STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105377	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longwood Health and Rehabilitation Center	1520 S Grant St Longwood, FL 32750

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to replace a broken bed in a timely manner to promote the right to a comfortable environment for 1 of 5 residents reviewed for environmental concerns, out of a total sample of 43 residents, (#24); and failed to clean and store resident care items appropriately in a shared bathroom in 1 of 32 rooms on the B Wing, (room [ROOM NUMBER]). Findings: 1. Review of the medical record revealed resident #24, an [AGE] year old female, was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diffuse large cell lymphoma, generalized muscle weakness, stroke with left side weakness and paralysis, spondylosis (degenerative changes in the spine), arthropathy (joint disease), and right hip fracture. The Minimum Data Set (MDS) Discharge-Return Anticipated assessment with assessment reference date of 3/25/24 revealed the resident's short-term memory was intact and she had independent cognitive skills for daily decision making. The document indicated resident #24 required partial to moderate assistance for toileting hygiene, bathing, dressing, and personal hygiene, and was always incontinent of bowel and bladder. Review of the medical record revealed resident #24 had a care plan for decreased ability to perform activities of daily living (ADLs) initiated on 11/13/23. The goals were the resident would participate in ADLs as tolerated and have her ADL needs met. The interventions directed nurses and Certified Nursing Assistants (CNAs) to, Arrange resident/patient environment as much as possible to facilitate ADL performance. On 4/08/24 at 11:13 AM, resident #24 stated the remote control for her bed stopped working on the weekend and it was not replaced until this morning. The resident explained she was forced to sleep seated in an upright position overnight. The resident used her arm to demonstrate the head of her bed was stuck at an angle of approximately 60 degrees. She said, The CNAs tried to fix the bed and they really tried to help but they couldn't do anything. It was so hard for them to even try and change my brief sitting up. They had to pull me down to the bottom of the bed. They told me the maintenance people don't work on the weekend and they did not consider that as an emergency. Resident #24 stated she now had mild left shoulder discomfort as a result of attempts to find a comfortable position for sleep while the head of her bed remained upright. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/24 at 1:01 PM, CNA D stated she was assigned to resident #24 during the 7:00 AM to 3:00 PM shift on Sunday 4/07/24. She recalled the resident's bed broke soon after lunchtime. CNA D said, She was sitting up pretty high. I had to rock her from side to side [to change her]. She said it was uncomfortable. CNA D stated she initiated an electronic work order and also reported the broken bed to the assigned nurse, Licensed Practical Nurse (LPN) C. On 4/10/24 at 1:20 PM, the Maintenance Director explained he was on call on the weekends and also had a Maintenance Assistant who attended to issues in the building on the weekends and after hours if necessary. He stated no staff contacted him regarding resident #24's broken bed over the weekend, and he was not aware of the concern until informed by Central Supply staff on Monday morning. The Maintenance Director stated anything that occurred in a resident room required immediate attention and staff could have replaced the broken bed with one of the many unoccupied beds in the facility. On 4/10/24 at 1:31 PM, the Central Supply Coordinator explained when he arrived at work on Monday, 4/08/24 at approximately 6:20 AM, nursing staff informed him of concerns regarding resident #24's bed. He verified the resident was in a seated position and he recalled, She was not fully upright, but she was in a position that I deemed uncomfortable. The Central Supply Coordinator validated there were functional beds available in empty rooms. On 4/12/24 at 10:36 AM, the Director of Nursing (DON) stated staff members could have switch out the resident's broken bed or called maintenance staff. He explained it was common sense and said, I think it was horrible. She should not have had to sleep in an upright bed. 2. On 4/08/24 at 11:58 AM, there were four plastic bath basins stacked on the lid of the toilet in the shared bathroom of room B-12. A gray bed pan was wedged between the grab bar and wall beside the toilet, and a dirty urinal hung from the grab bar. In addition, there were four containers of shaving cream on the right side of the sink. The resident care items were not labeled with names, room and bed information, or stored in plastic bags. On 4/09/24 at 8:57 AM, there were two bath basins on the lid of the toilet and the urinal still hung from the grab bar. A crusted dark yellow to brown substance was noted inside the bottom of the urinal. Four containers of shaving cream remained on the right side of the sink. On 4/10/24 at 1:49 PM, the location and condition of the bath basins, urinal, and shaving cream were unchanged. On 4/10/24 at 1:52 PM, the Evening Shift LPN Nursing Supervisor validated the bath basins and urinal in bathroom of room B-12 were not labeled to designate which of the residents in the semi-private room used the items. He confirmed the resident care items should be kept clean and stored in clear plastic bags. The resident in Bed A stated he used the shared bathroom and thought the urinal and basins belonged to the resident in Bed B. On 4/11/24 at 9:34 AM, there was an unlabeled hairbrush and four containers of shaving cream on the sink in the room B-12 bathroom. The resident in Bed A said, I don't know whose it is. It could be mine. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/12/24 at 10:38 AM, the DON stated residents' personal care items should be appropriately labeled and stored in plastic bags. He confirmed the bottles of shaving cream and the hairbrush should have been labeled and returned to the appropriate resident's drawer after use. The DON acknowledged there were concerns related to infection control and environmental cleanliness. He stated CNAs were responsible for storing residents' items appropriately and housekeeping staff should alert nursing staff if items were improperly stored or needed. Review of the facility's policy and procedure for Safe and Homelike Environment, revised 4/11/23, revealed the facility would provide a safe, clean, comfortable, and homelike environment to ensure residents received care and services safely. The document indicated the facility would provide necessary housekeeping and maintenance services to achieve that goal. The policy revealed the environment included residents' rooms and bathrooms and it defined sanitary conditions as those that prevented the spread of disease-causing organisms by methods such as ensuring resident care equipment was clean and properly stored. The policy revealed instructions to staff to, Report any furniture in disrepair to Maintenance promptly [and] report any unresolved environmental concerns to the Administrator.

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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** 45646 Based on interview, and record review, the facility failed to report an alleged violation of neglect for 1 of 2 residents reviewed for abuse, of a total sample of 43 residents, (#38). Findings: Cross reference F689 Resident #38 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including schizoaffective disorder, anxiety disorder, fracture of fifth metacarpal bone of left hand, muscle weakness, lack of coordination, and repeated falls. Review of the Minimum Data Set quarterly assessment with assessment reference date of 3/21/24 revealed resident #38 had a Brief Interview for Mental Status score of 13 which indicated she was cognitively intact. The document indicated the resident walked independently and had one fall without injury and one fall with injury during the last 90 days. The medical record contained a care plan revised on 10/09/23 which indicated resident #38 was at risk for falls related to deconditioning, weakness, medication use and cognition. Interventions included one-to-one supervision for safety which was initiated 1/29/24. A physician order dated 3/19/24 read, One to One Supervision [related to] behaviors/fall risk every shift. Review of resident #38's medical record revealed a progress notes written by Licensed Practical Nurse (LPN) A dated 4/05/24. The note indicated LPN A observed resident #38 walking in the hallway alone at approximately 11:15 PM. The resident was observed with blood on her nose and stated she fell in-between the bedside table and the walker when she was by herself because the sitter left before another one came. Review of facility assignment sheets revealed Certified Nursing Assistant (CNA) B was assigned to resident #38 on 4/05/24. On 4/11/24 at 1:59 PM, CNA B confirmed she was assigned to sit one-to-one with resident #38 during the 3 PM to 11 PM shift on 4/05/24. She stated resident #38 required one-to-one supervision for safety because of her multiple falls. CNA B recalled another employee was scheduled to relieve her but had not shown up. She explained she spoke to the 3 PM to 11 PM Supervisor on B-Wing who told her the employee was finishing her shift on B-Wing and would then come to relieve her. CNA B stated she returned to A-Wing and asked another employee at the desk to watch resident #38 until the 11 PM to 7 PM relief came over from B-Wing. CNA B reported she thought the other person was going to sit one-to-one with the resident. CNA B stated she went to resident #38's room, gathered her belongings and left the unit. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/11/24 at 2:25 PM, LPN A stated she was working on A-Wing the night of 4/05/24. She recalled she arrived a little late for her shift and observed resident #38 walking down the hall with blood on her nose from what appeared to be a scratch. LPN A reported the one-to-one sitter was not with resident #38 at the time. LPN A recalled resident #38 stated she fell between the bed and walker hitting her nose. LPN A stated she spoke to co-workers who informed her the one-to-one sitter left earlier. On 4/11/24 at 2:58 PM, the 3 PM to 11 PM Supervisor stated he was approached by CNA B at approximately 10:30 PM on 4/05/24, who told him she had enough and wanted to go home. The 3 PM to 11 PM Supervisor clarified CNA B came to B-Wing without resident #38. He stated he told CNA B the shift ended at 11:00 PM and to go back to the unit and sit one-to-one with resident #38 as assigned until the shift ended. He reported he observed CNA B go back to A-Wing so he went back into the office and continued his work. The 3 PM to 11 PM Supervisor stated he later learned CNA B left before the shift ended and notified the Director of Nursing (DON) and Assistant Director of Nursing (ADON) the next morning via a messaging service