STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilpin Hall	1101 Gilpin Avenue Wilmington, DE 19806

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 11599 Based on interviews, record review, and facility policy review, the facility failed to notify the Resident Representative (RR) following a fall with injuries for one of three residents (Resident (R) 94) out of a total sample of 34 residents. The failure created a delay for R94 to have their RR to get to the hospital to see before R94's condition worsened. Findings include: Review of the facility's Fall Prevention/Post Fall Policy and procedure, last reviewed 08/25/24, revealed the following: A. On admission 1. The nurse completes Morse Fall Scale. 2. If it is determined that the resident is at risk for falls a care plan will be put in the record. B. Post-fall l. An Incident Report will be completed. 2. Nurse will document in the resident's progress note. 3. Morse Fall Scale will be completed. 4. Contact responsible party, physician, and Director of Nursing. This should be documented in progress notes as well as Action section of incident report. Closed record review of R94's Admission Record, located under the Profile tab in the electronic medical record (EMR), revealed the resident was admitted to the facility with diagnoses that included dementia, abnormalities of gait and mobility, unspecified convulsions, and seizures. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R94's quarterly Minimum Data Set (MDS), located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 12/24/23, revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15 which indicated R94 had severe cognitive impairment. R94 was identified to be dependent on staff for all cares and was not walking at the time of the assessment. Review of R94's Care Plan, updated 1023/23 located under the Care Plan tab in the EMR noted R94 had a history of wandering and a history of falls. The resident attended the Safety Program, identified as the Cottage, from 9:00 AM to 8:00 PM. Safety interventions were identified as every 30 minute safety checks, safety helmet when out of bed, hipsters on at all times, followed by neurologist for seizures, non-slip footwear, wheelchair with anti tippers, and Physical Therapy evaluation and treatment dated 12/07/23. Review of a 12/24/23 Incident Report, provided by the Director of Nursing (DON), noted Resident witnessed by dietary staff getting up from wheelchair and falling to the floor. Dietary staff notified nursing staff. Resident assessed for injuries, noted W [with] facial laceration and bleeding from the mouth, upper/lower extrimities [extremities] assessed no limitations noted, VS [vital signs] assessed WNL [within normal limits], area noted with adequate lighting, wheelchair noted in lock position. PCP [primary care physician] notifled [notified], resident sent to hospital for further evaluation. Review of the Nurses Note, located under the Progress Notes tab in the EMR, dated 12/24/23 at 11:53 PM, read Resident witnessed by dietary staff getting up from wheelchair and falling to the floor. Dietary staff notified nursing staff. Resident assessed for injuries, noted w/ [with] facial laceration and bleeding from the mouth, upper/lower extrimities [extremities] assessed no limitations noted, VS [vital signs] assessed WNL [within normal limits], area noted with adequate lighting, free of clutter, wheelchair noted in lock position. PCP notified, resident sent to hospital for further evaluation. Attempted to notify POA, unsuccessful. The incident was identified to have occurred at 6:30 PM. Both the incident report and the nurses note were written by Licensed Practical Nurse (LPN)1. During an interview on 10/16/24 at 9:41 AM, R94's RR stated On Christmas eve, 12/24/23, her sister's friend who works at the hospital, notified her sister that [R94] was at the hospital. The sister called [R94's RR] who called the facility to ask what was going on. Neither the [R94's RR] or the sister had been notified by the facility. [R94] should not have been left alone. She was in a wheelchair next to the desk outside the nurse's station. She stood up and fell over the foot pedals. The facility never called me. R94's RR stated When I questioned nurse, the nurse [LPN1] said she called the resident's husband, she could not have, that number is disconnected, he passed on 11/01/23. Then the nurse said she had tried the next number, [RR's] cell, but couldn't get through. That's not true either. I did not receive any calls. By the time I got to the second hospital where she was transferred, [R94] was intubated, and I didn't get to speak to her. R94 was placed on Hospice (end of life) care and subsequently passed away. During an interview on 10/16/24 at 10:17 AM, LPN1 said I was on second floor, called when incident happened. I assessed the resident; she was bleeding from her head and lip. I called the ambulance, called the Power of Attorney [RR] home number, couldn't get through, tried both numbers but they didn't work. I remember that I talked to the daughter who had got wind of the incident, so I told her what happened and that I tried both numbers, they were busy or not working. [R94] was in the safety program, the Cottage, and had just come down from there. She was seated next to the desk, tried to get up and fell . Dietary saw it happen. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/18/24 at 11:55 AM, LPN5 stated I remember [R94], she walked all the time, we would have to encourage her to sit down or sit in the recliner to get her to rest, especially when she appeared tired. She did not always use a wheelchair, just sometimes. When you are sending someone to the hospital, you first take care of the resident, if bleeding put pressure, call doctor, get order to transmit, call ambulance, notify family. May not always check the box on the form, but always put it in the progress notes. The hospital transfer form for the 12/24/23 incident was not located in the EMR. The form had an area to check that the RR had been notified. The DON and Administrator were asked, on 10/18/24 at 12:19 PM, to locate the document. No documentation was provided as of exit on 10/18/24 at 4:00 PM. During an interview on 10/18/24 at 1:00 PM, the Administrator said she knew about the concern with notification because the RR had come in after the resident passed away. I thought [RR] had been notified.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on interview, record review, and facility policy review, the facility failed to provide Form CMS-10055 (Centers for Medicaid and Medicare Services) Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) to two of three residents (Resident (R) 10 and R77) reviewed for liability notices out of a total sample of 34 residents. This failure prevented the resident or responsible party the ability to make an informed decision related to the cost of continued therapy services. Findings include: Review of the CMS site, Form Instructions Advance Beneficiary Notice of Non-coverage (ABN) OMB Approval Number: 0938-0566 accessed at https://www.cms.gov/medicare/medicare-general-information/bni/downloads/abn-form-instructions.pdf on 06/04/24 revealed, The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Unless otherwise instructed to do so according to the specific guidance provided in these instructions, the notifier must not decide for the beneficiary which of the 3 checkboxes to select . If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: beneficiary refused to choose an option. 