STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. Building B. Wing	04/17/2025

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Evergreen Post Acute	3034 South Dupont Blvd Smyrna, DE 19977

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 47621 Based on record review and interview, it was determined that for one (R641) out of the seven residents reviewed for advanced directives, the facility failed to ensure that R641's' representative was included in the advanced directive acknowledgment as R641 had cognitive impairment. Findings include: Review of R641's clinical record revealed: 7/5/24 - R641 was admitted to the facility. 7/11/24 - R641's admission MDS documented a BIMS score of 11, which was reflective of moderate cognitive impairment. 4/11/25 10:05 AM - A review of R641's EMR revealed that R641's face sheet listed F4 (R641's daughter) as the emergency contact #1. The EMR also contained documentation of a signed and notarized POA with two witnesses dated from 2006 that named F4 as the sole POA for both durable medical and financial issues. 4/11/25 10:25 AM - A review of R641's admission paperwork revealed that E6 (SW) completed the Advance Directive Acknowledgment form with R641 on 7/5/24. A review of the form revealed that R641 printed her name on the signature line using a different first name and mispelling her last name, leaving a letter out of it. 4/11/25 11:04 AM - During an interview, E5 (SW Director) stated, For new admissions, we try to do the BIMS section of the MDS right away. If they come in during the evening, we try to do it the next day. A BIMS score for a person with cognitive impairment is 6 or 7. If they have a score of 10-11, then it is a judgment decision. We don't really have a cutoff score for when residents cannot make decisions. It is more of a judgment thing. There really is not any formal training for the BIMS test. It is a piece of paper that we follow. When filling out the Advance Directive Acknowledgement form, if they want more information about advanced directives, we get the ombudsman involved. 4/11/25 11:47 AM - During an interview, E2 (DON) stated, Normally, if the BIMS score is below 12, we get the family representative or POA involved in signing the paperwork. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 32810 Based on record review and interview, it was determined that for one (R188) out of four residents reviewed for Beneficiary Notification Review, the facility failed to ensure the resident was informed in advance of a change that occurred to their bill. Findings include: Review of R188's clinical record revealed: 5/2/24 - R188 was admitted to the facility. 6/1/24 - An Eligibility Verification Notice was provided to the facility by R188's insurance that indicated the resident had 0 days remaining for nursing home stay. 6/3/24 11:15 AM - A SNFABN notice was read over the telephone to R188's Responsible Party (RP)(R188's daughter) that explained beginning on 6/4/25 R188 and RP would be responsible to pay out of pocket for the R188's facility stay. The notice was completed by E5 (SW) and witnessed by E6 (SW). 4/11/25 8:15 AM - During an interview, E4 (BOM) confirmed that R188 and RP were not made aware of the change in billing in advance. E4 explained that the facility was made aware of R188's change in coverage on 6/3/24 and provided the SNFABN notice that same day, then charged R188 from the last date of coverage 5/26/24. 4/11/25 9:00 AM - A statement of the same date was provided to the surveyor by E4 (BOM) that indicated R188 was billed from 5/26/24 - 5/31/24 $506.00/day = $3036.00. Then billed 6/1/24 -6/3/24 $506.00/day = $1518.00 for room and board. The statement contained a projected write off of the bill dated 4/30/25. E4 stated she contacted corporate that morning and that R188 and RP would no longer be responsible for the bill. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). 46988 Based on record review and interviews, for one (R112) out of five sampled for abuse, it was determined that R112 was not free from involuntary seclusion. Findings include: Cross refer F684 and F880. Review of R112's clinical record revealed: 7/30/24 - R112 was admitted to the facility. 8/18/24 - A SBAR (physician's communication tool) documented that R112 had a rash on both arms and upper thighs. 8/18/24 3:15 PM - A nursing skin observation tool documented R112 had the following skin conditions noted: right antecubital rash, left antecubital rash, bilateral thighs front. 8/27/24 - A care plan documented that R112 was placed on isolation precautions related to scabies. 8/27/24 3:12 PM - A physician's order documented that R112 was on contact isolation due to scabies for fourteen days. R112's 8/24 MAR documented that Ivermectin oral tablets and Permethrin external cream for scabies were started on 8/29/24. 