STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105166	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Pointe Care Center	6020 Indiana Ave New Port Richey, FL 34653

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observations, interviews and record review, the facility 1) failed to provide access to quality care related to a dignified meal service for three residents (# 69, #43, and #89) out of 13 residents reviewed for dining, and 2) failed to ensure a catheter was stored in a privacy bag for one resident (#43) out of 29 sampled residents. Findings included: On 4/15/24 at 10:00 a.m. Resident #69 was observed in his room in bed. The resident was observed with food on his chest area and beard from his breakfast meal, and a small flying insect on his beard. The resident stated he fed himself. He stated the staff clean him up When they get around to it. During the interview, the resident confirmed he did not know he had food pieces on his beard, chest, and clothing. He said, I am blind I can't see. The resident stated he had oatmeal for breakfast. He did not know how long ago. The food remnants were noted to be mushy in texture. An interview was conducted with Staff I, Certified Nursing Assistant (CNA) on 4/15/24 at 10:12 a.m. She stated breakfast was served at 7:45 a.m. and Resident #69 ate independently. She stated the CNAs clean the residents up as soon as they are done with the meal. She observed Resident #69 with food on himself and stated she would clean the resident. Resident #69 was readmitted to the facility on ,d+[DATE] with diagnoses to include Type 2 Diabetes Mellitus (DM), unspecified malnutrition, blindness right and left eye category 5, Cerebral Vascular Accident (CVA), dysphagia and dehydration. A care plan for Resident #69, dated 5/31/23, revealed the resident had an alteration in visual function with interventions to provide Activities of Daily Living (ADL) tasks as needed and to provide verbal cues to locate objects or navigate in the environment. A self-care focus showed the resident had a grooming deficit related to generalized weakness, DM, CVA ,and chronic pain. Interventions included to provide hands on assistance with grooming. On 4/15/24 at 12:40 p.m., Resident # 69 was observed in his bed after lunch. The resident was observed with food spilled all over his shirt, chest area and his left shoulder as he leaned to the side of the bed. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/16/24 at 02:00 p.m., Resident #69 was observed in his room, he was noted licking a bowl. The resident's tray was removed from the room. The resident said, I can't see in this bowl. I am trying to feel for the pudding. The resident was observed with a towel on his chest area with food dropped on himself during the meal. The resident's beard and nails were observed with redness from meal sauce and brown color from the pudding. It was noted the other residents had finished their meal and trays had been removed from the halls. Resident #69 was not cleaned up from lunch which was served at 12:00 p. m. Review of a document titled, Documentation Survey Report, also known as CNA task log, dated April 2024, showed daily entries of 05 under eating, indicating the resident required set up or clean up assistance - Helper sets up or cleans up. Under personal hygiene, the documentation showed 01 documented daily indicating the resident was dependent - Helper does all of the effort, meaning resident does none of the effort to complete the activity. On 4/17/24 at 1:03 p.m., an interview was conducted with Staff K, CNA. She stated she assisted residents who eat in their rooms and cleans them up when she removes trays or right after they were done with their meals. She stated the residents should not wait hours to be cleaned up after meals. An interview was conducted on 4/17/24 at 1:06 p.m. with Staff G, CNA regarding Resident #69 being observed with food after the meal. She said, [Resident #69] refuses care. He has [small flying insects] on his beard and on himself all the time. She stated if the resident refused care, they let the nurse know. She stated she had not notified the nurse of any refusals that day. During dining observation on 4/17/24 at 12:40 p.m., Resident #43 was observed laying on his bed. His roommate was presented with his tray while this resident was not. An immediate interview was conducted with Staff G, CNA. She said to this surveyor, [Resident # 43] is a feed, that's why I didn't pass his tray. During a dining observation on 4/17/24 at 12:41 p.m., The Regional Nurse Consultant (RNC) asked Staff J, Registered Nurse (RN) if they needed help passing trays. She said, Yes, Resident #69 is not a feed. He needs cues. His roommate [Resident #43] is a feed. During a facility tour on 4/15/24 at 10:11 a.m., Resident #43 was observed in his bed. The resident was not interviewable. His catheter was observed hanging below his bed, visible to bystanders. His catheter was not stored in a privacy bag. (Photographic evidence was obtained.) On 4/18/24 at 10:50 a.m., an interview was conducted with the Assistant Director of Nursing (ADON) she stated, It is bad to leave the resident soiled after a meal. She stated if a resident refused care, she would have another staff try. She stated she would step away and come back and try again. She said regarding Resident #69, it is care planned. Sometimes you have to leave him and come back. Sometimes he refuses, but not all the time. The ADON stated the CNAs should report to the nurses and there should be documented re-attempts. She stated they should not wait a long time before returning to the resident. She stated the CNAs should document if a resident refused care and the attempts they made should be documented. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow -up interview was conducted on 4/18/24 at 12:35 p.m. with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The DON stated Resident #69 refuses care. She asked, How long was he waiting? When notified breakfast was served at 7:30 a.m. and at 10:12 a.m. the resident still had food on him, she said, Oh, okay. The DON stated regarding the catheter not being in a privacy bag I'm surprised. What room was that? 46234 An observation was conducted on 4/15/24 at 12:16 p.m. in the Unit 7 dining room. Four residents were sitting at a table for lunch. One resident had their tray and was eating, and the other three residents did not have a tray. At 12:18 p.m. the second resident was served their lunch tray, at 12:23 p.m. the third resident was served their lunch tray and at 12:27 p.m. the fourth and final resident at the table was served their lunch tray. (Photographic evidence obtained.) Review of a facility policy titled Dignity, dated February 2021, showed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Under policy interpretation and implementation, (1.) Residents are treated with dignity and respect at all times. 5. (e.) provided with a dignified dining experience. (8.) Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice not labeling or referring to the resident by his or her room number, diagnosis, or care needs. (12.) Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents keep urinary bags covered.