1. Review of R10's electronic medical record (EMR) titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of a document provided by the facility titled provided by the facility titled Notice of Medicare Non-Coverage indicated R10's skilled services ended on 10/12/24. Review of R10's EMR indicated the resident remained in the facility after the end of her skilled services. 2. Review of R77's EMR titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of a document provided by the facility titled provided by the facility titled Notice of Medicare Non-Coverage indicated R77's skilled services ended on 08/28/24. Review of R15's EMR indicated the resident remained in the facility after the end of her skilled services. During an interview conducted on 10/16/24 at 9:50 AM, the Admission Coordinator confirmed she never provided the ABN letter along with the NOMNC notice. During an interview conducted on 10/18/24 at 11:07 AM, the Administrator stated they have never provided the ABN notice since there were residents who remained in their facility and Medicaid was their payment source and this would add to the confusion for the resident and/or family members, if the facility broke down the costs to provide continued skilled services.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on facility policy review, record review, and interviews, the facility failed to ensure their grievance procedures were followed for one resident (Resident (R) 79) of one resident reviewed for grievances out of a total sample of 34 residents. This failure increased the potential for resident grievances to go unresolved. Findings include: Review of a policy provided by the facility titled Grievance Procedure dated 03/11/22 indicated .The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.Notice on how to make a grievance is included in the Resident Handbook, and is also reviewed upon admission, is posted on each nursing floor.A copy of this procedure must be given to the resident upon request. Equipment and Supplies.Point Click Care Risk Management Incident report form (online).Grievance Form. Review of R79's electronic medical record (EMR) titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of a document provided by the facility titled Grievance Log dated 01/16/24 indicated a family member of R79 filed a grievance alleging the resident did not receive a dinner tray the night before. Under a heading titled Resolution it revealed there was a delay in staff delivery. During an interview conducted on 10/16/24 at 12:01 PM, the Administrator stated she was the staff member who handled all of the facility grievances and stated she had no additional information to provide on the meal tray issue and R79. A subsequent interview was conducted on 10/16/24 at 12:23 PM, and the Administrator confirmed she did not provide residents and/or family members with a written response of grievance(s) which included the resolution.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07246 Based on record review, interviews, and facility policy review, the facility failed to ensure: seven of 10 residents (Residents (R)69, R83, R89, R87, R20, and R67) reviewed for abuse were free from resident-to-resident abuse. These failures increased the risk of continued abuse towards the residents. Findings include: 1. Review of the Abuse Policy/Procedure, review date 06/27/23, under Identification indicated . abuse, neglect or mistreatment may be suspected in, but not limited to the following situations: ii. Physical Abuse: Intentionally and unnecessarily inflicting pain, injury, or degradation to a resident' This includes, but is not limited to hit, push, kick, slap, pinch, or sexually molest any resident'. iii. Verbal Abuse: ridiculing or demeaning a resident, cursing directed to a resident, threatening to inflict harm or verbal abuse to a resident . Under Protection . c. Residents will be protected from other residents in various ways depending on the level and type of abuse. Alternatives may include changing resident rooms, altering resident care plans or discharging a resident from the facility to protect the safety of other residents. d. Incidents involving resident to resident abuse will be reviewed by the clinical team. A care plan review will also be conducted to implement interventions to avoid further instances . a.Review of R69's EMR Admission Record located under the Profile tab, indicated the resident was admitted to the facility with a diagnosis of Anxiety disorder, Dementia, and Major Depressive disorder, Review of R69's EMR quarterly MDS with an ARD of 08/26/24 indicated the resident had a BIMS score of three out of 15 which revealed the resident was cognitively impaired. Review of R69's EMR Care Plan located under the Care Plan tab, revision date 09/14/22, indicated the resident was at risk for elopement/wanderer, entering into other resident's rooms looking for family, car, related to impaired safety awareness and dementia. The Intervention/Tasks, revision date 12/22/21, indicated to distract resident from wandering, provide structured activities, visual safety checks every hour. Review of R69's EMR Nurse's Notes located under the Progress Notes tab, indicated that on 02/27/24 an altercation coming from R44's room was heard, R69 was observed placing his hand over his left eye. R69 was noted to have bloodshot and specks of blood within the orbital area. It was also documented in the same nurse's note that R69 stated he was hit in the eye by the other resident (R44) in the room. R69 was sent to the Emergency Department for further treatment and evaluation on 02/27/24 via ambulance services. Further review of the resident EMR indicated that R69 is on Xarelto, an anticoagulant medication, which can result in excessive bleeding and bruising. Review of the Emergency Department note, dated 02/27/24, indicated R69's sustained a Subconjunctival hemorrhage, and Corneal abrasion. R69 was discharged and returned to the nursing facility on 02/27/24 with a prescription for Erythromycin ophthalmic ointment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the ER Discharge Instructions, dated 02/27/24, revealed the following prescription: Erythromycin ophthalmic (erythromycin 0.5% ophthalmic ointment) 0.5 inch in the eye four times a day. Review of the Medication Administration Record (MAR) of the months of February and March 2024, revealed that the resident was started on the Erythromycin ointment at 9:00 AM and with the last dose given on 03/04/24 at 12 noon. Review of the MAR for February 2024 revealed that on 02/27/24 the resident was medicated with Tylenol 325 mg ii tablets for pain. The pain was documented at a 5 out of 10 at 9:11 AM and 5:14 PM. During a telephone interview on 10/18/24 at 10:17AM, Registered Nurse (RN)1 stated R69 had wandered into resident R44's room and RN1 heard R44 say get out of my room, get out of my room. RN1 stated he went into the room and observed R69 covering his eye. RN1 stated he separated both residents and examined R69's eye and noted that R69's eye was bloodshot with blood specks. RN1 stated he notified the physician and transferred R69 to the Emergency Department for further treatment and evaluation. RN1 also stated that he talked to R44 and asked him to use the call light or call a staff member when someone enters his room. RN1 further stated R44 was in agreement with calling staff when someone entered his room. Review of R44's EMR Admission Record located under the Profile tab, indicated the resident was admitted to the facility with diagnoses including Dementia and Alzheimer's disease. Review of R44's EMR annual MDS with an ARD of 08/16/24 