area, that oozed brownish, grey colored drainage as LPN#7 removed the dressing. The wound dressing was saturated in the brownish/grey colored drainage. LPN #7 replaced the dressing and explained that she was going to go notify the supervisor. (continued on next page)

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	075402	A. Building B. Wing	04/10/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Continued observation on 4/9/25 at 10:45 AM identified LPN#7 returned to Resident #57's room and put on new gloves, but no other PPE. LPN #7 identified that the supervisor was aware of the drainage and began to take the dressing off once again. At this time the Infection Prevention nurse (RN #4) entered the room. RN#4 was actively putting on a precautions gown and directed NA #7 and LPN #7 to put on PPE and indicated that the resident was on EBP. RN #4 took over wound care and sent LPN #7 out of the room to obtain additional sterile items for wound care. Interview on 4/9/25 at 11:06 AM with LPN #7 identified that Resident #57 had a blue dot on the name plaque and that the blue dot indicated the resident was on EBP and required PPE with care. LPN#7 identified that she should have had PPE on when providing wound care and could not identify why she did not put it on. Interview on 4/9/25 at 1:00 PM with RN #4 identified that all staff are educated on EBP, contact precautions, and use of PPE. RN#4 indicated that NA#7 was a long-term employee and had been educated on use of PPE and EBP. RN#7 also worked at the facility frequently and was aware of EBP and use of PPE. Interview on 4/9/25 at 1:57 PM with the ADNS who identified that all staff are educated on EBP and PPE use. Agency staff are oriented but have no formal education by the facility. The ADNS indicated that RN #4 does the staff competencies, and the expectation is that the rooms with the blue dots indicated residents who require EBP. Facility policy regarding Clinical Services: precautions to prevent infection identified that Enhanced Barrier Precautions (EBP) is an approach of targeted gown and glove use during high contact resident care activities that include chronic wounds, pressure ulcers.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, facility policy and interviews, during a review of the facility antibiotic stewardship program, the facility failed to ensure that the facility's antibiotic surveillance tracking report of antibiotic use, patterns and resistant trends was completed and reviewed at the quarterly medical staff meetings and for one of five sampled residents (Resident #13) reviewed for unnecessary medications, the facility failed to ensure that the antibiotic stewardship was followed for a resident receiving antibiotics. The findings include: 1. Review of the antibiotic stewardship program for the period of April 2023 to January 2024 with the Regional Director of Clinical Operations (RN #7) and the Infection Preventionist (IP) Nurse (RN #4) on 4/7/25 at 12:57 PM failed to identify any completed documentation presented quarterly at the Medical Staff meeting that included rates of antibiotic usage, patterns and resistance trends, and infections which meet McGeer for the use of Antibiotic therapy for their antibiotic stewardship program for the period of April 2023 to January 2024. Review of the monthly Antibiotic Reports provided by the facility identified incomplete information in various columns such as: the Healthcare Associated infection (H) or Community Acquired Infection (C), met or did not meet (McGeer's), and new prophylactic for the period of April 2023 through January 2024. Review of the quarterly reports for April 2023, July 2023 and October 2023 failed to identify any information regarding the facility's antibiotic stewardship program. Interview with RN #4 on 4/7/25 at 12:57 PM identified she was not working as the IP at the time and had only started working as the IP in February of 2024. Interview with RN #7 on 4/8/25 at 3:15 PM identified the monthly Antibiotic Reports were incomplete as she had some information from pharmacy reports for August 2023 through December 2023. She further identified that the facility had an IP at the time, and it was their responsibility to complete the monthly Antibiotic Report and quarterly reports for medical staff meetings. Review of the Antibiotic Stewardship policy identifies data and stewardship initiatives will be reviewed on a quarterly basis. 2. Resident #13's diagnoses included metabolic encephalopathy, chronic kidney disease stage 4, urge incontinence, and altered mental status. The admission MDS assessment dated [DATE] identified the resident had intact cognition, was dependent with toileting, was always incontinent of bowel and bladder, required partial/moderate assistance with personal hygiene, and substantial/maximal assistance to dependent for all transfers and mobility. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The current care plan in place identified the resident had a urinary tract infection (UTI) and was receiving antibiotics in addition to being on prophylactic antibiotic therapy for UTI prevention with interventions to administer antibiotic medications as ordered by the physician, assist resident with hand hygiene, monitor/document/report adverse reactions to antibiotic therapy and signs and symptoms of secondary infection related to antibiotic therapy. Physician's orders dated 3/28/25 directed to administer Ciprofloxacin (antibiotic) oral tablet 250 mg by mouth two times a day for UTI for 7 days (ending 4/5/25). Additionally, physician's orders directed to administer Methenamine Hippurate (antibiotic used to prevent and control UTI's) oral tablet 1 GM by mouth two times a day for UTI and was on hold from 3/31/25 to 4/5/25. The APRN's progress note dated 3/21/25 identified Resident #13 had a recent hospitalization for acute metabolic encephalopathy, likely secondary to infection (UTI) and received three antibiotics as treatment. The note further identified that Resident #13 continued to have altered mental status and dementia, received a neurology consult and was started on Trazodone (antidepressant) 25 mg every 6 hours for agitation and anxiety with plan to evaluate