9/3/24 - A physician (C5 NP) progress note documented that R112 was seen and examined for a scabies. C5 documented for R112 to continue on Permethrin external cream to skin at bedtime for seven days, then for two days a week, and to continue isolation precautions. 9/16/24 - A physician (C5 NP) progress note documented that R112 requested to be seen and wanted to be taken off isolation precautions. The progress note documented that the rash to upper extremities had resolved and that the rash was now on lower extremeties and inner thighs. E21 documented for R112 to continue on Permethrin external cream and added benadryl and hydrocortisone creams regimen for itching. R112 was to continue on contact isolation precautions. 10/4/24 - A physicians (C5) progress note documented R112 was seen for a follow up for scabies and that a new linear rash was noted on his abdomen. It was noted that the rash had improved with the applications of Permethrin cream. R112 was to continue on isolation precautions. 11/9/24 - A physicians order was written for R112 to have a consult with dermatology related to scabies. 11/13/24 - A physician progress note documented that R112 was seen for a follow up post dermatology consult, and dermatology diagnosed R112 with atopic dermatitis (generalized rash). Per dermatology, R112's rash was unrelated to scabies and contact isolation discontinued per order. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/8/25 6:48 AM - An interview with R112 revealed that R112 was on contact isolation for 78 days related to a misdiagnosed scabies outbreak. R112 stated I felt like a prisoner being confined to this room all that time and no one would listen to me until I saw the dermatologist. R112 stated that he did not receive showers until sometime in October. 4/14/25 10:48 AM - An interview with E38 (CNA) confirmed that R112 was on isolation precautions and unable to shower from August 27, 2024 to October 16, 2024. 4/15/25 10:30 AM - During an interview with C2 (NP) and C5 (NP), C2 stated that the providers do not determine how long a resident is on isolation precautions, that the facility mandates the timeframe. C2 and C5 confirmed that they did not refer to the CDC guidelines for the treatment of scabies for R112. Additionally, C2 stated that R112 had requested a meeting with the providers to discuss why he was still on isolation precautions, and C2 confirmed that once R112 was seen by dermatology, that R112's isolation precautions were removed. 4/15/25 11:12 AM - An interview with E1 (NHA) confirmed that the process of determining isolation precautions is a collaborative effort between the IDT team which includes input from the physician's, management, and the infection control preventionist. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 47621 Based on record review and interview, it was determined that for one (R136) out of forty-three sampled residents, the facility failed to complete a comprehensive assessment after R136 had a significant change in status. Findings include: Review of R136's clinical record revealed: 11/7/24 - R136 was admitted to the facility. 12/6/24 - R136 was admitted to hospice care. 1/2/25 - C2 (consultant NP) entered an order into R136's EMR, Hospice [local hospice service] every shift. This was twenty-seven days after R136 was admitted to a hospice service. 4/9/25 1:44 PM - A review of R136's EMR MDS schedule revealed there was no significant change MDS completed within fourteen days of R136's hospice admission. 4/10/25 11:02 AM - In a telephone interview, C1 (hospice office staff) confirmed. [R136] was admitted to our hospice service on 12/6/2024. 4/10/25 11:27 AM - During an interview, E4 (Business Office Manager) confirmed, [R136] went on hospice care on 12/6/24. 4/10/25 1:23 PM - During an interview, E11 (RNAC) confirmed that R136's MDS for a significant change was completed on 1/3/25, as soon as the MDS office became aware that R136 was placed on hospice services. We were not aware of the change. We did the mandatory MDS assessment as soon as we were notified. 4/11/25 9:36 AM - Review of the Ombudsman Transfer/Discharge list for December 2024 revealed R136 was listed as converting to hospice on 12/6/24. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 32810 Based on record reviewed and interview it was determined that for one (R196) out of forty-three residents sampled, the facility failed to ensure the person centered care plan included necessary interventions. Findings include: The facility policy on dialysis care last updated, January 2025 indicated, The nurse will monitor and document the status of the resident's access site. Review of R196's clinical record revealed: 2/15/25 - R196 was admitted to the facility with multiple diagnoses including kidney disease. 