indicated the resident had a BIMS score of five out of 15 which revealed the resident was cognitively impaired. Review of R44's EMR Care Plan located under the Care Plan tab, revision date 02/28/24, indicated the resident had the potential to become verbally and physically aggressive towards other residents that cause him to feel threatened or invade his personal space secondary to being impulsive, short tempered and territorial. The Intervention/Tasks revision dated 02/28/24 indicated the resident's behaviors was de-escalated by removing other persons from his space, . encourage seeking out of staff member when agitated before becoming physical . when the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress . Interview on 10/15/24 at 10:23AM, and 4:05 PM and on 10/18/24 at 8:15AM, R44 stated that R69 wanders into his room, and he tells him get out of my room but denied hitting R69. Interview on 10/18/24 at 5:20 PM, the Assistant Director of Nursing (ADON) stated R44 denied hitting resident R69. The ADON further stated that there have been no further altercations and or resident to resident abuse involving R44 and R69. b. Review of R83's EMR Admission Record located under the Profile tab, indicated the resident was admitted to the facility diagnoses of Dementia, Personality Disorders, and Major Depressive disorder. Review of R83's EMR annual MDS with ARD of 11/20/23 indicated the resident had no BIMS score to determine the resident's was cognitive status. The assessment revealed the resident was dependent on staff for activities of daily living (ADL). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R83's EMR Care Plan located under the Care Plan tab, revision date 11/25/22, indicated the resident had an ADL self-care performance deficit related to Dementia, and had limited physical mobility related to being non-ambulatory. The Intervention/Tasks revision date 11/25/22 under locomotion indicated R83 was dependent on staff for locomotion using a Geri-chair. Further review of the Care Plan revealed R83 was at risk for emotional distress related to male resident rubbing her stomach and while she was seated in the lounge waiting for dinner. The Intervention/Tasks initiated date 07/18/24 indicated resident remains in common area for increased observation. Review of R83's EMR Nurse's Notes located under the Progress Notes tab, indicated a late entry note dated 07/21/24 indicated that on 07/20/24 a male resident was observed rubbing R83's groin area. R83 was sitting in a Geri-chair at the TV lounge. Interview with R83 was attempted during the survey without success. During an interview on 10/16/24 at 1:09 PM, Dietary Aide (DA) 1 stated that R83 was sitting in her Geri-chair near the nurses' station when R64 was observed rubbing R83's legs near the groin area, she stated I was breaking down the trays after lunch and I saw what he was doing and I told the nurse immediately. I separated them first, and then told the nurse, there were no nurses or staff around they were busy taking people to their rooms. He just rolled himself over to her, she doesn't talk so she did not tell him to get away or push him away. I rolled him to the opposite side of the room, locked his wheelchair and went to get and tell the nurse. Review of R64's EMR Admission Record located under the Profile tab, indicated the resident was readmitted into the facility with a diagnosis of Dementia. Review of 64's EMR quarterly MDS with an ARD of 08/21/24 indicated the resident had a BIMS of five out of 15 which revealed the resident was cognitively impaired. The assessment revealed the resident was dependent on staff for activities of daily living (ADL). Review of R64's EMR Care Plan located under the Care Plan tab, revision date 01/25/24, indicated the resident needed adequate supervision and observation as he had a behavior of becoming sexually inappropriate with female residents with dementia/cognitive impairment. The Intervention/Tasks revision date 07/22/24 indicated R64 was placed on 1:1 monitoring due to safety concerns when out of bed, 30-minute safety checks when in bed, re-direct resident if he displays any inappropriate behavior or verbalizations, visual safety checks put into place to monitor residents' location. Review of R64's EMR Nurse's Notes located under the Progress Notes tab, indicated a late entry note dated 07/24/24, revealed Currently, resident is being monitored by 1:1 supervision. Alternate placement on another floor is also being explored. However, it is the opinion of the clinical team that resident's behavior will continue as he identifies another target. Also discussed option to locate another facility that could better address needs. An interview with R64 was attempted during the survey process without success. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/18/24 at 5:20 PM, the ADON stated that the dietary aide had stopped R64 if she had not stopped him, it could have gone a lot further. The ADON stated that no other incidences of touching other female residents have occurred to include resident R83. The ADON stated the dietary aide observed R64 touching the thighs of the resident near the groin area. R64 had wheel himself out of the Dining Room (DR) and approached the female resident who was sitting in her Geri chair outside the DR and near the nurses' station. R64 was immediately removed from the area and placed on 1:1 monitoring. The ADON further stated that the facility is trying to find more appropriate living arrangements for him. R64 remains on 1:1 monitoring until alternate placement is found for R64. 11599 c. Review of R89's Admission Record, located under the Profile tab in the EMR noted the resident was admitted with diagnoses that included dementia with agitation. Review of the quarterly MDS, located under the MDS tab in the EMR with an ARD of 07/18/24 revealed a BIMS score of six out of 15 which indicated R89 had severe cognitive impairment. Review of the Care Plan, dated 07/24, located under the Care Plan tab in the EMR revealed a problem of Potential to be verbally aggressive, short tempered, displaying outbursts related to dementia and poor impulse control. Included in the interventions were Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. When the resident becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. Review of R87's Admission Record, located under the Profile tab in the EMR noted the resident was initially admitted with diagnoses that included unspecified dementia, with mood disturbance, and cognitive communication deficit. Review of the admission MDS, located under the MDS tab in the EMR with an ARD of 09/12/24 revealed a BIMS score of seven out of 15 which indicated R87 had severe cognitive impairment. Review of the Care Plan, dated 07/24, located under the Care Plan tab in the EMR revealed no concerns related to behaviors, agitation, or aggression. Review of an incident report, dated 10/07/24, provided by the Assistant Director of Nurses (ADON), revealed Residents were sitting next to one another in common area. I was in hall talking with charge nurse and heard a commotion. I turned to look and saw [R87] standing up in front of [R89] holding her walker by the legs and trying to hit [R89]. Myself and the charge nurse immediately separated both residents. [R89] was ask what happened and she did not give me an answer. Just stated she did not do anything. She denied any pain and was assessed for injury. No inlury [injury] found. She was put on 15 min checks- [R87] was also assessed and visibly upset. He denied injury and stated he would be OK. Resident was noted with 2 small red scratches on his clavicle area. Both residents have a Hx [history] of dementia with anxiety. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/16/24 at 2:44 PM, the ADON, responsible for completing the investigation, stated [R89] was the aggressor. [R87] had his arm up talking with another resident, [R89] hit him on his arm. [R87] did not pay attention to her. [R89] then shook her hands at him. [R87] then stood up and pushed [R89]'s walker at her. The second time [R87] tried to hit [R89] with the walker, she held on and nothing occurred. 29728 d. Review of R20'sFace Sheet, located in the EMR under the Profile tab revealed R20 was admitted to the facility with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Depression, Anxiety and Acute Respiratory Failure. Review of the quarterly MDS located in the EMR under the MDS tab and dated 06/05/24, revealed the resident was assessed on the BIMS with a score of 14, indicating the resident was cognitively intact and exhibited no mood or behaviors during the same assessment period. Review of the resident's Care Plan located in the EMR under the Care Plan tab revealed the resident had the potential for sad mood, tearfulness, withdrawn state secondary to history of depression, anxiety and declining health. Review of a facility reported incident to the State Survey Agency (SSA) dated 04/01/24, indicated that the resident told the Director of Nursing (DON) that she wanted to talk to her privately about a particular aide. R20 said The evening aide screams at me. She verbalized that the aide makes her cry sometimes. Review of the facility's investigation revealed that in an interview with the DON and the Assistant Director of Nursing (ADON) it was revealed that Certified Nurse Aide (CNA) 7 was giving aide to R20 with an orientee. They turned the resident on her side and the resident started to scream in pain. CNA7 described and re-enacted backing away from the resident with her hands up in the air and saying, I'm not even touching you. CNA7 told the resident that her backside (used a derogatory term). She also told the resident that I guess that I will be in the DON's office on Tuesday. CNA7 described her relationship with the resident as friendly and they often joked around. The investigation determined that under the care of CNA7, the resident felt humiliated, tearful and manipulated. The resident was interviewed and indicated that she never felt comfortable with the aide, she disagreed with the description of their relationship. The CNA was initially suspended after the allegation was made and after the investigation, she was terminated from the facility. During an interview on 10/16/24 at 3:04 PM, R20 did not remember an incident with CNA7 and denied having any problems with staff. During an interview with the ADON on 10/16/24 at 3:36 PM, she stated that the resident about the incident. During the investigation, she asked the Quality Control Nurse to speak to the resident to see if she thinks the CNA should return to work. The resident stated she did not think the CNA should work at the facility. We decided to terminate her because of the resident's statement and what the CNA wrote up in her statement. The ADON also stated that she had not had any concerns about CNA7 before, she just would have a big mouth sometimes but she was a good worker. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the statement submitted by CNA7, dated 03/19/24 she stated, while changing R20, she was resistant to care, throwing her leg out of the bed at one point. I was not even touching her and she was screaming like I had my hands on her. I said to her, You sitting here yelling making it seem like I'm touching you and I'm leaning against the wall. The resident made the comment she would just leave or die. I stated you don't have to leave or die but please do not resist when someone is giving you care, you can do more harm to the aid than yourself. During an interview with the Quality Control Nurse on 10/17/24 at 9:52 AM, she stated she spoke to the resident about allowing CNA7 to return to work and the resident said no, she should not. She stated that she had not received any complaints regarding CNA7 in the past. In an interview with the DON, on 10/17/24 at 10:30 AM, she stated that she was involved with interviewing staff only when discipline was involved. The DON stated the way CNA7 described how she spoke to R20, just what she said to the resident, it was clear and concerning. After the interview with CNA7, I did not feel that she thought she had done anything wrong. We had to let her go. The ADON and I both thought she should not be here and was terminated. We did not feel like she was fixable. The DON stated she could not remember any complaints from other residents concerning CNA7's behavior. The DON stated that as soon as she found out about the incident, CNA7 was suspended and terminated. 12679 e. Review of R67's EMR titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R67's EMR titled annual MDS with an ARD of 08/29/23 indicated the resident had a BIMS score of six out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident had no behaviors. During an interview on 10/17/24 at 2:09 PM, R67 stated he did not remember the resident-to-resident which involved R95. The resident stated he was not fearful and stated he was fine. Review of R95's EMR titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R95's EMR titled quarterly MDS with an ARD of 10/23/23 indicated the clinical staff could not determine the resident's BIMS and revealed the resident had short-term and long-term memory problems. The assessment indicated the resident had physical/verbal behavior directed towards others. Review of R95's EMR titled administration Progress Notes located under the Prog (Progress) Note dated 12/25/23 indicated the resident was observed to punch R67 in the eye and the resident was then redirected from the area. Review of a document provided by the facility titled Physical indicated R67 reported to the facility that R95 punched him in the left eye. R67 said that R95 attempted to open the dining room door. R67 stated he tried to stop R95 from doing so and that was when R95 punched him in the eye. The clinical staff assessed the resident and there were no injuries. The resident's physician and responsible party were notified of the incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29728 Based on review of facility policy, record review, and interview, the facility failed to ensure three of three residents (Residents (R) 20, R67, and R95) allegations of physical/verbal abuse were fully investigated out of sample of six residents reviewed for abuse out of a total sample of 34 residents. This lack of investigation had the potential to lead to continued episodes physical and verbal abuse. Findings include: Review of a policy provided by the facility titled Resident Abuse Policy/Procedure dated 06/27/23, indicated . Investigation.Facility will thoroughly investigate any incidents reported regarding the identification if incident as listed above.The facility will investigate all incident reports based on information obtained from witness statements, caregiver statements, and interviews as available. 