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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** 46498 Based on observations, record review, and interviews, the facility failed to ensure a grievance was filed related to a resident's room changed for one resident (#87), out of eight residents sampled. Findings Include: During an observation made on 04/15/2024 at 10:45 AM., Resident #87 was observed laying down in her bed with her call light within reach. The Resident said she would like to have a room change because she doesn't get along with her roommate. She said she spoke to the Social Services Assistant multiple times about wanting to move to another room, but nothing has been done about it. During an observation made on 04/16/2024 at 12:00 PM., Resident #87 was observed sitting up in her wheelchair with a blanket placed over her lap. She stated she and her roommate got into a verbal fight last night and she really wants her room to change. She said she was not made aware of the facility grievance process. Review of the medical record showed Resident #87 was admitted to the facility on [DATE] with diagnoses to include bipolar disorder, unspecified, major depressive disorder, recurrent, mild, acute kidney failure unspecified. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], showed the resident had a Brief Interview Mental Status (BIMS) score of 09, which indicated moderate cognitive impairment. During an interview on 4/17/2024 at 4: 37 p.m., with Staff P, Social Service Assistant, SSA, she stated Resident #87 spoke with her about wanting to have a room changed a few times because she was not getting along with her roommate. She stated Resident #87 told her a few weeks ago that she and her roommate do not get along with each other and she wants a room change. Staff P stated she told Resident #87 when a room becomes available, she will work on moving her to another room. During an Interview on 4/17/2024 at 4:37 p.m., with the Social Service Director, SSD, she stated her assistant told her about Resident #87 wanting to have a room change but they did not have any rooms available at this time. Resident #87 has an infection, and we were not able to change her out of that room but when a room becomes available, we told her that we will do our best to change her to another room. She stated Resident #87 likes to fixate on things and will not let some things go once she gets it in her head. We did not document the conversation we had with the resident about the room change and the reason we were not able to move her out of the room she is in at this time. My assistant should have put a progress note in the system showing that she spoke with the resident about the room change and a grievance should have been filed on the resident's behalf if we were not able to accommodate her need. Review of the facility policy titled, Grievance/ Complaint, Filing, ,revised April 2017, showed the following: (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy statement: Resident and their representatives have the right to file grievance, either orally or in writing, to the facility staff or to the agency designated to hear grievance (e.g., thee State Ombudsman) The administrator and staff will make prompt effort to resolve grievances to the satisfaction of the resident and/or representative. Policy Interpretation and Implementation: 3. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Action on such issues will be responded to in writing, including a rationale for the response.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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** 41015 Based on observations, interviews, and record review, the facility failed to ensure two residents (#210 and #211), assisted with care by a Certified Nursing Assistant (CNA), was free from verbal/psychosocial abuse. out of twelve residents sampled for abuse. Findings included: During an interview on 04/15/24 12:00 p.m., Resident #210 stated Staff A, CNA this weekend started using the F bomb and stated she was just not doing it over the weekend. Resident #210 stated Staff A, CNA also was on her phone with the earbuds talking to someone about threesomes. Resident #210's Family Representative (FR), present during the interview, also stated I didn't even go to work today, I came in because I am worried about my mom and her care. Resident #210's FR stated when she and Resident #210 reported Staff A, CNA over the weekend to Staff E, Licensed Practical Nurse (LPN) , Staff A, CNA ,after being reassigned, came back into Resident #210's room and asked what she did wrong. Resident #210 stated she felt very uncomfortable and even a little threatened. Resident #210's FR informed Staff A they felt very uncomfortable and Staff A left the room. During an interview on 04/15/24 at 12:15 p.m., Resident #211's family member stated he was certainly grateful for Resident #210 and the FR who spoke up to ensure Staff A, CNA was no longer able to work with Resident #211. Resident #211's family member stated he was not present during the time Staff A, CNA was being disrespectful and verbally aggressive towards Resident #211 but all the information could be obtained by speaking with Resident #210 and Resident #210's FR. Review of the Admission Record showed Resident #210 was admitted to the facility on [DATE] with diagnoses that included fracture of unspecified part of neck of femur subsequent encounter for closed fracture with routine healing, cerebellar ataxia in diseases classified elsewhere, polyneuropathy, heart failure and spinal stenosis. Review of the Brief Interview For Mental Status (BIMS) Evaluation dated 04/15/24 showed Resident #210 had a BIMS score of 14 (cognitively intact. During a second interview on 04/15/24 at 2:50 p.m. Resident #210 stated the incident occurred on Sunday 04/14/24. Resident #210 recalled it all started when the roommate (Resident #211) had to go to the bathroom. Resident #210 stated she heard Staff A, CNA yell at Resident #211 saying Don't do that, you are going to make me have to clean {expletive} off the call light pull string. Resident #210 stated Staff A, CNA took Resident #211's wheelchair, shoved it out of the bathroom door and It hit my bed. Resident #210 stated she heard Staff A, CNA state, I don't feel like this {expletive} crap today. Resident #210 stated her FR walked in to visit about that time and was also present in the room. Resident #210 stated Staff A, CNA was on the phone and was talking about :threesomes and cussing. Resident #210 stated both she and Resident #210's FR talked with Staff E, LPN about it and she stated Staff A, CNA would not be coming back into the room. Resident #210 stated after lunch Staff A, CNA came back in to the room to pick up the lunch tray and began interrogating and asking why she was reassigned. Resident #210 stated, It was like she was going to get one more dig in. Resident #210 stated the FR spoke up and informed Staff A the conversation was getting very uncomfortable and Staff A, CNA left the room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's actual working schedule for 04/14/24 revealed Staff A, CNA was assigned to both Resident #210 and Resident #211 for the 6:45 a.m.-3:15 p.m. shift. During an interview on 04/15/24 at 3:12 p.m., the Staffing Coordinator (SC) identified Staff A, CNA as the CNA assigned to Resident #210 and Resident #211's room on 04/14/24. Review of the facility's reportable's for April 2024 showed no reportable for the date of 04/14/24. During an interview on 04/15/24 at approximately 3:20 p.m., the Administrator stated there were no additional reportable's for April. During an interview on 04/15/24 at 3:30 p.m., Staff A, CNA stated she provided care for Resident #210 and #211 on Sunday 04/14/24 until she was reassigned from the room. Staff A, CNA stated she really did not know why she got reassigned and no one gave her any specific reason for the reassignment. Staff A, CNA stated Staff E, LPN came to her and told her she would no longer be working with Resident #210 and Resident #211. Staff A, CNA stated she tried to inquire about why she was reassigned but no one would give her answers. Staff A, CNA stated no one told her she could not go back into Resident #210 and Resident #211's room. Staff A, CNA stated later in the day she was picking up lunch trays and went back into Resident #210 and Resident #211's room when the residents and Resident #210's family representative (FR) acted as if they were stunned and uncomfortable. Staff A, CNA stated the response gave her an uncomfortable feeling as well. Staff A, CNA stated at the time of tray pick, she asked Resident #210 and Resident #210's FR if there was a problem, but Resident's 210's FR stated this was making them very uncomfortable, so she left the room. Staff A, CNA stated no one ever told her she was not allowed to go back into the room, so she apologized to Resident #210 and Resident #210's FR but she still did not understand why everyone felt so uncomfortable. Staff A, CNA stated she tried to inquire a couple more times with staff as to why she was reassigned but no supervisor ever gave her any other information. Staff A, CNA stated she still knows nothing about why her room assignments got changed. During an interview on 04/15/24 at 3:46 p.m., Staff E, Licensed Practical Nurse (LPN) stated on Sunday 04/14/24 she was addressed by both Resident #210 and Resident #211 about Staff A, CNA being on her phone with ear buds and cursing. Staff E, LPN stated she decided to just go ahead and remove Staff A,CNA from Resident #210 and Resident #211's room and replace her with another CNA. Staff E, LPN stated she reported this to the supervisor Staff F, Registered Nurse (RN) who stated she would have a talk with Staff A, CNA. Staff E, LPN stated later Sunday afternoon Staff A, CNA took it upon herself to go back into Resident #210 and Resident #211's room . Staff E, LPN stated she never told Staff A, CNA why she was reassigned because she reported it to the supervisor on duty Staff F, RN. Staff E, LPN stated Staff F, RN was the supervisor and told her she would take care of it. Staff E, LPN stated she reported to Staff F, RN the information about Staff A, CNA cursing and all the actions that Staff A, exhibited towards Resident #210 and Resident #211. Staff E, LPN stated when she spoke with Resident #210 and Family Representative (FR) she was informed Staff A, CNA was cussing, using the F word and talking about threesomes. Staff E, stated she apologized for Staff A, CNA's behavior and informed Resident #210 and Resident #211 that Staff A, CNA would not go back into the room. Staff E, LPN stated she told all this information to Staff F, RN. Staff E, LPN stated that she would have reported this incident but respecting the chain of command she reported it to Staff F, RN who was the supervisor to take the information from there. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/15/24 at 4:20 p.m., Staff F, RN stated on Sunday 04/14/24 Staff A, CNA was reassigned from Resident #210 and Resident #211's room . Staff F, RN stated Staff E, LPN reported concerns that Resident #210 and Resident #211 had about Staff A, CNA. Staff F, ,RN stated she heard there were personality conflicts and since personalities do not always mesh Staff A, CNA's assignment was reassigned. Staff F, RN stated it was reported to her Resident #210 and Resident #211 were unhappy, so Staff E, LPN tried to smooth things over by removing Staff A, CNA from Resident #210 and Resident #211's room. Staff F, RN stated Staff A, CNA was Loud with a Big Personality but stated that is just Staff A, CNA's personality. Staff F, RN stated Staff E, LPN told her about a wheelchair that may have been pushed out of the bathroom while assisting Resident #211 and hit the wall or something and the Residents didn't care for that behavior. Staff F, RN stated she did not follow up with Resident #210 and Resident #211 about Staff A, CNA because she was under the impression Staff E, LPN took care of it. Staff F, RN stated she was never told about Staff A, CNA ever being on the phone or using any profanity. Staff F, RN stated she was a mandated reporter so if Staff E, LPN would have reported anything to her about Staff A, CNA using profanity directed towards residents that behavior would have required her to report it. Staff F, RN stated Staff E, LPN stated that she took care of it. During an interview on 04/15/24 at 4:35 p.m., with the Administrator and the DON, the DON stated she just spoke with Staff F, RN about 20 minutes before meeting with the survey team. The DON stated Staff F, RN just reported to her that Staff A, CNA was reassigned from Resident #210 and Resident #211's room on Sunday 04/14/24 because the Residents didn't care for Staff A, CNA. The DON stated Staff F, RN told DON Staff E, LPN talked with both Resident #210, Resident #210's Family Representative(FR) and Resident #211 and answered a ton of questions and everything seemed fine after that. The DON stated the chain of command for reporting would be for Staff E, LPN to report to Staff F, RN and then Staff F, RN should report to the DON who also identified herself as the Risk Manager. The DON stated if anything was reported to her related to abuse then Staff A, CNA would have been suspended immediately and an investigation would have been initiated. The DON stated that she had not even heard of any concerns related to Staff A, CNA and Residents #210 and #211 until 20 minutes prior to meeting with the survey team. During an interview on 04/15/24 at 4:45 p.m., Resident #211 stated on Sunday 04/14/24 Staff A, CNA was cussing. Resident #211 stated she could hear Staff A, CNA talking to someone on the phone. Resident #211 stated she could hear Staff A, CNA Talking about me. Resident #211 stated It didn't make me feel very good but what could I do? Resident #211 stated, I am blind with 1% vision in one eye and only about 7% in the other eye (legally blind). Resident #211 stated, I was afraid when Staff A, CNA was acting like that. Review of the Admission Record revealed Resident #211 was admitted to the facility on [DATE] with diagnoses that included acute bronchitis, weakness, unspecified falls, unspecified visual loss, depression and anxiety disorder. Review Resident #211's care plan showed the following: Focus: Resident has experienced a traumatic event that could lead to manifestation of Post Traumatic Stress Disorder (PTSD) or other psychosocial issues change in health status, loss of past roles. The goal included: Resident will have minimum negative changes in thinking and mood through next review. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Interventions included: Allow resident to make decisions, encourage resident participation in activities of choice, encourage resident to express emotions in a safe, private environment, provide reassurance and reorientation to facility, staff, and current situation as needed and refer to counseling/psych as needed. Focus: Resident #211 has an alteration in visual function diagnoses of glaucoma, diagnosis legally blind. Resident #211is at increased risk for falls with visual deficiencies at risk for malnutrition with visual deficiency. The goal showed, Resident will remain safe in the surrounding environment thru the next review date with assist form staff. The interventions included: administer medication as ordered, administer eye gtts (drops) as ordered, provide adequate lighting, provide assist with ADL tasks as needed, maintain a safe environment; notify resident of changes in environment as needed, provide verbal cues to locate objects or navigate in the environment, read written material to resident as needed. Review of the Brief Interview For Mental Status (BIMS) Evaluation dated 04/15/24 showed Resident #211 had a BIMS score of 13 (cognitively intact). During an interview on 04/16/24 at 4:35 p.m., The Regional Nurse Consultant (RNC) stated she thought Staff A, CNA's behavior was unprofessional and inappropriate, but she did not see it as abuse. The RNC stated she would have handled it differently than this administration and would have fired Staff A, CNA for the behavior. Review of the facility's policy Identifying Types of Abuse revised date 09/2022 showed, Mental and Verbal Abuse 1. Mental abuse is the use of verbal and non-verbal conduct which cause (or has the potential to cause) the resident to experience humiliation, intimidation, fear , shame, agitation and degradation. 2. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of verbal written or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Psychosocial Outcomes 1. Some situations of abuse do not result in an observable physical injury or the psychosocial effects of abuse may not to be immediately apparent. 2. Abuse may result in psychological, behavioral, or psychosocial outcomes including, but not limited to, the following: a. Fear of a person or place of being left alone, of being in the dark, and/or disturbed sleep and nightmares. Review of facility's policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised date 2021 showed, Policy Statement Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation 3. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems. 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect residents from any further harm during investigation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on observations, interviews, and record review, the facility failed to report an allegation of verbal/psychosocial abuse for two residents (#210 and #211) out of twelve residents. Findings included: Review of the facility's policy Identifying Types of Abuse revised date 09/2022 showed, Mental and Verbal Abuse 1. Mental abuse is the use of verbal and non-verbal conduct which cause (or has the potential to cause) the resident to experience humiliation, intimidation, fear , shame, agitation and degradation. 2. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of verbal written or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Psychosocial Outcomes 1. Some situations of abuse do not result in an observable physical injury or the psychosocial effects of abuse may not to be immediately apparent. 2. Abuse may result in psychological, behavioral, or psychosocial outcomes including, but not limited to, the following: a. Fear of a person or place of being left alone, of being in the dark, and/or disturbed sleep and nightmares. During an interview on 04/15/24 12:00 p.m., Resident #210 stated Staff A, CNA this weekend started using the F bomb and stated she was just not doing it over the weekend. Resident #210 stated Staff A, CNA also was on her phone with the earbuds talking to someone about threesomes. Resident #210's Family Representative (FR), present during the interview, also stated I didn't even go to work today, I came in because I am worried about my mom and her care. Resident #210's FR stated when she and Resident #210 reported Staff A, CNA over the weekend to Staff E, Licensed Practical Nurse (LPN) , Staff A, CNA ,after being reassigned, came back into Resident #210's room and asked what she did wrong. Resident #210 stated she felt very uncomfortable and even a little threatened. Resident #210's FR informed Staff A they felt very uncomfortable and Staff A left the room. During an interview on 04/15/24 at 12:15 p.m., Resident #211's family member stated he was certainly grateful for Resident #210 and the FR who spoke up to ensure Staff A, CNA was no longer able to work with Resident #211. Resident #211's family member stated he was not present during the time Staff A, CNA was being disrespectful and verbally aggressive towards Resident #211 but all the information could be obtained by speaking with Resident #210 and Resident #210's FR. Review of the Admission Record showed Resident #210 was admitted to the facility on [DATE] with diagnoses that included fracture of unspecified part of neck of femur subsequent encounter for closed fracture with routine healing, cerebellar ataxia in diseases classified elsewhere, polyneuropathy, heart failure and spinal stenosis. Review of the Brief Interview For Mental Status (BIMS) Evaluation dated 04/15/24 showed Resident #210 had a BIMS score of 14 (cognitively intact. (continued on next page)

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	105166	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Pointe Care Center	6020 Indiana Ave New Port Richey, FL 34653