2/16/25 - A task was added to R196's physicians orders for blood pressure medications for staff not to obtain blood pressures on the resident's right arm. 2/18/25 - A care plan was created for R196's renal disease. Interventions for the care plan included dialysis twice a week, monitor lab and report abnormal results, observe for and report any signs of infection/leaking/dislodgement of dialysis catheter and record weights and report changes. There was no evidence that the care plan included an intervention to avoid blood pressures to the right arm due to the dialysis catheter. 2/21/25 - An admission MDS assessment documented that R196 received dialysis. 4/17/25 4:26 PM - During an interview E2 (DON) confirmed the finding. 4/17/25 5:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47114 Based on record review and interview, it was determined that for five residents (R91, R119, R120, R130, and R440) out of forty three sampled residents, it was determined that for R440 and R130 the facility failed to implement care plan interventions. For R12, the facility failed to hold a quarterly care plan meeting. For R91, R119, and R120 the facility failted to have input from all required interdisciplinary team (IDT) members at the residents' care plan meetings. Findings include: 1. Review of R440's clinical record revealed: 4/1/25 - R440 was admitted to the facility with the diagnosis of syndrome of inappropriate antidiuretic hormone secretion (a condition in which high levels of a hormone cause the body to retain water). 4/2/25 3:00 PM - A physician's was order written for R440 that documented Fluid restriction 1200 milliters a day. 4/2/25 - R440's care plan that was initiated on 4/2/25 documented potential/alteration in nutritional status r/t (sic) need for mechanically altered, fluid restricted diet. The care plan lacked evidence the resident was resistive to the physician's order for a fluid restrictive diet. 4/8/25 10:09 AM - An observation revealed that R440 had a water pitcher sitting on the nightstand next to the bed filled with ice water, and a large drinking mug sitting on the over bed table next to R440's bed filled with liquid. [R440] stated, oh that has Gatorade in it. 4/9/25 8:53 AM - A second observation revealed that R440 had a water pitcher and two other large drinking mugs at the bedside. 4/9/25 9:15 AM - An interview with E16 (RN, UM) confirmed that R440 does not comply with fluid restrictions. E16 stated, [R440's] wife brings in additional fluids for him, we have educated them we are keeping a close eye on it and I'm going to check to see if the care plan was updated to reflect this problem, if not I'm updating it now, we are going to stay on top of that. 4/9/25 - R440's care plan, revised 4/9/25, documented resistive/noncompliant with treatment/care related to disbelief in value of treatment (resident and family has been educated numerous times on risks associated with not following fluid restrictions) interventions included provide education about risks of not complying with therapeutic regimen, provide education to patient/family. Cross Refer, F677 example 1 2. Review of R130's clincial record revealed: 3/7/25 - R130 was admitted to the facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/10/25 - A review of R130's care plan for ADL self-care deficit documented [R440's] will be clean, dressed and well-groomed daily to promote dignity and psychosocial wellbeing for ninety days. R440's interventions included assist with daily hygiene, grooming, dressing, oral care, and eating as needed. 3/13/25 - R130's admission MDS assessment documented the resident was severely cognitively impaired and required substantial maximum assistance for personal hygiene and grooming. 4/8/25 9:26 AM and 4/11/25 11:07 AM - Observations confirmed that R130's nails on both hands were long, with dark encrusted debris underneath each nail. E16 (RN UM) confirmed that R130 needed nail care. 4/11/25 11:07 AM - E16 (RN UM) stated Well last week the CNA was trying to do [R130's] nail care and she ecame combative so it couldn't get done. E16 also confirmed R130's ADL care plan had not been revised to reflect refusal of nail care. E16 stated, No she has not been care planned for refusing nail care. 40260 3. Review of R119's clinical record revealed: 5/13/24 - R119 was admitted to the facility. 5/20/24 - An admission MDS was completed. 5/22/24 - The admission Resident Care Conference Attendance Sheet for R119's post admission care plan meeting lacked evidence of attendance or input from a physician, a registered nurse, a CNA, or dietary staff. 4/17/25 8:34 AM - In an email communication, the surveyor notified E1 (NHA) and E2 (DON) that there was a lack of evidence of input by all IDT members at the initial care plan meeting. E1 responded that the facility will ensure participation from these parties immediately and ongoing in all care plan meetings, including the initial meetings. 4. Review of R120's clinical record revealed: 5/14/24 - R120 was admitted to the facility. 