they used to communicate. He stated the message included information that CNA B left her shift early without permission. He explained if she wanted to leave early because of a stressful one-to-one assignment, maybe she was not the right person to do the assignment. He re-iterated he did not give her permission to leave, and if she left early, it was against his direct order. The 3 PM to 11 PM Supervisor stated he did not receive any response from the DON or ADON, and was not questioned as to what happened or asked to provide a statement. On 04/11/24 at 5:48 PM, the DON and Regional Nursing Consultant verified resident #38 experienced an unwitnessed fall with minor injury on 4/05/24. The DON explained the one-to-one sitter assigned to resident #38 left her shift early before she was relieved. He clarified the expectation was the one-to-one sitter should not have left and should have remained with the resident until she was relieved by another staff. He acknowledged CNA B's actions could possibly be neglect. The DON explained the 3 PM to 11 PM Supervisor sent him a message via messaging service, but he did not have an audible notification to alert him there was a message and was not aware of the situation until Monday morning, 4/08/24. He acknowledged an allegation or suspicion of neglect should have been reported immediately and the report filed within 24 hours. The DON and Regional Nurse Consultant stated the report would be filed today (4/11/24). He reported CNA B was removed from the schedule as of 4/11/24. Review of staffing schedule and assignment sheets provided by the Staffing Coordinator revealed CNA B was scheduled to work 4/05/24, 4/06/24, 4/07/24, 4/08/24, 4/10/24 and 4/11/24. The staffing schedule and assignment sheets showed CNA B was assigned to sit one-to-one with resident #38 on 4/05/24, 4/07/24, 4/08/24 and 4/10/24. The facility's Abuse, Neglect and Exploitation policy and procedure revised 11/16/23 indicated the facility would have written procedures which included reporting of all alleged violations to the Administrator/designee, state agency, adult protective services and to all other required agencies within specified timeframes. The document clarified reporting should be no later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury. The document read, The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: . D. Room or staffing changes, if necessary to protect the resident(s) from the alleged perpetrator.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview and record review, the facility failed to ensure care plan meetings were attended by residents and/or their representatives, and the required members of the interdisciplinary team (IDT) for 2 of 4 residents reviewed for care planning, of a total sample of 43 residents, (#8 and #24). Findings: 1. Review of the medical record revealed resident #8, a [AGE] year old male, was admitted to the facility on [DATE] with diagnoses including Multiple Sclerosis, hypertension, depression, anxiety, generalized muscle weakness, and mild protein-calorie malnutrition. The resident's face sheet listed his mother as his emergency contact, and included her address, telephone number, and email contact information. The Minimum Data Set (MDS) Annual assessment with assessment reference date (ARD) of 12/22/23 revealed resident #8 was interviewed regarding his preferences. The document indicated the resident felt it was very important to have family involved in discussions about his care. Review of the MDS Quarterly assessment with ARD of 3/18/24 revealed resident #8 had adequate hearing and vision, clear speech, clear comprehension, and was able to express his ideas and wants. The resident had a Brief Interview for Mental Status score of 15 which indicated he was cognitively intact. On 4/08/24 at 11:37 AM, resident #8 stated he had never been invited to a care plan meeting or participated in any IDT meetings in his room. Resident #8's mother was at his bedside and she explained since her son's admission to the facility in December 2022, she attended the first and only care plan meeting in January 2024. The resident's mother stated the facility did not send invitation letters ahead of time and staff were aware email was not her preferred method of communication. She confirmed it was very important to her and her son to be involved in discussions regarding all aspects of his care. Resident #8 validated attendance at care plan meetings would be beneficial as the care team could address his concerns. Review of Care Plan Meeting Minute forms revealed from December 2022 to April 2024, the facility scheduled five care plan meetings for resident #8. Attendance sheets showed four of the five meetings, the Admission meeting on 1/03/23 and Quarterly meetings on 4/20/23, 7/06/23, and 10/31/23, were not attended by the resident or his mother. The forms showed none of the five meetings were attended by a Certified Nursing Assistant (CNA), and there was no representative from the Dietary department at the meeting on 4/20/23. The attendance sheet for the meeting on 7/06/23 was signed by an MDS nurse only and indicated the meeting was rescheduled. However, there was no documentation in the medical record to show the meeting was ever held. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/10/24 at 4:40 PM, MDS Coordinator F explained it was essential for residents and/or their representatives to be invited to and participate in care plan meetings. He acknowledged the care plan meeting minutes indicated resident #8's mother only attended the recent annual care plan meeting on 1/11/24. He confirmed the facility should make efforts to accommodate preferences for location and time of care plan meetings to ensure all necessary participants were involved. MDS Coordinator F reviewed resident #8's medical record and confirmed there was no evidence the resident ever received an invitation or attended a care plan meeting. He verified there were no IDT progress notes regarding any care plan meeting discussions for this resident. 2. Review of the medical record revealed resident #24, an [AGE] year old female, was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diffuse large cell lymphoma, generalized muscle weakness, stroke with left side weakness and paralysis, spondylosis (degenerative changes in the spine), arthropathy (joint disease), and right hip fracture. The resident's face sheet listed her son and granddaughter as emergency contacts and included their contact information. The MDS Admission assessment with ARD of 11/17/23 revealed resident #24 was interviewed regarding her preferences. The document indicated the resident felt it was very important to have family or a close friend involved in discussions about her care. The MDS Discharge-Return Anticipated assessment with ARD of 3/25/24 revealed the resident's short-term memory was intact and she had independent cognitive skills for daily decision making. On 4/08/24 at 11:16 AM, resident #24 stated she did not recall receiving either written or verbal invitations to care plan meetings. Review of the medical record revealed no documentation of an Admission care plan meeting in November 2023. A Care Plan Meeting Minutes form dated 2/22/24 indicated a quarterly meeting was attended by resident #24, and only two members of the IDT, MDS Coordinator E and the Social Services Assistant. On 4/10/24 at 4:30 PM, MDS Coordinator F confirmed care plan meetings should be held on admission and then quarterly. He validated resident #24's medical record did not include care plan meeting invitations for the resident and her representatives or documentation of a care plan meeting on admission. MDS Coordinator E explained the purpose of the care plan meeting was to identify and discuss the resident's needs to ensure the provision of appropriate care and services. She verified the meetings should be attended by MDS staff, Unit Managers, and representatives of the Therapy, Dietary, and Activities department. MDS Coordinator E explained the facility was running behind with care plan meetings, and some meetings either did not take place or were not attended by the required members of the IDT. On 4/12/24 at 10:43 AM, the Director of Nursing stated his expectation was residents and/or their representatives and all required members of the IDT would participate in care plan meetings. He verified MDS staff were to document a summary of the discussions in the medical record after the meeting to ensure all team members were aware of concerns, requests, and changes in the plan of care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure for Comprehensive Care Plans, revised on 7/27/22, revealed the care planning process would incorporate the resident's preferences in developing the goals of care. The document indicated the care plan would be prepared by an IDT that included at least a Registered Nurse and Certified Nursing Assistant who were familiar with the resident's needs, a member of Food and Nutrition Services, and the resident and/or the representative. The policy revealed additional staff would attend as determined by the resident's needs. The document indicated the care plan would be reviewed and revised by the IDT after each comprehensive and quarterly MDS assessment.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to provide timely and appropriate treatment and services to maintain and/or improve the ability to perform activities of daily livings (ADLs) related to eating for 1 of 1 resident reviewed for decline in ADLs, of a total sample of 43 residents, (#8). Findings: Review of the medical record revealed resident #8, a [AGE] year old male, was admitted to the facility on [DATE] with diagnoses including Multiple Sclerosis, generalized muscle weakness, lack of coordination, unspecified muscle contracture, and mild protein-calorie malnutrition. The Minimum Data Set (MDS) Quarterly assessment with assessment reference date of 3/18/24 revealed resident #8 had adequate hearing and vision, clear speech, clear comprehension, and was able to express his ideas and wants. The resident had a Brief Interview for Mental Status score of 15, which indicated he was cognitively intact. The MDS assessment revealed resident #8 had functional limitation in range of motion with impairment of all extremities and he required partial to moderate assistance for eating. The document indicated resident #8 last received Occupational Therapy services from 1/02/23 to 2/22/23, and he did not receive Restorative Nursing Program Services during the 7-day look back period. Resident #8 had a care plan for decreased ability to perform ADLs including eating, initiated on 1/04/23. The goal was the resident would maintain the highest possible level of ADL ability as evidenced by his ability to perform ADLs. The interventions included, monitor the resident for decline in ADL function and refer to therapy if a decline in ADLs was noted, provide therapy services as ordered by the physician, and monitor for complications of immobility and contractures. A care plan for nutritional problems, initiated on 1/10/23, revealed resident #8 had inconsistent