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a second interview on 04/15/24 at 2:50 p.m. Resident #210 stated the incident occurred on Sunday 04/14/24. Resident #210 recalled it all started when the roommate (Resident #211) had to go to the bathroom. Resident #210 stated she heard Staff A, CNA yell at Resident #211 saying Don't do that, you are going to make me have to clean {expletive} off the call light pull string. Resident #210 stated Staff A, CNA took Resident #211's wheelchair, shoved it out of the bathroom door and It hit my bed. Resident #210 stated she heard Staff A, CNA state, I don't feel like this {expletive} crap today. Resident #210 stated her FR walked in to visit about that time and was also present in the room. Resident #210 stated Staff A, CNA was on the phone and was talking about :threesomes and cussing. Resident #210 stated both she and Resident #210's FR talked with Staff E, LPN about it and she stated Staff A, CNA would not be coming back into the room. Resident #210 stated after lunch Staff A, CNA came back in to the room to pick up the lunch tray and began interrogating and asking why she was reassigned. Resident #210 stated, It was like she was going to get one more dig in. Resident #210 stated the FR spoke up and informed Staff A the conversation was getting very uncomfortable and Staff A, CNA left the room. Review of the facility's actual working schedule for 04/14/24 revealed Staff A, CNA was assigned to both Resident #210 and Resident #211 for the 6:45 a.m.-3:15 p.m. shift. During an interview on 04/15/24 at 3:12 p.m., the Staffing Coordinator (SC) identified Staff A, CNA as the CNA assigned to Resident #210 and Resident #211's room on 04/14/24. Review of the facility's reportable's for April 2024 showed no reportable for the date of 04/14/24. During an interview on 04/15/24 at approximately 3:20 p.m., the Administrator stated there were no additional reportable's for April. During an interview on 04/15/24 at 3:30 p.m., Staff A, CNA stated she provided care for Resident #210 and #211 on Sunday 04/14/24 until she was reassigned from the room. Staff A, CNA stated she really did not know why she got reassigned and no one gave her any specific reason for the reassignment. Staff A, CNA stated Staff E, LPN came to her and told her she would no longer be working with Resident #210 and Resident #211. Staff A, CNA stated she tried to inquire about why she was reassigned but no one would give her answers. Staff A, CNA stated no one told her she could not go back into Resident #210 and Resident #211's room. Staff A, CNA stated later in the day she was picking up lunch trays and went back into Resident #210 and Resident #211's room when the residents and Resident #210's family representative (FR) acted as if they were stunned and uncomfortable. Staff A, CNA stated the response gave her an uncomfortable feeling as well. Staff A, CNA stated at the time of tray pick, she asked Resident #210 and Resident #210's FR if there was a problem, but Resident's 210's FR stated this was making them very uncomfortable, so she left the room. Staff A, CNA stated no one ever told her she was not allowed to go back into the room, so she apologized to Resident #210 and Resident #210's FR but she still did not understand why everyone felt so uncomfortable. Staff A, CNA stated she tried to inquire a couple more times with staff as to why she was reassigned but no supervisor ever gave her any other information. Staff A, CNA stated she still knows nothing about why her room assignments got changed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/24 at 3:46 p.m., Staff E, Licensed Practical Nurse (LPN) stated on Sunday 04/14/24 she was addressed by both Resident #210 and Resident #211 about Staff A, CNA being on her phone with ear buds and cursing. Staff E, LPN stated she decided to just go ahead and remove Staff A,CNA from Resident #210 and Resident #211's room and replace her with another CNA. Staff E, LPN stated she reported this to the supervisor Staff F, Registered Nurse (RN) who stated she would have a talk with Staff A, CNA. Staff E, LPN stated later Sunday afternoon Staff A, CNA took it upon herself to go back into Resident #210 and Resident #211's room . Staff E, LPN stated she never told Staff A, CNA why she was reassigned because she reported it to the supervisor on duty Staff F, RN. Staff E, LPN stated Staff F, RN was the supervisor and told her she would take care of it. Staff E, LPN stated she reported to Staff F, RN the information about Staff A, CNA cursing and all the actions that Staff A, exhibited towards Resident #210 and Resident #211. Staff E, LPN stated when she spoke with Resident #210 and Family Representative (FR) she was informed Staff A, CNA was cussing, using the F word and talking about threesomes. Staff E, stated she apologized for Staff A, CNA's behavior and informed Resident #210 and Resident #211 that Staff A, CNA would not go back into the room. Staff E, LPN stated she told all this information to Staff F, RN. Staff E, LPN stated that she would have reported this incident but respecting the chain of command she reported it to Staff F, RN who was the supervisor to take the information from there. During an interview on 04/15/24 at 4:20 p.m., Staff F, RN stated on Sunday 04/14/24 Staff A, CNA was reassigned from Resident #210 and Resident #211's room . Staff F, RN stated Staff E, LPN reported concerns that Resident #210 and Resident #211 had about Staff A, CNA. Staff F, ,RN stated she heard there were personality conflicts and since personalities do not always mesh Staff A, CNA's assignment was reassigned. Staff F, RN stated it was reported to her Resident #210 and Resident #211 were unhappy, so Staff E, LPN tried to smooth things over by removing Staff A, CNA from Resident #210 and Resident #211's room. Staff F, RN stated Staff A, CNA was Loud with a Big Personality but stated that is just Staff A, CNA's personality. Staff F, RN stated Staff E, LPN told her about a wheelchair that may have been pushed out of the bathroom while assisting Resident #211 and hit the wall or something and the Residents didn't care for that behavior. Staff F, RN stated she did not follow up with Resident #210 and Resident #211 about Staff A, CNA because she was under the impression Staff E, LPN took care of it. Staff F, RN stated she was never told about Staff A, CNA ever being on the phone or using any profanity. Staff F, RN stated she was a mandated reporter so if Staff E, LPN would have reported anything to her about Staff A, CNA using profanity directed towards residents that behavior would have required her to report it. Staff F, RN stated Staff E, LPN stated that she took care of it. During an interview on 04/15/24 at 4:35 p.m., with the Administrator and the DON, the DON stated she just spoke with Staff F, RN about 20 minutes before meeting with the survey team. The DON stated Staff F, RN just reported to her that Staff A, CNA was reassigned from Resident #210 and Resident #211's room on Sunday 04/14/24 because the Residents didn't care for Staff A, CNA. The DON stated Staff F, RN told DON Staff E, LPN talked with both Resident #210, Resident #210's Family Representative(FR) and Resident #211 and answered a ton of questions and everything seemed fine after that. The DON stated the chain of command for reporting would be for Staff E, LPN to report to Staff F, RN and then Staff F, RN should report to the DON who also identified herself as the Risk Manager. The DON stated if anything was reported to her related to abuse then Staff A, CNA would have been suspended immediately and an investigation would have been initiated. The DON stated that she had not even heard of any concerns related to Staff A, CNA and Residents #210 and #211 until 20 minutes prior to meeting with the survey team. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/24 at 4:45 p.m., Resident #211 stated on Sunday 04/14/24 Staff A, CNA was cussing. Resident #211 stated she could hear Staff A, CNA talking to someone on the phone. Resident #211 stated she could hear Staff A, CNA Talking about me. Resident #211 stated It didn't make me feel very good but what could I do? Resident #211 stated, I am blind with 1% vision in one eye and only about 7% in the other eye (legally blind). Resident #211 stated, I was afraid when Staff A, CNA was acting like that. Review of the Admission Record revealed Resident #211 was admitted to the facility on [DATE] with diagnoses that included acute bronchitis, weakness, unspecified falls, unspecified visual loss, depression and anxiety disorder. Review Resident #211's care plan showed the following: Focus: Resident has experienced a traumatic event that could lead to manifestation of Post Traumatic Stress Disorder (PTSD) or other psychosocial issues change in health status, loss of past roles. The goal included: Resident will have minimum negative changes in thinking and mood through next review. The Interventions included: Allow resident to make decisions, encourage resident participation in activities of choice, encourage resident to express emotions in a safe, private environment, provide reassurance and reorientation to facility, staff, and current situation as needed and refer to counseling/psych as needed. Focus: Resident #211 has an alteration in visual function diagnoses of glaucoma, diagnosis legally blind. Resident #211is at increased risk for falls with visual deficiencies at risk for malnutrition with visual deficiency. The goal showed, Resident will remain safe in the surrounding environment thru the next review date with assist form staff. The interventions included: administer medication as ordered, administer eye gtts (drops) as ordered, provide adequate lighting, provide assist with ADL tasks as needed, maintain a safe environment; notify resident of changes in environment as needed, provide verbal cues to locate objects or navigate in the environment, read written material to resident as needed. Review of the Brief Interview For Mental Status (BIMS) Evaluation dated 04/15/24 showed Resident #211 had a BIMS score of 13 (cognitively intact). During an interview on 04/16/24 at 4:35 p.m., The Regional Nurse Consultant (RNC) stated she thought Staff A, CNA's behavior was unprofessional and inappropriate, but she did not see it as abuse. The RNC stated she would have handled it differently than this administration and would have fired Staff A, CNA for the behavior. During an interview on 04/17/24 at 8:23 a.m., the DON stated all the staff know they are to report accurate information up the chain, so as the Risk Manager she is able to obtain accurate information to report an allegation and it can be handled properly. The DON stated she believed this was not abuse just a case of bad customer service. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility's policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised date 2021 showed, Policy Statement Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation 3. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems. 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect residents from any further harm during investigation.