urine culture and sensitivity. The APRN's progress note dated 3/24/25 identified the Resident #13 had a urinalysis that showed greater than 100,000 bacteria which suggested contamination or colonization; however, the urine culture was negative, and the resident denied bladder pain, fever, chills, or sweats, and will recollect urine ensuring straight catheterization with a clean sample to obtain more accurate results. The lab results report dated 3/23/25 identified the urine culture collected via straight catheter showed the growth of multiple gram positive and negative organisms with three or more species recovered, none predominant and suggested either specimen contamination or patient colonization. The APRN's progress note dated 3/28/25 identified the resident was seen for follow-up evaluation of urinary tract infection. Assessment and plan identified the urinalysis was discussed with medical director and revealed greater than 100,000 bacteria with no species predominant, suggesting colonization versus contamination. The note indicated the resident was symptomatic with mild altered mental status, bladder distention, and costovertebral angle tenderness (CVA). Although likely colonization, will treat to decrease bacterial load with Cipro 250 mg twice daily for 7 days. Additionally, the resident reported feeling constipated despite having a bowel movement and Senna was increased to 2 tablets twice daily. The lab results report dated 3/28/25 identified the urine culture, collected via straight catheter showed the growth of multiple gram positive and negative organism with three or more species recovered, none predominant and indicated the culture results suggest either specimen contamination or patient colonization. The March 2025 MAR (medication administration record) identified Resident #13 was administered Methenamine Hippurate oral tablet 1 GM by mouth two times a day for UTI every day of the month with the exception of the 2nd dose on March 31st. The MAR for April 2025 identified Resident #13 was administered Cipro oral tablet 250 mg by mouth two times daily for UTI on April 1st, 2nd, 3rd, and 4th. It further identified Resident #13 was administered Methenamine Hippurate Oral Tablet 1 GM by mouth two times a day for UTI was held from 4/1 through 4/5/25 and was administered as ordered beginning 4/5/25 through 4/10/25. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 4/7/25 at 11:58 AM with LPN#6 identified Resident #13 had a decline in cognitive ability and indicated that the antibiotic was completed the previous day, and the altered mental status persisted. The March 2025 MAR identified the resident was administered Cipro oral tablet 250 mg by mouth two times a day for UTI as ordered on March 29th, 30th, and 31st. Interview on 4/8/25 at 2:42 PM with RN#4 identified when she receives culture results, she fills out and reviews the McGeer's criteria and if the resident does not meet criteria, she notifies the APRN. RN#4 indicated she noticed an increase in prescribing antibiotics for UTIs that are continued even though the resident doesn't meet the criteria. RN #4 indicated the McGeer's criteria is in place to prevent multi drug resistant organisms from developing but indicated the process was not being followed by the providers. Interview on 4/9/25 at 11:09 AM with APRN#1 identified that she was aware there was a set of criteria used to determine continuation of an antibiotic and acknowledged the McGeer's criteria from her training and indicated that she doesn't use it 100% because it doesn't take into account altered mental status changes. APRN#1 identified that if there is no growth found in a culture she would discontinue the antibiotic. APRN#1 indicated that she starts the antibiotic while waiting for culture and sensitivity results. In reference to Resident #13, APRN identified that the family was difficult and wanted the resident to have antibiotics because the family refused to acknowledge the progression of the dementia, so APRN#1 indicated she gave the resident the antibiotic because of excessive colonization, although there was not one bacteria identified as predominant. APRN#1 indicated the prophylactic antibiotic should be discontinued while the resident was receiving another antibiotic. APRN#1 identified she was aware the facility had recommendations for prescribing antibiotics but has not addressed anyone regarding her thoughts or practice preferences. Interview on 4/10/25 at 12:05 PM with RN#4 (IP) identified that when she reviews the McGeer's criteria she speaks with the APRN and identified why the resident did not meet criteria to continue antibiotics. RN#4 indicated the APRN identified that the resident had altered mental status and continued the antibiotic despite not meeting criteria. Interview on 4/11/25 at 11:50 AM with the Medical Director identified that he would never agree to keeping a resident on an antibiotic if the culture growth did not come back with a sensitivity. The medical director indicated there were other ways to treat UTI using probiotics or prophylactics and indicated that overuse of a broad-spectrum antibiotic would make a resident more susceptible to additional infection. Review of the Antibiotic Stewardship Policy identified the physician, nursing, and pharmacy leads will be responsible for promoting and overseeing antibiotic stewardship activities and to promote safe and effective use of antibiotics that will adequately treat the patient for susceptible bacterial infections and minimize the emergence of bacterial resistance in the facility and community by monitoring and changing broad spectrum antibiotics to appropriate narrowed therapy. Review of the Clinical services 72-hour UTI tracking and pathway identified if empiric antibiotics are prescribed, collect urine specimens for culture and sensitivity before antibiotic therapy is initiated, review urine culture results and indicated that more than two different organisms indicate contamination. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to ensure that Resident #57 was not administered Ciprofloxacin when there was no laboratory indication for the medication and the signs and symptoms did not meet McGeers criteria.