1. Review of R20'sFace Sheet, located in the EMR under the Profile tab revealed R 20 was admitted to the facility with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Depression, Anxiety, and Acute Respiratory Failure. Review of the quarterly MDS located in the EMR under the MDS tab, dated 06/05/24 revealed the resident indicating the resident was cognitively intact and exhibited no mood or behaviors during the same assessment period. Review of the resident's Care Plan located in the EMR under the Care Plan tab revealed R20 had the potential for sad mood, tearfulness, withdrawn state secondary to history of depression, anxiety, and declining health. Review of the facility's investigation of a facility reported incident to the State Survey Agency (SSA) dated 04/01/24, revealed that in an interview with the DON and the Assistant Director of Nursing (ADON), Certified Nurse Aide (CNA) 7 stated she was giving aide to R20 with an orientee. They turned the resident on her side and the resident started to scream in pain. CNA7 described and re-enacted backing away from the resident with her hands up in the air and said, I'm not even touching you. CNA7 told the resident that her backside (used a derogatory term) was showing. She also told the resident that I guess that I will be in the DON's office on Tuesday. CNA7 described her relationship with the resident as friendly, and they often joked around. The investigation determined that under the care of CNA7, the resident felt humiliated, tearful, and manipulated. The resident was interviewed and indicated that she never felt comfortable with the aide, and she disagreed with the description of their relationship. CNA7 was initially suspended after the allegation was made and after the investigation, she was terminated from the facility. During an interview with the ADON on 10/16/24 at 3:36 PM, she stated that the DON spoke to the resident about the incident since the DON was responsible for investigating and reporting the incidents. During the investigation, the Quality Control Nurse was asked to speak to the resident to see if she thought CNA7 should return to work after suspension. R20 stated she did not think CNA7 should work at the facility. So, based on the statement from R20 and CNA7, the decision was made to terminate CNA7. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked for documentation of other interviews conducted during the investigation, the ADON stated that she did not interview other residents during the investigation that may have had any interactions or care provided by CNA7. The ADON stated she had asked other staff about CNA7, and they did not have any problems with her. When asked if she documented the interviews with other staff members regarding CNA 7, she stated no, she did not have any written documentation. 12679 2. Review of R67's electronic medical record (EMR) titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. 3. Review of R95's EMR titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of a document provided by the facility titled Physical dated 12/25/23 indicated R67 reported to staff he was punched in the eye by R95. R67 stated he attempted to intervene when R95 tried to open the dining room door. Continued review of the file failed to contain evidence of other potential staff and residents who may have witnessed the incident. During an interview on 10/17/24 at 12:29 PM, the Assistant Director of Nursing (ADON), with the Director of Nursing present, confirmed the investigative file did not contain evidence of interviews gathered from potential witnesses which would include staff and residents. During an interview on 10/18/24 at 11:10 AM, the Administrator stated the staff collect interviews from potential witnesses depending on the situation.

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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** 07246 Based on record review, interview, and facility policy review, the facility failed to ensure one of four residents (Resident (R) 30) reviewed for accident hazards did not suffer a delay in treatment when the facility did not notify the physician of the delay in obtaining an x-ray as ordered. R30 experienced swelling to the right knee area and was administered non-narcotic pain medication for three days. The x-ray was obtained three days after being originally ordered and showed the resident had suffered an acute fracture to the distal femur. Findings include: Review of R30's electronic medical record (EMR) Admission Record located under the Profile tab, indicated the resident was admitted to the facility on [DATE] with a diagnosis of Arthropathy (arthritis), Dementia, and Alzheimer's disease. Review of R30's EMR annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/28/24 indicated the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15 which revealed the resident was cognitively impaired. The assessment indicated R30 was dependent on staff for transfer (movement from one surface to another) mobility and activities of daily living (ADL). Review of R30's EMR Nurse's Notes located under the Progress Notes tab, indicated that on 07/19/24 at 3:17 PM, R30 was noted to have swelling to her right knee. The physician was notified and ordered a 2-view x-ray of the right knee. On 07/19/24 at 10:02 PM Nurse's Notes indicated R30's right knee remained with swelling and awaiting x-ray to be completed. Further review of the Nurse's Notes for 07/19/24 indicated R30 was medicated for pain with Tylenol. On 07/20/24 at 2:23 PM Nurse's Notes indicated an ice pack was applied to the right knee. Tylenol 325mg two tablets administered for pain. waiting for x-ray to the R[right] knee. On 07/20/24 at 9:55 PM Nurse's Notes indicated affected leg supported with pillow, awaiting x-ray of right leg. On 07/21/24 at 3:19 PM Nurse's Notes indicated Tylenol administered for right knee pain. Attempted to reach Mobilex [x-ray] to know when staff was coming for x-ray no response. On 07/21/24 at 9:19 PM Nurse's Notes indicated resident continues with swelling to R knee, pain medication administered. Awaiting x-ray of the right knee. Review of R30's EMR Nurse's Notes and Orders revealed no documentation the physician was notified that the ordered x-ray had not been obtained. There was no documentation the facility attempted to contact another mobile x-ray company. There was no documentation the facility attempted to obtain physician guidance related to the resident's need for pain medication. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nurse's Notes revealed that the attending physician was called three days later on 07/22/24 at 9:51 AM and notified of the delay in completing the x-ray. On 07/22/24 at 9:51 AM nurse's notes indicated resident continued with right knee pain with movement, Tylenol administered as needed. [name of x-ray facility] contacted requesting estimated time of arrival for x-ray. The physician was notified [that the x-ray had yet to be completed], resident to remain on bedrest until x-ray is completed. Further review of the Nurse's Notes indicated that the x-ray to the right knee was completed on 07/22/24 at 10:41 PM, three days after the x-ray was ordered. On 07/23/24 at 7:28 AM nurse's notes indicated x-ray results received with following conclusion acute fracture of right distal femur [thigh bone are close to the knee] with modest displacement and angulation [fractured bone segments at an angle], old fracture of right mid patella [kneecap] with modest displacement without callus formation. Intact right knee Arthroplasty. MD [physician] made aware. On 07/23/24 at 10:14 AM nurse's notes indicated Oxycodone 1 tablet po Q 6H PRN for Pain . Oxycodone is a narcotic pain medication. In addition, the nurse's notes dated 07/23/24 indicated R30 was diagnosed with a fractured femur and sent to the Emergency Department for evaluation of the right knee and swelling, and her pain