meal intake and required finger foods. The goal was resident #8 would maintain adequate nutritional status. The interventions included provide and serve diet as ordered, monitor and record meal intake, and the Registered Dietitian was to evaluate the resident and make recommendations as needed. On 4/08/24 at 11:37 AM, resident #8's mother stated she attended a care plan meeting approximately three months ago, during which she discussed concerns regarding her son's ability to feed himself. She explained he was supposed to receive finger foods due to limited mobility in his hands, but the kitchen often gave him oatmeal, rice or corn even though he could not use utensils. The resident's mother recalled, They said they would find a curved spoon for him so he could feed himself. We asked for therapy and they said he is on the list. She verified the facility had not yet started therapy to work on his eating skills and he had not been provided with a specialty utensil. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #8's Annual Care Plan Meeting Minutes form dated 1/11/24 revealed attendees included his mother and father, representatives from the Nursing and Social Services departments, Advanced Practice Registered Nurse (APRN) G, and the Certified Dietary Manager (CDM). The meeting was not attended by any staff from the therapy department and there was no documentation of discussions regarding therapy services or adaptive utensils. On 4/10/24 at 5:53 PM, the CDM recalled resident #8's last care plan meeting and discussions with the resident's parents. The CDM confirmed he suggested an adaptive spoon for resident #8 as a possible approach to improve his food options and intake. He stated to his knowledge, he could not make a therapy referral but he expected the Nursing department to follow up. The CDM said, I never heard anything about it after that. On 4/11/24 at 9:41 AM, Licensed Practical Nurse (LPN) C stated she was regularly assigned to care for resident #8. She confirmed the resident had limited mobility in his hands, but he could grasp and hold some items. LPN C said, It might be beneficial for him to have a device to feed himself. On 4/11/24 at 9:46 AM, resident #8 expressed interest in an adaptive spoon as he felt he would be able to eat a wider selection of foods if he were able to feed himself. On 4/11/24 at 10:02 AM, the Director of Rehabilitation explained all residents in the facility were screened by therapy staff at least quarterly, to identify if they would benefit from therapy services. She stated the quarterly screening was a brief, general screening, but staff could complete a screening request form if a specific area of concern was identified. The Director of Rehabilitation confirmed she did not receive a screening request form after resident #8's care plan meeting in January. She verified referrals were important as they provided the opportunity for therapy staff to evaluate, identify, and treat ADL concerns. The Director of Rehabilitation stated resident #8's quarterly screenings done on 6/24/23, 9/16/23, 12/22/23, and 3/19/24 did not result in recommendations for therapy services. She provided a Patient Observation(s) for Therapy Form dated 4/09/24, completed by the Director of Nursing (DON), that indicated resident #8, Needs help eating. On 4/11/24 at 1:01 PM, APRN G recalled the care plan meeting discussion regarding adaptive devices for self-feeding. She stated although resident #8 was expected to decline due to his disease process, he could maintain or possibly increase strength in his upper extremities and participate in his ADLs with therapy interventions. On 4/12/24 at 10:43 AM, the DON verified someone from the Nursing department should have referred resident #8 for therapy services after the care plan meeting in January 2024. He explained once he was made aware, he investigated, and completed the referral form himself. The DON said, I feel that the facility should have helped him to continue feeding himself. The facility's policy and procedure for Activities of Daily Living (ADLs), revised 11/29/22, revealed the facility would ensure a resident's abilities in ADLs did not deteriorate unless unavoidable. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure for Adaptive Feeding Equipment, revised in January 2024, revealed residents who required assistance in feeding were potential candidates for adaptive utensil use, as determined by the Occupational Therapist. The document indicated residents who needed assistance should be referred to therapy services and if treatment was deemed necessary, a plan would be developed to include use of adaptive equipment. The policy revealed the Dietary department would be notified of the resident's need for adaptive equipment and the appropriate utensil would be placed on the resident's meal trays.