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observations, interviews, record review, the facility failed to ensure Activity of Daily Living (ADL) assistance was provided to one resident (#45) out of ten residents sampled. Finding Include: On 4/15/2024 at 10:30 AM., Resident #45 was observed laying down in his bed dressed in a red shirt and newspapers spread out all over his bed. Resident #45 was not able to communicate his needs. On 04/16/204 and 4/17/2024, at 11:00 AM., Resident #45 was observed laying down in his bed, dressed in the same red shirt for 3 days in a row. The same newspapers were observed for 3 days spread out all over his bed. Resident #45 was not able to communicate his needs. Review of the medical record showed Resident #45 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include but not limited to Autistic Disorder, Chronic Kidney Disease Stage 3, other mechanical complication of other Urinary Devices and Implants, Sequelae, and Down Syndrome, unspecified. Review of a Quarterly Minimum Data Set (MDS) ARD/ Target Date 2/20/2024, showed in section C0100 no was answered indicting Resident #45 is rarely/never understood and a Brief Interview for Mental Status should not be conducted. Further review of section C100 showed Resident #45 was severely cognitively impaired. Review of Resident #45's care plan showed the following: Focus: Resident having a self-care deficit with dressing, grooming, bathing related to r/t: cognitive deficit, diagnoses of down syndrome, autism, generalized weakness, limited endurance visional limitations, Resident requires staff assistance/ cueing to participate with ADL's (Activity of Daily Living). Date initiated: 08/08/2018 and revised on: 01/26/2023. Interventions for providing hands-on assistance with dressing, grooming, bathing as needed, observed for decline in ADL function; report to the physician as indicated. Date initiated 08/08/2024 and revised on 01/26/2024. Review of the medical record showed no documentation to support Resident #45 had an ADL decline or behaviors with refusing ADL care. During an interview on 04/17/2024 at 11:00 AM., with Staff M, Certified Nursing Assistant, (CNA), she stated she stated at the facility two weeks ago and she was caring for Resident #45. She stated she had not completed full ADLs on Resident #45 because she really doesn't know all his care needs. She stated she had emptied his catheter and did not change the resident shirt from the night because she thought the night shift staff took care of dressing the resident. She stated she did not know what type of care the resident needed. She stated, I usually work on the other hall. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/2024 at 11:20 AM., with Staff N, License Practical Nurse (LPN), she stated when she first starts her shift at 7:00 AM., she does rounds to ensure all her residents are safe, and their beds are in low positions. If a resident is awake, she asks them if they are experiencing any pain. She said she checks on residents who are incontinent to make sure they are dry and clean. She stated she had been assigned to Resident #45 for the last three days but was not aware that he had the same shirt on for three days in a roll. She stated it was an oversight on her behalf and she will assist the resident immediately with his care. She stated her expectations are CNA's should make sure that ADL care is provided to their residents every day and residents are provided with clean clothes. If a CNA is experiencing problems with a resident they should notify her so she can assist them by using a different approach to provide care for the resident. She stated Resident #45 has not had any behavior reported to her during the days she has worked with him as his nurse. During an interview on 04/18/2024 at 2:00 PM., with the Director of Nursing, DON, she stated her expectation is that residents have ADL's performed on them every day. If staff are dealing with a resident refusing ADL care, then they report it to their nurse so the nurse can document the resident's behavior and provide further assistance. She stated no resident should be left in the same shirt for three days. Review of the facility policy titled, Activities of Daily Living (ADL's) Supporting, revised 03/2018 showed the following: Resident will be provides with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 1. Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition (s) demonstrate that diminishing ADLs are unavoidable. a. The existence of a clinical diagnosis or condition does not alone justify a decline in a resident's ability to perform ADLs. b. Unavoidable decline may occur if he or she: (1) has a debilitating diseases with known functional decline; (2) has suffered the onset of an acute episode that caused physical or mental disability and is receiving care to restore or maintain functional abilities; and/or (3) refuses care and treatment to restore or maintain functional abilities and: a) the resident and or representative has been informed of the risk and benefits of the proposed care or treatment; and b) he or she has been offered alternative intervention to minimize further decline; and c) the refusal and information are documented in the resident's clinical record. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance. 4. If resident with cognitive impairment or dementia care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observations, interviews, and record review, the facility failed to ensure four dependent residents (#45, #43, #69, and #72) were provided with activities out of ten residents sampled. Findings Include: Multiple observations were made on 4/15/2024 at 10:00 a.m., 1:00 p.m., and 4:00 p.m., showing Resident #45 laying down in his bed dressed in a red shirt and newspapers spread out all over his bed. Resident # 45 was not able to communicate his needs. During an observation made on 04/16/204 at 10:30 a.m., and at 3:00 p.m., and on 4/17/2024 at 11:00 a.m. Resident #45 was observed laying down in his bed, dressed in the same red shirt for 3 days in a row. The same newspapers were observed for 3 days spread out all over his bed. Resident # 45 was not able to communicate his needs. Review of the medical record showed Resident #45 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Autistic Disorder, Chronic Kidney Disease Stage 3, other mechanical complication of other Urinary Devices and Implants, Sequelae, and Down Syndrome, Unspecified. Review of a Quarterly Minimum Data Set (MDS) ARD/ Target Date 2/20/2024, showed in section C0100 no was answered indicting Resident #45 is rarely/never understood and a Brief Interview for Mental Status should not be conducted. Further review of section C100 showed Resident #45 was severely impaired. Review of Resident #45's care plan showed the following: Focus: The resident is at risk for decreased social interaction/ activity participation, due to severe cognitive impairment, fluctuating responses to external stimuli do to (d/t) down syndrome, autistic, limited verbalization, impaired physical mobility, dependent on staff for all needs. Interventions: to provide cues and assist to complete tasks while in activity programs as needed. Activity staff to provide in room [ROOM NUMBER]:1 visit, including sunshine visits, various tactile activities. During an interview on 4/18/2024 at 2:00 p.m., with the Activities Director, he stated he creates his activity program from the information he gathers from residents upon admission and from resident council meetings. He stated room visits are done every day for wellness checks around 4 or 4:15 p.m. every day. He stated he had not provided any activities or room visit for Resident #45 all week because he was too busy. 43453 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During multiple facility tours on 04/15/24 from 09:58 a.m. to 2:30 p.m. Resident #72 was observed in the dining room sitting at a table by himself. The resident was not interacting with anyone. The resident was not participating in any activities. On 04/15/24 at 02:21 p.m. Resident #72 was observed still sitting in the dining room at the same spot. The resident was observed growing restless, noted standing, looking around and then sitting down. Resident was noted to be confused. Review of the admission record showed Resident #72 was admitted to the facility on [DATE] with a diagnosis of dementia. Review of resident #72's Care Plan, dated 03/20/24, showed a focus indicating Resident #72 was at risk for decreased social interaction/activity participation related to dementia with interventions to include assist with television programs, provide monthly activity calendar in room, encourage social interactions with staff and peers and to encourage family/loved ones to ring music, television etc. for stimulation. A focus in the care plan showed Resident 372 has severe cognitive deficits and does not respond to verbal or tactile stimuli with interventions for activities' staff to provide in room [ROOM NUMBER]:1 visits, music etc. Resident #72 has an alteration in communication ability related to does not communicate needs at all, does not speak English; primary language is: Polish Interventions: included to ask resident yes/no questions, provide interpreter as needed, ask family to interpret as able and for staff to anticipate need and verify with resident as able. On 04/15/24 at 02:35 p.m. an interview was conducted with Staff G, Certified Nursing Assistant (CNA). She stated the resident spoke Polish. She said, He is hard to understand. I did not ask him if he wanted to leave the dining room or if he needed to use the restroom. He is sometimes resistive. Residents should be checked on at least every 2 hours. On 04/15/24 at 2:40 p.m. an interview was conducted with Staff J, Registered Nurse (RN). She confirmed seeing Resident #72 in the dining area all morning. She stated she had seen him since 11 a.m. On 04/15/24 at 2:45 p.m. an interview was conducted with the Director of Nursing (DON). She stated their residents should be attended to at least three times per shift. During multiple tours on 04/16/24 and 04/17/24 Resident #72 was observed in the dining room seated at a table by himself without interaction. The resident was not engaged in any activities. During multiple tours on 04/15/24, 04/16/24, and 04/17/24, Residents #69 and #43 were observed laying in their beds without a television or radio on. The residents were observed in their room without activities or social interactions. Review of the admission record showed Resident #69 was admitted to the facility on [DATE] an initial admitted [DATE] with diagnoses of blindness right and left eye category 5, and Cerebral Vascular Accident (CVA). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a care plan, dated 05/16/22, revealed Resident #69 was at risk for decreased social interaction/activity participation related to being legally blind. Activity preferences indicated Resident #69 had impaired physical mobility and enjoyed listening to fishing shows, national geographic, music and family visits. Interventions included providing assistance with television programs of choice. Providing monthly activity calendar in room, encourage social interactions with staff and peers and to encourage family/loved ones to bring in music, television for increased stimulation. Review of the admission record showed Resident #43 was admitted to the facility 11/21/23 an initial admitted [DATE] with diagnoses of dementia. Review of a care plan, dated 02/28/24, showed Resident #43 was capable of pursuing his own activities with motivation and encouragement. Resident prefers to watch television, spend time with families and listening to music. Interventions included determining which individual activities [Resident #43] preferred and provide any related materials, to provide monthly calendar in room, invite to daily activities of choice and encourage resident to voice needs and concerns related to independent leisure tasks as needed. On 04/18/24 at 1:20 p.m. an interview was conducted with the Activities Director. He stated a lot of times he tried to conduct 1:1 activities in the afternoons. He stated the wellness check in the activity's calendar meant 1:1 activities. He stated he would see the ones who would like an activity brought to them such as magazines or books or just a conversation. The Activities Director said, I have a spreadsheet with listed name of the residents. I don't write the specific names of the residents who participated. I am not charting an individual's participation. I just tally the count. He stated he had an assistant but would normally be by himself on Mondays and Tuesdays. He stated the assistant worked weekends by herself. The Activities Director said, It can be a lot. The Activities Director confirmed he had not checked on Residents #69, #43 and #72 all week. He said, [Resident #69] enjoys just being in his room watching TV or listening to the radio. It should be on. You are right. I did not check on him this week. [Resident #43] does come out. When is out, he participates in activities with encouragement. I have not seen him this week. A family member visits and gets him out. I have not seen him this week. I did not get around to see him. I could have asked the CNAs to get him up. I did not get to it. [Resident #72] is in the dining room a lot. I have not seen him participate in any activities. I tried to get him into Polish activities like music. I have not figured him out yet. I know he has a language barrier. He sits and watches people. It is not realistic to engage all the residents. I have quite a few that do not come out of the rooms. I try my best. Review of the facility policy titled, Activity Programs, revised June 2018, showed Activity programs are designed to meet the interest of and support the physical, mental and psychological well-being of each resident. 1. The activity program is provided to support the well-being of residents and to encourage both independence and community interaction

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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** 46234 Based on observation, interview, and record review the facility failed to ensure proper orders and documentation were in the medical record for two residents (#10 and #255) out of twenty-nine sampled residents. Findings included: Review of Resident #10's care plan showed she was receiving hospice services. Review of Resident #10's physician orders did not show an active order in place for hospice services. There was a previous order for hospice, dated 5/31/22, which was discontinued on 6/6/22. Review of admission records showed Resident #10 was admitted on [DATE] and readmitted on [DATE] with diagnoses including dementia, psychotic disturbance, anxiety, and malnutrition. Review of Resident #10's hard chart and electronic medical record showed no documentation or notes from hospice services. An interview was conducted on 4/17/24 at 10:05 a.m. with Staff Q, Licensed Practical Nurse (LPN). She said Resident #10 was receiving hospice services. She pulled out the resident's hard chart and showed the hospice team and contact information noted on Resident #10's chart. When asked if the resident had an order for hospice she said Oh it's there she has been on hospice a long time. Staff Q reviewed Resident #10's medical record and confirmed there was no order for hospice services. Staff Q said maybe Resident #10 was disenrolled from hospice because she didn't meet the criteria any longer. When asked where notes are from hospice visits, Staff Q said she isn't sure hospice leaves any notes. An interview was conducted on 4/17/24 at 10:21 a.m. with Staff H, LPN/Unit Manager (UM). She said Resident #10 is hospice but she wasn't sure where hospice notes are. She said they may be in the Director of Nursing's (DON) office. An interview was conducted on 4/17/24 at 10:28 a.m. with the DON. She confirmed Resident #10 was on hospice. The DON said hospice notes should be scanned into the medical record. She reviewed the record and was unable to find any hospice notes or documentation for Resident #10. The DON also confirmed there was no physician order for hospice for Resident #10. The DON checked the facility's previous charting system in case the information didn't transfer to the new system. She said she could only find the order that was discontinued in 2022. The DON said an order should be in Resident #10's medical record. She also said hospice notes should be in the record, so the resident's nurses are able to view them. Review of lab results for Resident #255 showed he had a critically low hemoglobin level on 4/9/24. The Lab Results Report showed the lab was collected on 4/9/24 at 7:02 p.m. and the facility's laboratory servicing company was notified of the critical lab result on 4/9/24 at 8:57 p.m. The lab results showed they were faxed to the facility on [DATE] at 9:08 p.m. (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 Admission Record showed Resident #255 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of the kidney, history of transient ischemic attach and cerebral infarction, and anemia. Review of Resident #255's progress notes did not show any documentation a provider was notified of the critical lab values on 4/9/24. There was a progress note dated 4/10/24 at 7:08 a.m. showing the lab called about critical lab results for Resident #255, the resident's primary care nurse practitioner (NP) was notified, and she gave orders for the resident to be sent to the hospital. An interview was conducted on 4/18/24 at 10:50 a.m. with the DON. The DON reviewed Resident #255's medical record and noted the order for STAT (immediate) labs was placed on 4/9/24 at 10:42 a.m. When asked why it took almost 8 1/2 hours for STAT labs to be drawn, the DON stated, STAT labs have been challenging at times. She said STAT labs should have results within 4-6 hours of being ordered. The DON confirmed there was no documentation showing a provider was notified of the critical lab values. She said she knows the nurse spoke with the NP but there should be documentation in the record. An interview was conducted on 4/18/24 at 11:25 a.m. with Staff R, Medical Records. She confirmed all facility records for Resident #255 had been scanned into his electronic medical record and there are no additional closed records or hospice notes. An interview was conducted on 4/18/24 at 11:59 a.m. with Resident #255's primary care NP. She said she didn't know what the deal was with the labs, but STAT orders should be drawn within 4 hours and results are typically back within two hours after that. Review of a facility policy titled Hospice Program, revised July 2017, showed the following: Policy Statement Hospice services are available to residents at the end of life. Policy Interpretation and Implementation 9. In general, it is the responsibility of the hospice to manage the resident's care as it related to the terminal illness and related conditions, including: . c. Providing medical direction, nursing, and clinical management of the terminal illness. 10. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriate based on the individual resident's needs. Review of a facility policy titled Lab and Diagnostic Test Results-Clinical Protocol, reviewed November 2018, showed the following: Options for Physician Notification (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. A physician can be notified by phone, fax, voicemail, e-mail, mail, pager, or a telephone message to another person acting as the physician's agent (for example, office staff). a. Facility staff should document information about when, how and to whom the information was provided and the response. This should be done in the Progress Notes section of the medical record and not on the lab results report, because test results should be correlated with other relevant information such as the individual's overall situation, current symptoms, advance directives, prognosis,etc. Review of a facility policy titled Charting and Documentation, revised July 2017, showed the following: Policy Statement All services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observations, interviews and record review, the facility did not ensure foot care was provided when needed for one resident (#69) out of one residents sampled. Findings included: During a facility tour on 04/15/24 at 10:10 a.m., Resident #69 was observed in his bed. His toe nails were observed with dark nail beds and black residue around the toe nails. An immediate interview was conducted with the resident who did not know what was wrong with his feet or toenails. He asked this surveyor what they looked like. He said, Lady, I am blind. I have not seen my feet or nails. He stated he did not know if the staff were applying anything to his feet. Review of a Primary Care Physician (PCP) progress note, dated 02/07/24, showed Resident #69 had a follow up visit chief complaint, At risk patient with long thickened painful nails. Patient is seen today for treatment of painful and thickened toenails bilateral feet. Patient has pain secondary to thickening and dystrophy of the infected (mycotic) nail plate. Thickening and dystrophic nail has been present for many months. Debridement of the nails has helped previously to control pain and inflammation of periungual nail borders. The patient has a reoccurrence of pain as the nail grows and becomes thickened . The plan note showed Nursing staff to contact me immediately if any erythema, purulence, or other signs of infection be present, otherwise patient is to be seen in 6-8 weeks. Review of the Electronic Medical Record (EMR) for Resident #69 did not show the physician had been contacted or had seen this resident since the visit in February. Review of April 2024 physician orders for Resident #69 conducted on 04/15/24 at 11:00 a.m. showed the resident did not have active treatment orders for his skin condition. Review of the admission record showed Resident #69 was admitted to the facility on [DATE] an initial admitted [DATE] with diagnoses of Type 2 Diabetes Mellitus (DM), unspecified malnutrition, blindness right and left eye category 5,and Cerebral Vascular Accident (CVA). Review of a care plan for Resident #69, dated 05/31/23, revealed the resident had an alteration in visual function, with interventions to provide ADL tasks as needed and to provide verbal cues to locate objects or navigate in the environment. A self-care focus showed the resident had a grooming deficit with .grooming related to generalized weakness, DM, CVA and chronic pain. Interventions included providing hands-on assistance with dressing, grooming, and bathing. Review of Resident #69's weekly skin assessments for the months of March and April 2024 showed four documents were completed indicating the resident's skin condition was normal. On 04/13/24 skin condition is normal, dry, flaky, and fragile. On 04/06/24 skin condition is normal, dry, flaky, and fragile. On 03/30/24 skin condition is normal. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/23/24 skin condition is normal, dry, flaky, and fragile. On 03/16/24 skin condition is normal, dry, and fragile. On 04/18/24 at 09:18 a.m., an interview was conducted with Staff L, Registered Nurse (RN) she observed Resident #69's feet and stated the resident should be getting skin prep. She stated she would review his chart. Staff L followed up with this surveyor at 09:54 a.m. and stated they just ordered a cream for his feet. She stated the physician ordered Ammonium Lactate External Cream 12% to be applied to bilateral legs and feet every shift. She stated Resident #69 was on the list to be seen by the podiatrist next time he was in the building. Staff L, RN reviewed the electronic medical record and confirmed she could not find podiatry notes for this resident. An interview was conducted on 04/18/24 at 10:02 a.m., with Staff H Licensed Practical Nurse (LPN) She stated the resident was seen by his PCP on 02/7/24. The UM stated she did not know if he had been seen by a podiatrist since his admission. She stated she had not seen the resident's feet and did not know the condition they were in. She stated she was not aware there were any concerns. On 04/18/24 at 10:59 A.m. an interview was conducted with the Assistant Director of Nursing (ADON). She said, As a nurse they [nurses] should do skin checks and report any concerns, or the CNAs to report any skin impairments. The ADON reviewed residents skin assessments with surveyor and noted they indicated normal skin. She stated if a resident had any kind of skin impairment, it should be documented. She stated she would assess the resident herself. On 04/18/24 at 12:59 p.m. an interview was conducted with the Director of Nursing (DON) and the Nursing Home Administrator (NHA). The DON stated the resident should have been seen by podiatrist. She said, There should be notes. She reviewed the skin assessments with surveyor showing normal skin assessments were documented without any noted impairments. She stated she would follow-up. Review of a facility policy titled, Fingernails/Toenails, Care of, dated February 2018, showed the purpose of this procedure are to clean the nail bed, to keep nails trimmed, to prevent infections. Under general guidelines: 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulator impairments. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. 5. Watch for and report any changes in the color of the skin around the nail bed, blueness of the nails, any signs of poor circulation, cracking of the skin between the toes, any swelling, bleeding etc. 6. Stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observations, interviews and record reviews, the facility did not accommodate dietary preferences related to alternate meal requests for four residents (#351, #18, #352, and #86) out of 13 sampled residents. Findings included: 1. On 04/15/24 at 10:31 a.m. an interview was conducted with Resident #351 who stated food was not palatable. He said sometimes the food is cold. He described the supper last night, which was lima beans, carrots, and what he described as broth (but was supposed to be soup), fruit from a can, and no bread/crackers. He stated dietary comes by to get choices, but they never bring what he wants. He said follow up is nonexistent. On 04/15/24 at 12:52 p.m. resident #351 said, The food {expletive}. I don't like anything. He stated the food has no seasoning/salt. He described the lunch as very bland. The resident stated he was not offered an alternative even though he doesn't like the options. During the interview the roommate stated nobody asked if he wanted an alternate meal choice and he didn't know he could ask for an alternative. Review of the admission record showed Resident #351 was admitted to the facility on [DATE] with a diagnoses of dehydration, and dysphagia. Review of Resident #351's Admission Minimum Data Set (MDS), dated [DATE], revealed in Section C-Cognitive and Patterns a Brief Interview for Mental Status (BIMS) score of 12, intact cognition. Review of April 2024 physician orders for Resident #351 showed the resident received a regular texture diet, thin consistency, large portions with breakfast and fortified foods with meals for nutrition. Review of Resident #351's care plan, dated 03/29/24, under the nutrition focus showed the resident has an alteration in nutrition related to a variable PO (by mouth) intake. The goal, revised on 04/12/24, showed honoring resident's food preferences. Interventions included providing diet as ordered, providing alternate as needed, and honor food preferences. 2. On 04/17/24 at 12:42 p.m. Resident #18 was observed during lunch service. The resident stated to Staff G, Certified Nursing Assistant (CNA) that was not what he wanted. He said, I don't want the soup. I wanted two sandwiches. I ordered this last night. During the observation, the resident's tray was noted without sandwiches. Resident #18 stated he put in his request the night before. Resident#18 said, It happens all the time. During the interview Staff H, Licensed Practical Nurse (LPN)/ Unit Manager (UM) stated she would get him a sandwich. She said, It should have been on the tray if he asked the night before. Review of the Admission Record for Resident #18 showed the most recent admitted [DATE] and an initial original admitted [DATE], with a diagnoses morbid severe obesity and Type 2 Diabetes Mellitus. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #18's MDS, dated [DATE], revealed in Section C-Cognitive and Patterns BIMS score of 15, intact cognition. Review of the April 2024 physician orders for Resident #18 did not show the resident's dietary orders. Review of resident #18's care plan, initiated on 08/25/20 under the focus of nutrition showed the resident has an alteration in nutrition related to a therapeutic diet with a history of changing dislikes and preferences often. Interventions included providing diet as ordered, providing alternate as needed, and honor food preferences. 3. An interview was conducted with Resident #352 on 04/15/24 at 12:48 p.m. Resident #352 stated he doesn't like the food as it's not food he normally would eat. He said, When I request food as an alternate choice, I do not get what I want. Review of Resident #352's meal ticket, dated 04/29/24 sic (04/15/24), revealed the resident was served mushroom gravy, steamed summer squash, pureed black-eyed peas, dinner roll buttered, mechanical/altered ground orange gelatin (photographic evidence was obtained). During the observation, the resident stated this is not what he ordered and he did not like any of these meal items. Review of the Admission Record showed Resident #352 was admitted to the facility on [DATE] with diagnoses to include chronic kidney disease stage 4. Review of the April 2024 physician orders for Resident #352 showed the resident received a mechanical soft texture diet, thin consistency, no straws for nutrition. Review of Resident #352's care plan, dated 04/15/24, under the focus of nutrition showed the resident has an alteration in nutrition related to a variable oral (PO) intake. Interventions included providing diet as ordered, providing alternate as needed, and honor food preferences. 4. An interview was conducted on 04/15/24 at 10:50 a.m. with Resident #86. Resident #86 stated she generally likes the food; however, she doesn't ask for an alternate if she doesn't like the option. Resident #86 stated, She did not know she could ask for an alternate option. Review of the Admission Record for Resident #86 showed an admitted [DATE] with diagnoses to include noninfective gastroenteritis and colitis and constipation. Review of Resident #86's Quarterly MDS, dated [DATE], revealed in Section C-Cognitive and Patterns a BIMS score of 99, indicating the resident was not interviewable. Review of the April 2024 physician orders for Resident #86 showed the resident received a regular texture diet, thin consistency, and super cereal with breakfast for nutrition. Review of Resident #86's care plan, dated 08/26/23, under the focus of nutrition showed the resident has an alteration in nutrition related to a variable PO intake. Interventions included providing diet as ordered, providing alternate as needed, and honor food preferences. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 4/18/24 at 6:09 p.m. with the Dietary Manager (DM). The DM stated she was responsible for interviewing residents and collecting their food preferences. The DM stated during the 3pm-11pm shift, the CNAs collect the food preferences from the residents. The DM stated she gives the food preferences interview to the Registered Dietitian (RD-1), who puts the information into the meal tracker system. The DM stated the meal tracker system is a new system. She stated the meal tracker system is not interfaced completely, therefore, there have been some issues with residents not getting their preferences and alternate choices. The DM stated she was aware there was an issue, which was identified a month and a half ago. She stated she was aware residents have been reporting they were not receiving the options they wanted, despite being asked the day prior by staff. She stated she brought this concern up during their morning staff meetings. She said, I am keeping the food preferences and substitute paper from the residents who are saying they are not getting the food choices they want. The DM stated she was monitoring their process. Review of the facility's policy titled, Dining and Food Preferences, dated October 2019, showed it is a center policy that individual dining, food, and beverages preferences are identified for all residents/patients. Under action steps, (6.) The Dining Services Director, RDN or other clinically qualified nutrition professional, or designee, will enter information pertinent to the individual meal pan into the plan of care, (7.) The individual tray assembly ticket will identify allergies, food and beverage preferences or special requests, and adaptive equipment as appropriate, (8.) Upon meal service, any resident/patient with expressed or observed refusal of food and/or beverage will be offered an alternate selection of comparable nutrition value, (9.) The alternate meal and/or beverage will be provided in a timely manner.