management was adjusted to better regulate her pain. While R30 had initially been receiving Tylenol for pain relief, a stronger medication, Morphine was prescribed upon her return to the facility to more effectively address the pain associated with the fractured femur. On 07/23/24 at 12:14 PM nurse's notes indicated R30 was sent to the Emergency Department for an Ortho consult and further evaluation and treatment. Interview on 10/19/24 at 12:30 PM, the Director of Nursing (DON) confirmed that obtaining the x-ray was delayed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07246 Based on observation, interview, record review, and facility policy review, the facility failed to ensure one of four residents (Resident (R) 30) reviewed for accident hazards out of a total sample of 34 was transferred using the appropriate mechanical lift and number of staff as per the resident's plan of care. Findings include: Review of the EZ Lift Policy and Procedures revised date 08/01/24 indicated under Purpose . To prevent injury to the resident and staff when lifting and transferring . Key Procedural Points item 1. There will be (2) staff at all times when using the EZ way Lift or EZ Way stand up lift. Review of R30's electronic medical record (EMR) Admission Record located under the Profile tab, indicated the resident was admitted to the facility on [DATE] with a diagnosis of Arthropathy (arthritis), Dementia, and Alzheimer's disease. Review of R30's EMR annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/28/24 indicated the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15 which revealed the resident was cognitively impaired. The assessment indicated R30 was dependent on staff for transfers (movement from one surface to another) and activities of daily living (ADL-bathing, toileting, dressing). Review of R30's EMR Care Plan located under the Care Plan tab, revision date 02/06/20, indicated the resident had an ADL self-care performance deficit related to dementia and decreased mobility. The Intervention/Tasks revision, dated 01/09/24, under transfers indicated R30 was a Hoyer lift with two staff. Review of the facility's follow up report to the State Survey Agency (SSA), dated 07/26/24, indicated our investigation checked hours of video to check on who took care of resident on that particular day . we believe that CNA caring for the resident might have used incorrect mechanical lift . Review of documentation provided by the Director of Nursing (DON), dated 07/24/24, revealed video reviewed which indicated Certified Nursing Assistant (CNA) 9 took the stand-up lift into R30's room that morning and was later seen removing the stand-up lift from the room and placing it in the hallway. After lunch, the video showed CNA 9 taking the resident into the spa room alone and leaving the spa room two minutes later. CNA9 was then seen getting another CNA and the Hoyer lift and taking it into the resident's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a written statement by CNA9 dated 07/18/24 and 07/19/24 provided by the DON revealed: Question: Did you help transfer resident to wheelchair? - Response by CNA: Yes, transfer to wheelchair. Question: How did you transfer Resident? Who assisted you with transfer? Response by CNA: Mechanical Lift 2 person. Review of Employee Warning Record dated 7/19/24 indicated that the CNA was witnessed using the wrong lift on a resident and not having a second person assist. She failed to follow the resident's care plan and failed to follow the company policy of having a 2nd person with her while using the lift. She was previously made aware of this policy and signed a lift agreement that she knew if she would be terminated if she violated this policy . During an interview on 10/19/24 at 12:30 PM, the DON confirmed that she reviewed the videos for several days prior to the incident and observed CNA9 take the stand-up lift into R30's room and later removing the stand-up lift and placing it in the hallway. And then after lunch CNA 9 was seen in the video taking the resident into the spa room alone. The DON stated that two people are to be used when the stand-up and Hoyer lift are used. The DON further stated that patient care information provided to CNAs in Point Click Care (PCC) under the Tasks tab included patient care information under the Task Care Record, Kardex and Task List. The DON confirmed CNA9 was aware of how the R30 was to be transferred by two staff using the Hoyer lift Review of the PCC patient care information under the Task Care Record, Kardex and Task List revealed that the facility staff, including CNA9, had easy access to the resident's care activities information to include ADL's, safety, bed mobility, bathing, and transfers. Review of the PCC Kardex documentation for R30 for the month of July 2024 indicated that R30 was assessed as a 4/3for the task of ADL-Transferring Hoyer Lift (2) staff members. The legend indicated 4 was Total assistance and 3 was Two plus person physical assist. CNA9 was aware that R30 was Total Dependence for transfer and required transfer support of 2 plus people when transferring with the use of the Hoyer Lift and not with the standup lift. Review of the Lift agreement signed and dated by CNA 7 on 07/12/23 revealed I verify that I have received training for the proper use of the EZ lift. I understand that there must always be two employees present while using the lifts . 29728 2. Review of the Face Sheet located in the Electronic Medical Record (EMR) under the Profile tab revealed R38 was admitted to the facility with diagnoses including Multiple Sclerosis. Review of the quarterly Minimum Data Set (MDS) assessment located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 09/25/24 revealed the resident was assessed with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R38 was cognitively intact. Further review of this MDS revealed R38 had no impairment of the upper extremities and was independent with eating. Review of the Care plan located in the EMR under the Care Plan tab revealed R38 was identified as being independent of dressing his upper extremity and with hygiene. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the resident's room on 10/14/24 at 10:04 AM revealed R38 was in his room in his electric wheelchair, well dressed, alert and oriented. On the nightstand next to the bed, R38 had multiple bottles of water and a Keurig single use coffee maker. During an interview on 10/14/24 at 1:35 PM, R38 stated that he has had the Keurig for several years and he has never had a problem with it. He does not drink the water at the facility, which is used to make coffee, so that is why he has his own coffee maker. During an interview with the Assistant Director of Nursing (ADON) on 10/14/24 at approximately 2:30 PM, she stated she did not think the resident used the Keurig, but staff made it for him. She did not know if the resident had been assessed for the use of the Keurig. She stated that she would observe R38 using the Keurig coffee maker for safety. Further review of the EMR revealed no documentation of an assessment for the safe use of the Keurig coffee maker.