5/20/24 - An admission MDS was completed. 5/20/24 - The admission Resident Care Conference Attendance Sheet for R120's post admission care plan meeting lacked evidence of attendance or input from a physician, a registered nurse, a CNA, or dietary staff. 4/17/25 8:34 AM - In an email communication, the surveyor notified E1 (NHA) and E2 (DON) that there was a lack of evidence of input by all IDT members at the initial care plan meeting. E1 responded that the facility will ensure participation from these parties immediately and ongoing in all care plan meetings, including the initial meetings. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46988 5. Review of R91's clinical record revealed: 2/27/25 - R91 was admitted to the facility. 3/5/25 - An admission MDS was completed for R91. 3/7/25 10:00 AM - The admission Resident Care Conference Attendance Sheet for R91's post admission care plan meeting lacked evidence of attendance or input from a physician, a CNA, or dietary staff. 4/14/25 11:57 AM - An interview with E5 (SW) confirmed that all members of the interdisciplinary team were not present or provided input on 3/7/25 for R91's care plan meeting. E5 confirmed input from the physician, CNA, and dietary was not provided. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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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. 46988 Based on interview and record review it was determined that for two (R112 and R644) out of forty three residents reviewed in the investigative sample, the facility failed to ensure received treatment and care in accordance with professional standards of practice and physician orders. Findings include: 1. Review of R112's clinical record revealed: Cross refer F603 and F880 7/30/24 - R112 was admitted to the facility. 8/27/24 3:12 PM - A physician's order documented that R112 was on contact isolation due to scabies for fourteen days. 11/9/24 - A physicians order was written for R112 consult to dermatology related to scabies. 11/13/24 - A specialist physician's (dermatologist) progress note documented that R112 was not contagious and to remove isolation precautions. 4/15/25 10:30 AM - An interview with C2 (NP) and C5 (NP) confirmed that R112 was on contact precautions from 8/27/24 to 11/13/24. There was a ten week delay in consulting the dermatologist resulting in R112 being in isolation for 78 days. 47621 2. R644's clinical record revealed: Cross refer F760 9/12/24 - R644 admitted to the facility with diagnoses including but not limited to, heart failure and chronic obstructive pulmonary disease. 10/2/24 - C2 (contractor NP) entered order in R644's EMR stating, DC (discontinue) PICC (peripherally inserted central catheter) RUE (right upper extremity) . 10/3/24 - R644's Resident Care Conference Attendance Record documented that E23 (RN) and F3 (R644's daughter) participated in this discharge planning conference. The paperwork stated, PICC will be pulled by nursing . 10/5/24 - R644 was discharged home on hospice services. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/11/25 2:08 PM - During a telephone interview, F3 (R644's daughter) stated, .When my mom [R644] arrived home after discharge from Evergreen, her PICC line was still in. It was supposed to be taken out at Evergreen prior to discharge.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39058 Based on observation, record review and interview, it was determined that for one (R35) out of 11 resiedents reviewed for accidents the facility failed to implement a care planned fall intervention. Findings include: Review of R35's clinical record revealed: 6/27/24 - R35 was admitted to the facility. 6/27/24 - An admission MDS documented the resident required extensive to total assistance with most ADLs, including transfers and mobility. The resident was dependent for bed mobility, toileting, and dressing. 9/25/24 - R35 was readmitted to the facility from the hospital with diagnoses including a right broken leg from a fall at the facility. A care plan revised on 10/2/24 included a new intervention for fall mats to be placed at the bedside when R35 is in bed. 10/3/24 - A fall risk assessment scored R35 at 17, indicating a high risk. On the following dates, no fall mats were observed at the bedside while R35 was in bed: 4/8/25 at 7:46 AM 4/11/25 at 2:27 PM 4/15/25 at 10:25 AM On 4/15/25 from approximately 10:55 AM to 11:00 AM, during an interview and observation with E15 (CNA) and E16 (CNA) it was confirmed there were no fall mats at the bedside or in the room. 4/15/25 11:10 AM - An interview with E16 (Unit Manager) and E2 (Director of Nursing) it was revealed that the intervention for fall mats was listed on the task list. E2 confirmed that fall mats should have been placed at the bedside while R35 was in bed and stated the issue would be addressed immediately. On 4/16/25 at 8:23 AM, during a final observation, R35 was in bed with fall mats appropriately in place. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47621 Based on record review and interview, it was determined that for one (R644) out of eleven residents, the facility failed to ensure that R644 was free of medication error. On 9/13/24, R644 was inadvertently given the incorrect medications (amlodopine 10mg, benzapril 40mg, Coreg 25 mg and selevamer 800mg). This medication error resulted in harm as R644's blood pressure significantly dropped and she was sent emergently to the hospital for evaluation and treatment. This harm is being cited as past non-compliance. Findings include: Facility's Medication Administration policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Procedure: 3. Identify resident by photo in the MAR (medication administration record) . 10. Compare medication source with MAR to verify resident name, medication name, form, dose, route and time . Rev. 1/2025 Review of R644's clinical record revealed: 9/12/24 - R644 admitted to the facility with diagnoses including but not limited to, heart failure and chronic obstructive pulmonary disease. 9/13/24 9:30 AM - E23 (staff RN) documented in R644's EMR progress notes, Resident's vital signs checked and resident noted to be hypotensive 65/26 in LUE (left upper extremity) . 9/13/24 9:37 AM - C6 (EMT) documented in R644's prehospital care report, . The staff relayed the patient [R644] was given amlodipine 10 mg, benzaprine 40 mg, Coreg 25 mg and sevelamer 800 mg this morning at 8:20 AM. The staff relayed that those medications are not prescribed for the patient and the patient was suppose to be given amlodipine 5 mg, clonidine 0.1mg, furosemide 40 mg and losaratan 100 mg. The staff relayed that they checked the patient's blood pressure an hour after the medication mix-up and found the patient to be hypotensive and 911 was activated . 9/13/24 9:48 AM - R644's blood pressure (BP) documented on the prehospital care report as 50/20. 9/13/24 9:53 AM - R644's blood pressure (BP) documented on the prehospital care report as 50/26. 9/13/24 3:25 PM - C7 (hospital ER DO) documented on R644's ER visit summary, .Reason for visit: drug overdose, Diagnosis: hypotension .You were seen here in the emergency room for your low blood pressure after taking the wrong medication. We did an evaluation that included blood work and gave you IV fluids . Blood pressure 110/51 . 9/14/24 1:31 AM -E27 (LPN) documented in R644's EMR progress notes, .Resident returned from [hospital] via stretcher accompanied by 2 EMTs . VS 132/78 (BP), 72 (HR), 18 (Respirations), 97.9 (temperature), 98 (pulse oximetry) on O2 (oxygen) . R644 spent approximately 16 hours in the hospital ER receiving IV fluids and having her vital signs monitored. R644 returned to the facility on [DATE] at 1:31 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Post Acute	3034 South Dupont Blvd Smyrna, DE 19977

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	9/18/24 - R644's admission MDS documented a BIMS score of 14, which was reflective of normal cognition. 4/11/25 2:03 PM -During a telephone interview, C6 confirmed that E27 (LPN) admitted to accidentally giving R644 her roommate's medications. 4/11/25 3:12 PM - A review of the facility's incident investigation provided a typed and signed statement from E27 (staff LPN) stating,Around 8:15 AM, I pulled R644 roommate's medications. I was looking at the name in the room, there was only one name in there. I took her blood pressure, and it was normal. I called her [R644's roommate's name]. I said to R644, 'I have your medication' and she said I need my medication in pudding. I did not know she [R644] was hard of hearing. I gave medication and then I went to the roommate in B bed and that's when I realized I gave A bed, B bed's medication. I looked at the arm bands after I realized I made a mistake. At 8:20 AM the unit manager contacted the provider and provider stated to recheck the vital signs in a n hour. I re-checked her in about an hour later. Her blood pressure was 74/55 automatic blood pressure machine and then re-checked again still low. At 9:21 AM the unit manager contacted the provider and received orders to send to the ER for evaluation. 4/14/25 11:30 AM - An attempt to contact E27 for an interview was unsuccessful. 4/16/25 3:30 PM - A review of all the documentation of the corrective action plan completed by the facility included: -Timely reporting to the state Agency -Additional education regarding medication administration for E27 -Additional monitoring of E27 including a 3-person med pass with the Pharmacist to verify her knowledge of med administration and shadowing during all med passes until she was cleared for normal duty. E27 was terminated on 1/1/25 for failing to perform the requirements of the job. -Notification of the family informing them of the medication error It was verified by the surveyor that the corrections were completed as of 9/18/24 through document review and interview. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47621 Based on record review and interview, it was determined that for two (R14 and R639) out of twelve residents reviewed for infection control, the facility failed to initiate and maintain appropriate precautions per CDC guidelines. Additionally the facility failed to follow standard precautions. Findings include: CDC's Infection Control Appendix A: Type and duration of Precautions Recommended for Selected Infections and Conditions .Multidrug-resistant organisms, infection or colonization (e.g., MRSA, VRE, VISA/VRSA, ESBLs, resistant S.pneumoniae) Contact + Standard . February 7, 2025 Facility's Infection Prevention and control Program Policy: .Policy Explanation and Compliance Guidelines: . 5. Isolation Protocol (Transmission-Based Precautions): a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines. Rev 1/2025 Facility's Enhanced Barrier Precaution Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO). Enhanced Barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices). 1.Review of R14's clinical record revealed: 12/13/20 - R14 was admitted to the facility with diagnoses including but not limited to, multiple sclerosis, seizures and S/P colostomy. 10/5/23 - 10:23 AM - C3 (consultant medical director) documented in R14's progress note, .History of present illness: Patient is a [AGE] year old male with past medical history significant for HTN (hypertension) . colostomy . 4/1/24 - New EBP guidelines from CMS were effective in long term care facilities. 11/22/24 - C2 (consultant NP) initiated an order in R14's EMR, Enhanced Barrier precautions related to history of ESBL urine, colostomy. Every shift for monitoring. The facility failed to initiate EBP for R14 until eight months (from 4/1/24 to 11/22/24) after the new guidelines were mandated. 4/16/25 - 12:01 PM - During an interview, E2 (DON) confirmed that R14 has had a colostomy since he has been in the facility. 2. Review of R639's clinical record revealed: 6/21/24 - R639 was admitted to the facility with diagnoses including but not limited to, chronic obstructive pulmonary disease. (continued on next page)

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	085020	A. Building B. Wing	04/17/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/3/24 - 5:37 PM - C4 (hospital MD) documented in R639's discharge summary, Principal diagnosis: MRSA pneumonia . due to positive MRSA swab . discharge medications: .linezolid 600 mg (milligram) tablet- take 1 tablet by mouth 2 times a day for 20 days . 10/3/24 - C2 (NP) entered order in R639's EMR stating, linezolid tablet 600 mg - give 1 tablet by mouth every 12 hours for infection of lungs for 20 days. 4/16/25 - 10:35 AM - A review of R639's EMR revealed that there was not a contact precautions order in effect while R639 was being treated for MRSA pneumonia with linezolid (antibiotic to treat MRSA pneumonia). The facility failed to initiate contact precautions for R639 while he was being treated for MRSA pneumonia from 10/3/24 to 10/24/24. 47114 4/8/25 6:16 AM - A random observation revealed a clear plastic trash bag with dirty briefs and gloves was sitting on the floor in front of room [ROOM NUMBER] which had signage on the door that indicated EBP (Enhanced Barrier Precautions). 4/8/25 6:20 AM - E26 (CNA) was observed leaving room [ROOM NUMBER] wearing disposable gloves. E26 picked up the trashbag and proceeded to walk across the hallway to room [ROOM NUMBER] another room with EBP signage on the door, placed the trash bag on the floor and entered the room wearing the contaminated gloves on both hands. 4/8/25 6:41 AM - During an interview E2 (DON) observed the trash bag was sitting on the floor in the doorway of room [ROOM NUMBER]. E2 stated, No this should not be it should go directly to the biohazard room. E2 picked the trash bag up off the floor, E26 opened the door to leave room [ROOM NUMBER] wearing gloves, E2 stopped E26 in the hallway and educated the CNA on wearing gloves, hand washing and that trash should not go from room to room and is to be taken to the biohazard room for disposal. The trash was disposed off by E2. 4/8/25 8:31 AM - An additional observation of room [ROOM NUMBER] with EBP signage revealed a clear plastic bag with dirty linen and a bag with briefs and other trash were sitting on the floor inside of room [ROOM NUMBER]. E16 (RN, UM) entered room [ROOM NUMBER] and picked the bags up off the floor. E16 confirmed and stated, Yes I know the trash bags being left on the floor is an infection control concern. E16 proceeded to take the bags to the biohazard room for disposal. 4/17/25 1:45 PM -Findings were reviewed with E1 (NHA) and E2 (DON).