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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** 41015 Based on observation, interviews, and record review, the facility failed to ensure an effective infection control program was implemented related to 1) the use of personal protective equipment (PPE) for two of three designated transmission based precaution (TBP) rooms, 2) no hand hygiene provided to residents prior to meals for four of four hallways, and 3) the Infection Preventionist (IP) conducting appropriate surveillance for influenza. Findings included: During an interview on 04/15/24 at 1:20 p.m., Resident #209's Family Representative (FR) stated Resident #209 tested negative for influenza and the droplet precautions sign was placed on the door for his roommate who went out to the hospital. Resident #209's FR stated she did not know why the droplet precaution sign remained on Resident #209's door when he tested negative for influenza. (Photographic evidence obtained). An observation on 04/15/24 at 1:25 p.m., revealed Staff A, Certified Nursing Assistant (CNA) walked into Resident #209's room, past Droplet Precaution sign and PPE, and entered the room without donning PPE. Staff A, CNA was observed taking Resident #209 out of the room and began to wheel him down the hall. An immediate interview on 04/15/24 at 1:25 p.m., was conducted. Staff A, CNA stated Resident #209 was good and not on precautions because he did not have a blue band on his wrist to show that she needed to don a gown and glove to assist him. During an interview on 04/15/24 at 1:30 p.m., Staff B Licensed Practical Nurse (LPN) stated Resident #209 had an active order for droplet precautions and Staff A, CNA should have appropriately donned PPE for any droplet precaution rooms. Staff B, LPN stated Resident #209 should not be out of his room and being wheeled down to the hall to the shower room right now due to being on droplet precautions. Review of the Admission Record showed Resident #209 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia, anemia, Type II Diabetes, ventricular tachycardia, and acute chronic systolic (congestive) heart failure. A physician order, dated 04/12/24 revealed, Follow Droplet isolation related to active Flu A + status. All cares to be provided in room only. During an interview on 04/16/24 at 3:00 p.m., the Infection Preventionist (IP) stated blue bands were used in the facility to only alert therapists and our staff a resident is on enhance precautions because of a peripherally inserted central catheter (PICC) line or other catheters. The IP stated the blue bands are only used for enhanced precaution rooms. The IP stated blue bands had nothing to do with droplet precautions and all PPE should be worn in droplet precaution rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 04/15/24 at 12:30 p.m., revealed seven residents sitting in the front dining room located near the facility lobby. Staff C, CNA was observed passing hydration to the residents. Staff C, CNA was not observed providing hand hygiene to the residents during the passing of hydration. Additional observations of tray pass in the facility revealed the following: - On 04/17/24 at 12:00 p.m., there was no hand hygiene offered during tray pass to residents who resided in rooms 18 to 30. - On 04/17/24 at 12:15 p.m., there was no hand hygiene offered during tray pass to residents who resided in rooms 1 to 17. - On 04/17/24 at 12:22 p.m., there was no hand hygiene offered to 13 residents during hydration pass in the front dining room near the lobby. - On 04/17/24 at 12:30 p.m., there was no hand hygiene offered during tray pass to residents who resided in rooms 41 to 52. - On 04/17/24 at 12:40 p.m., there was no hand hygiene offered to 13 residents during tray pass in the front dining room near the lobby. During an interview on 04/17/24 at 1:15 p.m., Resident #210 stated No staff never offer hand hygiene. Resident #210 stated, I actually had my daughter bring me some hand hygiene wipes from home. Review of the Admission Record showed Resident #210 was admitted to the facility on [DATE] with diagnoses that included fracture of unspecified part of the neck of left femur, subsequent encounter for closed fracture with routine healing, cerebellar ataxia in disease, polyneuropathy, heart failure, and spinal stenosis. Review of the Brief Interview For Mental Status (BIMS) evaluation, dated 04/14/24, revealed Resident #210 had a BIMS score of 14 (cognitively intact). During an interview on 04/17/24 at 1:20 p.m., Resident #65 stated, No, I have never been offered any hand sanitizer from staff and actually I have never heard staff offer hand hygiene to anyone. Review of the Admission Record showed Resident #65 was admitted to the facility on [DATE] with diagnoses that included Sepsis, Hyperlipidemia, Cystitis without hematuria and urinary tract infection. Review of Resident #65's quarterly Minimum Data Set (MDS), dated [DATE], Section C-Cognitive Patterns revealed a BIMS of 11 (moderately impaired). During an interview on 04/17/24 at 5:16 p.m., Resident #205 stated, No and they never do. regarding hand hygiene. A review of the Admission Record showed Resident #205 was admitted to the facility on [DATE] with diagnoses that included Syncope and collapse, hyperthyroidism, dehydration, hypokalemia, depression and Parkinson's. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105166	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Pointe Care Center	6020 Indiana Ave New Port Richey, FL 34653

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #205's quarterly Minimum Data Set (MDS), dated [DATE], Section C-Cognitive Patterns revealed a BIMS of 13 (cognitively intact). During an interview on 04/17/24 at 1:25 p.m., Staff C, CNA stated she did not carry around hand sanitizer to provide to residents for hand hygiene. Staff C, CNA stated if Residents needed hand hygiene, they could use the sink or any of the two hand sanitizer stations located on the walls of the dining room. Staff C, CNA stated she was picky about her hands, and she washed, and hand sanitized all the time. Review of the facility's policy Influenza, Prevention and Control of Season, revised date March 2022, showed, Infection Precautions 1. Contact and Droplet precautions are implemented for residents with suspected or confirmed influenza for seven (7) days after illness onset or 24 hours after the resolution of fever and respiratory symptoms, whichever is longer. Precautions may be applied for longer periods based on clinical judgement. Review of the facility's policy Handwashing/Hand Hygiene, dated August 2019, showed, 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 5. Residents, family members and/or visitors will be encouraged to practice hand hygiene through the use of fact sheets, pamphlets, and/or other written material provided at the time of admission and/or posted throughout the facility. 7. Use an alcohol based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: .o. Before and after eating or handling food. 46234 An observation was made on 4/15/24 at 10:51 p.m. of Resident #89 going to lunch in the dining room. The resident had black debris under her fingernails. When asked if staff helped her clean her hands or nails, she said no. The resident was observed eating her lunch with her hands and nails dirty. Her nails remained dirty on 4/16/24. (Photographic evidence obtained) An observation was made on 4/16/24 at 8:58 a.m. of Staff B, Licensed Practical Nurse (LPN) during medication administration. Staff B, LPN donned PPE to enter a room on isolation precautions. When exiting the room, she went to the medication cart with PPE still on, prior to performing hand hygiene, opened the drawer and placed items in the cart. She then removed her PPE in the hall and threw it in the trash can placed in the hallway. An observation was made on 4/16/24 at 9:13 a.m. of Staff N, LPN during medication administration. Staff N administered an inhaler to a resident, exited the room, opened the medication cart, and placed the inhaler inside without performing hand hygiene. (continued on next page)

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	105166	A. Building B. Wing	04/18/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 4/16/24 at 2:58 p.m. with the Assistant Director of Nursing (ADON). The ADON said PPE should be removed inside the room and placed in the trash before exiting. She said the health department came to the facility a week prior and told them PPE should be removed and thrown away in the room. She said changes could not be implemented overnight and they needed to get big trash cans for the rooms. The PPE trash cans remained in the hallway on 4/17 and 4/18/24. The ADON confirmed staff should perform hand hygiene after each resident, prior to touching the medication cart. Review of the facility's policy Handwashing/Hand Hygiene, dated August 2019, showed, 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 5. Residents, family members and/or visitors will be encouraged to practice hand hygiene through the use of fact sheets, pamphlets, and/or other written material provided at the time of admission and/or posted throughout the facility. 7. Use an alcohol based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: .o. Before and after eating or handling food.