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07246 Based on record review, interview, and facility policy review, the facility failed to provide pain management that met professional standards for one of one resident (Resident (R) 30) reviewed for pain out of a total sample of 34 residents. R30 experienced swelling of the right knee area and received non-narcotic pain medication (Tylenol) while waiting three days for an x-ray. The facility failed to assess the resident's pain, failed to conduct pre and post pain medication assessments, and failed to indicate why Tylenol was administered to the resident. The x-ray revealed the resident had sustained a fracture to the right distal femur. Cross-Reference F684. Findings include: Review of the Pain Management Policy, reviewed date 11/15/23, under Key Procedural Point indicated Residents have a right to be free from pain. Review of R30's electronic medical record (EMR) Admission Record located under the Profile tab, indicated the resident was admitted to the facility on [DATE] with a diagnosis of Arthropathy (arthritis), Dementia, and Alzheimer's disease. Review of R30's EMR annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/28/24 indicated the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15 which revealed the resident was cognitively impaired. The assessment indicated R30 was dependent on staff for transfer (movement from one surface to another) mobility and activities of daily living (ADL). Review of R30's EMR Nurse's Notes located under the Progress Notes tab, indicated that on 07/19/24 at 3:17 PM, R30 was noted to have swelling to her right knee. The physician was notified and ordered a 2-view x-ray of the right knee. On 07/19/24 at 10:02 PM Nurse's Notes indicated R30's right knee remained with swelling and awaiting x-ray to be completed. Further review of the Nurse's Notes for 07/19/24 indicated R30 was medicated for pain with Tylenol. On 07/20/24 at 2:23 PM Nurse's Notes indicated an ice pack was applied to the right knee. Tylenol 325mg two tablets administered for pain. waiting for x-ray to the R[right] knee. On 07/20/24 at 9:55 PM Nurse's Notes indicated affected leg supported with pillow, awaiting x-ray of right leg. On 07/21/24 at 3:19 PM Nurse's Notes indicated Tylenol administered for right knee pain. Attempted to reach Mobilex [x-ray] to know when staff was coming for x-ray no response. On 07/21/24 at 9:19 PM Nurse's Notes indicated resident continues with swelling to R knee, pain medication administered. Awaiting x-ray of the right knee. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/22/24 at 9:51 AM nurse's notes indicated resident continued with right knee pain with movement, Tylenol administered as needed. [name of x-ray facility] contacted requesting estimated time of arrival for x-ray. The physician was notified [that the x-ray had yet to be completed], resident to remain on bedrest until x-ray is completed. Further review of the Nurse's Notes indicated that the x-ray to the right knee was completed on 07/22/24 at 10:41 PM, three days after the x-ray was ordered. Review of R30's Medication Administration Record (MAR) for the month of July 2024 revealed R30 received five doses of Tylenol 325mg II tablets from July 19, 2024 - July 23, 2024, for pain management prior to her visit to the Emergency Department on July 23, 2024. There was no documentation the resident's pain was assessed before the Tylenol was administered or afterwards to determine if relief had been obtained. On 07/23/24 at 7:28AM nurse's notes indicated x-ray results received with following conclusion acute fracture of right distal femur [thigh bone are close to the knee] with modest displacement and angulation [fractured bone segments at an angle], old fracture of right mid patella [kneecap] with modest displacement without callus formation. Intact right knee Arthroplasty. MD [physician] made aware. On 07/23/24 at 10:14AM nurse's notes indicated Oxycodone 1 tablet po Q 6H PRN for Pain . Oxycodone is a narcotic pain medication. In addition, the nurse's notes dated 07/23/24 indicated R30 was diagnosed with a fractured femur and sent to the Emergency Department for evaluation of the right knee and swelling, and her pain management was adjusted to better regulate her pain. While R30 had initially been receiving Tylenol for pain relief, a stronger medication, Morphine was prescribed upon her return to the facility to more effectively address the pain associated with the fractured femur. On 07/23/24 at 12:14 PM nurse's notes indicated R30 was sent to the Emergency Department for an Ortho consult and further evaluation and treatment. On 07/23/24 at 4:14 PM nurse's notes indicated R30 was to be discharged from the hospital and returned to the facility with an order for Morphine one tablet by mouth every six hours as needed for Moderate pain. Review of R30's Medication Administration Record (MAR) for the month of July 2024 revealed R30 received Morphine Sulfate 15mg for pain from July 24, 2024 - July 28, 2024, for a total of six doses after returning to the facility from the Emergency Department. Per the MAR July 2024 the resident had two orders: Morphine Sulfate 15mg one tablet every 6 hours: 07/24/24 Morphine 15mg one tablet administered at 9:26 AM for a pain level 6 and at 9:55 PM for a pain level 3 07/25/24 Morphine 15mg one tablet was administered at 2:19 PM for a pain level 7 (continued on next page)

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	085047	A. Building B. Wing	10/17/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Morphine Sulfate 15mg one tablet every 4 hours for Right femur fracture for moderate pain 1-5. 07/27/24 Morphine 15mg for a pain level of 5. 07/28/24 Morphine at 9:42 AM for a pain level 8 and at 8:00 PM for a pain level of 3 Interview on 10/19/24 at 12:30 PM, the Director of Nursing (DON) confirmed that obtaining the x-ray was delayed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07246 Based on observation, staff interviews, and review of the facility's policy, the facility failed to 1.) ensure staff changed gloves, performed hand hygiene, and followed proper cleaning techniques for one of one resident (Resident (R) 30) observed during incontinence care and one of one resident (R88) observed during wound care from a sample of 34 residents, and 2.) ensure staff followed recommended disinfectant drying times to disinfect a multi-use glucometer for two residents (R1 and R6) observed during medication pass. These failures increased the risk of cross contamination. Findings include: 1. Review of the facility's policy titled, Handwashing review date 02/28/24, revealed, Purpose To prevent or minimize the transfer of pathogens. 1. Hand washing is the most important procedure used to prevent the spread of pathogens. Review of the facility's policy titled, Peri Care of the Female Resident review date 01/03/24, revealed under Purpose To provide cleanliness and comfort while enhancing infection and irritation prevention . Cleaning is always done anterior to posterior (front to back) . Staff must change gloves after direct exposure to bodily fluids or fecal matter and clean/disinfect hands prior to completing resident care and touching other clean surfaces. Review of R30's Admission Record located in the electronic medical record (EMR) under the Profile tab revealed she was admitted to the facility with diagnoses of Arthropathy (arthritis), Dementia, and Alzheimer's disease. Review of R30's EMR annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/28/24 indicated the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15 which revealed the resident was cognitively impaired. The resident required maximum assistance for toileting and was frequently incontinent of bowel and bladder. Review of R30's Care Plan located in the EMR under the Care Plan tab indicated the resident had bladder and bowel incontinence related to dementia, and impaired mobility with interventions to provide peri care after each incontinent episode. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/16/24 at 1:55 PM, Certified Nursing Assistant (CNA) 4 and (CNA) 5 provided incontinence care to R30. CNA 4 and CNA5 each donned a pair of gloves, removed the resident's pants and adult brief. After removing the adult brief, R30 was turned on her right side and was observed to be incontinent of bowel with brown fecal material noted on the resident's right and left buttocks. Using the same gloves, CNA 4 cleaned the top of the resident's perineal area in a downward motion. CNA 4 did not separate R30's labia. CNA4 then discarded the soiled used wipes directly onto the floor. CNA 4 and CNA5 then turned R30 on her left side and CNA 5 cleaned the resident left and right buttock cheek and anal area in a back to front motion towards the labia with disposable wipes removing large amounts of fecal material. Resident R30 was then turned on her back, CNA 4 then repeated to clean the top of the peri area in a downward motion removing fecal material. After cleaning the resident, R30 was turned on her right side and a clean adult brief was applied. With the same soiled gloves, the resident's pants were pulled up and her white blouse was adjusted. CNA4 and CNA5 then adjusted the resident's pillows and pulled up the blue comforter, adjusted to call light within reach of the resident. CNA 4 then moved the resident's bed in place (against the wall) moving the bed by the footboard with the same soiled gloves. After picking up the soiled disposable wipes from the floor, CNA 4 removed and discarded her soiled gloves, CNA 4 was observed to leave R30's room without washing her hands. During an interview with CNA 4 and CNA5, immediately after the observation, CNA 4 and CNA5 confirmed they should have cleaned the peri area from top to bottom, separating the labia and cleaning the buttock and rectal area from front to back to avoid contamination of the vaginal/peri-area. The CNAs stated that they should have removed their soiled gloves after cleaning the resident's soiled body areas, and before putting on a clean brief and adjusting the resident's clothing and, pillow, comforter and before repositioning the call-light. During an interview with the Director of Nursing (DON) on 10/17/24 at 10:00 AM, she confirmed the CNAs should have changed her gloves and washed their hands. 29728 2. Review of the facility's policy titled, Dressing Change, dated 04/18/24, revealed, . Purpose to prevent contamination of wound, while restoring skin integrity and monitor healing process . create clean field with paper towels or drape . Open dressing pack . Put on first pair of disposable gloves . Remove soiled dressing and discard in plastic bag . Dispose of gloves in plastic bag . Wash hands . Put on second pair of disposable gloves . Pour prescribed solution onto gauze to be used for cleaning . Cleanse wound with prescribed solution . Apply prescribed medication if ordered . Apply dressings and secure with tape . Remove gloves and discard with all unused supplies in plastic bag . Wash hands . Review of R88's Face Sheet, located in the electronic medical record (EMR) under the Profile tab, revealed R88 was admitted on [DATE] with diagnosis of diabetes mellitus, muscle weakness, atrial fibrillation, malignant neoplasm of left kidney, peripheral vascular disease, and a stage III pressure sore. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/16/24 at 9:10 AM, LPN1, LPN2, and Certified Nursing Assistant (CNA) 3 were observed performing wound care for R88's stage III sacral pressure sore. LPN1 had placed her dressing change supplies on top of the overbed table. A protective barrier was not observed under the supplies. Prior to beginning the wound care, LPN2 suggested cleaning the resident before wound care to minimize the time she needed to be turned. A wash basin was placed on the same overbed table with the supplies and was used to wash the resident. After the bath was completed, the basin was removed from the overbed table which left a wet spot in the same area. Without cleaning the table, LPN1 proceeded to begin with the dressing change. She put on a pair of disposable gloves, removed the soiled dressing from the resident's sacral area and removed the gauze from the wound bed. LPN1 placed the soiled dressing in a plastic bag and removed her soiled gloves. Without performing hand hygiene, she put on a new pair of gloves and used a clean gauze and wound cleaner from the overbed table to clean the resident's wound. After cleaning the wound, LPN1 disposed of the gauze and gloves in the plastic bag and, without performing hand hygiene, she put on another pair of disposable gloves and placed a medicated ointment on top of a medicated gauze in the wound bed and covered the wound with a dressing. After completing the wound care, LPN1 removed her gloves and placed the remaining dressing supplies in the plastic bag and washed her hands. During an interview on 10/16/24 at 9:10 AM, LPN1 stated that she did not disinfect the top of the overbed table after CNA 3 removed the wash basin that left water on the table. LPN1 confirmed that she did not wash her hands between changing from soiled to clean gloves and stated she should have. During an interview with the Infection Preventionist (IP) on 10/16/24 at 3:14 PM, the IP stated that the nurse performing the wound care should have washed her hands between changing her soiled gloves to clean gloves and the overbed table should have been disinfected again after removing the wash basin. 3. Review of the facility's policy titled, Cleaning of Glucometers, dated 08/27/24, revealed, . The purpose of this procedure is to prevent the spread of infection . clean glucometers after every use . clean glucometer with approved product . allow appropriate amount of time for product to dry before using equipment on another resident . Review of the Clorox Healthcare Bleach Germicidal Wipes manufacturer's guidelines, located on the product's container, revealed the recommended drying times ranged from 30 seconds to kill bacteria to one minute to kill bloodborne pathogens. During an observation on 10/14/24 at 10:49 AM, Licensed Practical Nurse (LPN)4 prepared a blood glucose monitor to check the blood glucose level for RRe1. Using a disinfecting wipe, LPN4 wiped the monitor several times. Without allowing the disinfecting solution to dry, she used a tissue to wipe the monitor dry. LPN4 completed the blood glucose test for R1 and placed the monitor back on top of her medication cart. LPN4 used another disinfectant wipe on the same blood glucose monitor and approached R6 in the hallway. Before allowing enough time for the monitor to dry, LPN4 again used a tissue to dry the monitor before conducting the blood glucose test for R6. After obtaining the test, LPN4 placed the blood glucose monitor directly on top of the medication cart without a protective barrier underneath the monitor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/15/24 at 2:34 PM, LPN4 was asked what process she followed for disinfecting the blood glucose monitor. She stated, I wiped the monitor, I was supposed to leave it for three minutes. I used the tissue because [the surveyor] was there. LPN4 stated, Usually, I would wait three minutes to air dry. She stated she had worked at the facility for four years and received training on blood glucose monitors when she was hired. During an interview on 10/15/24 at 1:42 PM, the Director of Nursing (DON) stated that the nurses are trained to allow three minutes for the disinfectant to dry on the blood glucose monitors when cleaning. She stated this was included in their policy.