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36489 Based on observation, interview, and record review, the facility failed to provide adequate activities of daily living care (ADLs) for dependent residents related to shaving and nail care for 3 of 5 residents reviewed for ADLs, of a total sample of 43 residents, (#73, #77, and #83). Findings: 1. Review of the medical record revealed resident #83, a [AGE] year old male, was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including stroke with left side weakness and paralysis, adult failure to thrive, and generalized muscle weakness. Review of the Minimum Data Set (MDS) Significant change in status assessment with assessment reference date (ARD) of 2/09/24 revealed resident #83 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact. The MDS assessment showed resident #83 exhibited no behavioral symptoms and did not reject evaluation or care that was necessary to achieve his goals for health and well-being. The resident had functional limitation in range of motion with impairment to his upper and lower extremities on one side. The document revealed resident #83 was dependent on staff for personal hygiene and bathing. Resident #83 had a care plan for risk for decreased ability to perform ADLs related to chronic disease process and recent illness, initiated on 3/29/23. The interventions instructed nursing staff to assist the resident with ADLs including bathing. On 4/08/24 at 4:43 PM, inspection of resident #83's hands revealed all fingernails were dirty, with a significant amount of dark brown to black substance underneath all nails. The right hand fingernails were approximately 1/3 inch long and the left hand fingernails were longer. When asked if he wanted staff to provide nail care, resident #83 said, Of course, I want my nails to be trimmed and clean. They haven't done my nails in a while. It's been maybe two or three months. On 4/08/24 at 4:44 PM, the Assistant Director of Nursing (ADON) confirmed resident #83's fingernails were dirty and too long. She validated the length of his fingernails as 1/3 inch and longer. The resident informed the ADON he wanted his fingernails cut, but he had not reminded the Certified Nursing Assistants (CNAs) for a while. The ADON explained it was unnecessary for residents to remind staff to perform ADL care. Review of resident #83's Weekly Skin Evaluation forms revealed nurses completed full-body evaluations on 3/18/24, 3/26/24, and 4/02/24. The forms showed the nurses did not note the condition of the resident's fingernails. Review of an ADL flow sheet dated 3/14/24 to 4/11/24 revealed CNA documentation of one refusal of a bath during the 30-day look back period. 2. Review of the medical record revealed resident #77, an [AGE] year old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included dementia and the need for assistance with personal care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS Quarterly assessment with ARD of 3/13/24 revealed resident #77 had a BIMS score of 8, which indicated moderate cognitive impairment. The MDS assessment showed resident #77 exhibited no behavioral symptoms and did not reject evaluation or care that was necessary to achieve his goals for health and well-being. The resident required substantial to maximal assistance for personal hygiene. Review of resident #77's medical record revealed he had a care plan for ADL self-care deficit initiated on 10/11/22. The interventions indicated the resident required assistance of one staff member for personal hygiene. A care plan for hospice services due to end-stage heart failure, initiated on 3/24/23, had a goal for the resident to be comfortable through his end of life journey. The interventions included provide ADL support. On 4/08/24 at 10:09 AM, resident #77 had long, bristly, unkempt facial hair on his cheeks, chin, and neck. The resident's hair was long and messy, and the fingernails on both hands were long, jagged, and sharp, with a dark brown substance wedged under all nails. Resident #77 rubbed his face and stated he would like to be shaved, but more than anything, he wanted a haircut. On 4/08/24 at 10:58 AM, resident #77's assigned nurse, Registered Nurse (RN) J, confirmed all residents had designated shower days. When asked if she monitored her assigned residents' personal hygiene and supervised CNAs to ensure ADL care was done, RN J stated she assumed CNAs knew what to do and when to do it. On 4/08/24 at 11:01 AM, RN J assessed resident #77's hands and described his fingernails as dirty and long. She acknowledged the resident needed to be shaved. RN J stated she did not notice the ADL concerns when she administered his medication earlier that shift. On 4/08/24 at 11:03 AM, CNA I confirmed she was assigned to care for resident #77 during the 7:00 AM to 3:00 PM shift. She was informed the resident had dirty fingernails, unshaved facial hair, and an overall unkempt appearance. She stated she attempted personal hygiene care within the last hour, but the resident refused. On 4/08/24 at 4:21 PM, resident #77 remained unshaved and his fingernails were still long, jagged, and dirty. On 4/08/24 at 4:59 PM, resident #77's ADL status was unchanged. The B Wing Unit Manager (UM) assessed the resident and validated the findings related to nail care and shaving. She stated he was scheduled to have a bath today on the day shift and the assigned CNA should have provided full personal hygiene care. Resident #77 confirmed he still wanted to be shaved, get a haircut, and have his fingernails cut. Review of resident #77's Weekly Skin Evaluation forms revealed nurses completed full-body evaluations on 3/18/24, 3/26/24, 3/29/24, and 4/05/24. The forms did not show documentation regarding the condition of the resident's fingernails. Review of an ADL flow sheet dated 3/16/24 to 4/09/24 revealed no CNA documentation of refusal of a bath during the 30-day look back period. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record revealed resident #73, a [AGE] year old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included traumatic subdural hemorrhage (brain bleed), seizures, and carpal tunnel syndrome. Review of the MDS Quarterly assessment with ARD of 12/26/23 revealed resident #73 had clear speech, clear comprehension, and was able to express his ideas and wants. The resident's BIMS score was 14, which indicated he was cognitively intact. He exhibited no behavioral symptoms and did not reject evaluation or care that was necessary to achieve his goals for health and well-being. The MDS assessment showed resident #73 was dependent on staff for personal hygiene and bathing. Resident #73 had a care plan for ADL self-care performance deficit related to weakness and decreased mobility, initiated on 4/21/22. The interventions included total dependence on one staff member for bathing, extensive assistance of one staff member for personal hygiene, and perform skin inspection. On 4/08/24 at 10:37 AM, resident #73 had an excessive amount of facial hair. His long whiskers covered both cheeks, his chin and extended down his neck towards the collarbones. The resident stated he asked a few times, but had not been shaved since he transferred to the B Wing from the other unit approximately three months ago. He recalled a CNA on the other unit used to shave him regularly with an electric razor. Resident #73 confirmed he would prefer to get rid of the untidy hair on his cheeks and neck, and keep a moustache with a neatly trimmed goatee. On 4/08/24 at 4:55 PM, the B Wing UM discussed the concerns identified regarding inadequate personal hygiene care for residents #73, #77, and #83. The UM stated she monitored the ADL status of residents on the B Wing by randomly spot-checking to ensure CNAs performed ADL care as required. She explained simply documenting refusal of care was not enough, and she expected nurses and CNAs to offer encouragement and intervene to promote acceptance of necessary care. The UM verified baths and nail care were to be provided at a minimum of twice weekly. She stated nurses and CNAs on all shifts were responsible for inspecting residents' overall ADL and hygiene status and provide care as necessary. On 4/12/24 at 10:48 AM, the Director of Nursing (DON) stated nurses were ultimately responsible for observing their assigned residents' ADL status and ensuring appropriate personal hygiene care was provided. He explained opportunities to identify concerns related to nail care included when CNAs performed or assisted with hand hygiene before meals and when nurses conducted weekly skin evaluations. He verified assistance with bathing, nail care, and shaving should be provided on scheduled days and as needed. He explained all refusals of care should be reported to the nurse and recorded by the CNA as three or more instances would trigger an alert for the UM. Review of the job description for Certified Nursing Assistant, dated April 2020, revealed the CNA would perform direct care duties under the supervision of licensed nurses. Essential duties included the provision of personal care such as bathing and grooming, daily and as needed. The facility's policy and procedure for Activities of Daily Living, revised on 11/29/22, revealed staff would provide ADL care and services including bathing and grooming. The document read, A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646 Based on interview, and record review, the facility failed to provide appropriate supervision to prevent a fall with minor injury for 1 of 5 residents reviewed for accidents, of a total sample of 43 residents, (#38). Findings: Cross reference F609 Resident #38 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including schizoaffective disorder, anxiety disorder, fracture of fifth metacarpal bone of left hand, muscle weakness, lack of coordination, and repeated falls. Review of the Minimum Data Set quarterly assessment with assessment reference date of 3/21/24 revealed resident #38 had a Brief Interview for Mental Status score of 13 which indicated she was cognitively intact. The document indicated the resident walked independently and had one fall without injury and one fall with injury during the previous 90 days. A care plan with revision date 10/09/23 indicated resident #38 was at risk for falls related to deconditioning, weakness, medication use and cognition. Interventions included one-to-one supervision for safety which was initiated 1/29/24. Review of resident #38's medical record revealed a physician order dated 3/19/24 for one-to-one supervision every shift related to behaviors and fall risk. The resident demographic sheet listed the resident as high risk for fall with one-on-one supervision. Review of the facility's incident log revealed resident #38 had a witnessed fall on 2/11/24, a witnessed fall on 3/09/24 and an unwitnessed fall on 4/05/24. Review of resident #38's medical record revealed a progress note written by Licensed Practical Nurse (LPN) A dated 4/05/24. The note indicated LPN A observed resident #38 walking in the hallway alone at approximately 11:15 PM. The resident was observed with blood on her nose and stated she fell in-between the bedside table and the walker when she was by herself because the sitter left before another one came. On 4/11/24 at 1:59 PM, Certified Nursing Assistant (CNA) B confirmed she was assigned to sit one-to-one with resident #38 during the 3-11 shift on 4/05/24. She stated resident #38 required one-to-one supervision for safety because of her multiple falls. CNA B recalled another employee was scheduled to relieve her but was not there yet. She explained she spoke to the 3 PM to 11 PM Supervisor on B-Wing who told her the employee was finishing her shift on B-Wing and would then come to relieve her. CNA B stated she returned to A-Wing and asked another employee to watch resident #38 until relief came. CNA B explained she thought the other employee was going to sit one-to-one with resident #38, so she gathered her belongings and left. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/11/24 at 2:25 PM, LPN A stated she was working on A-Wing the night of 4/05/24. She recalled when she arrived, she observed resident #38 walking down the hall with blood on her nose from a scratch. LPN A stated the one-to-one sitter was not with resident #38 at the time. LPN A recalled resident #38 said she fell between the bed and walker hitting her nose. LPN A stated she spoke to co-workers who informed her the one-to-one sitter left earlier. On 4/11/24 at 2:58 PM, the 3 PM to 11 PM Supervisor stated he was approached by CNA B at approximately 10:30 PM on 4/05/24. He recalled CNA B came to B-Wing alone without resident #38 and told him she had enough and wanted to go home. He stated he told CNA B her shift ended at 11:00 PM and to go back to the unit and sit one -on-one with resident #38 as assigned until the shift ended. He reported he observed CNA B going back to A-Wing and he went back into the office and continued his work. The 3 PM to 11 PM Supervisor stated he later learned CNA B left her shift early and he notified the Director of Nursing (DON) and Assistant Director of Nursing (ADON) the next morning via a messaging service they use to communicate. He stated the message included information that CNA B left her shift early without permission. He explained if she wanted to leave early because of a stressful one -on-one assignment, maybe she was not the person to do it. He re-iterated he did not give her permission to leave. On 04/11/24 at 5:48 PM, the DON and Regional Nursing Consultant verified resident #38 experienced an unwitnessed fall with minor injury on 4/05/24. The DON reviewed the fall on 4/05/24 and reported resident #38 came out from her room into the hallway and reported she had fallen in her room. Resident #38 had blood on her nose from what looked like a scratch. He explained resident #38 was supposed to be on one -on-one supervision due to her fall risk. He stated resident #38 was impulsive with poor safety awareness and had previous falls so she was placed on one -on-one supervision purely for her safety. The DON acknowledged resident #38 fell after the one -on-one sitter left her unsupervised. The DON stated the expectation was a one -on-one sitter would remain with the resident until relieved by another staff member. He stated, She should not have left. The facility's Accidents and Supervision policy and procedure revised 10/18/22 read, Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: a. Defined by type and frequency [and] b. Based on the individual resident's assessed needs and identified hazards in the resident environment.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892 Based on observation, interview, and record review, the facility failed to ensure care and services for intravenous (IV) catheters according to standards of practice for 2 of 2 residents reviewed for IV catheter care, of a total sample of 43 residents, (#90, & #108). Findings: 1. Resident #90 was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included diabetes, diabetic neuropathy, chronic obstructive pulmonary disease, displaced left femur, Methicillin Resistant Staphylococcus Aureus (MRSA), chronic kidney disease, and hypertension. On 4/08/24 at 1:52 PM, resident #90 was in bed in his room. He had a peripherally inserted central line catheter (PICC) to his left upper arm with a semi-permeable dressing dated 3/31/24. He said he was getting intravenous medication for a, MRSA infection. A peripherally inserted central catheter, also called a PICC line, is a long, thin tube that's inserted through a vein in your arm .(retrieved on 4/23/24 from www.mayoclinic.org). Review of resident #90's medical record revealed a Physician order dated 4/05/24 to observe catheter site every shift before and after medication administration and dressing changes for redness, swelling, warmth and or loosening or soiled dressing. There was another order dated 4/05/24 that incorrectly identified the type of IV resident #90 had as a Midline instead of a PICC. The order read for nurses to change the Midline dressing every week on Wednesday with transparent dressing. On 4/08/24 at 1:49 PM, when asked why resident #90's dressing had not been changed for 8 days, since 3/31/24, the Assistant Director of Nursing stated PICC dressings were changed on Wednesdays. She explained because the resident had been readmitted to the facility on a Friday, the PICC dressing was not due to be changed until the next Wednesday, 4/10/24 . The Infusion Nurses Society specified IV site care frequency was based on type of dressing: Transparent semipermeable dressings should be changed every 5-7 days and gauze dressings should be changed every 2 days, (retrieved on 4/23/24 from www.sciencedirect.com). 2. Resident #108, a [AGE] year-old female was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included systemic Lupus (autoimmune disease), convulsion, disease of spinal cord and encounter for surgical aftercare following surgery on the nervous system. On 4/08/24 at 1:16 PM, resident #108 sat in a wheelchair in her room. She had a Midline IV catheter on her right upper arm. The dressing site had a semipermeable dressing dated 3/22/24. She stated nurses used the Midline for blood draws in the hospital, but the IV tubing was getting bothersome and she planned to ask the nurse to remove it. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/08/24 at 1:22 PM, assigned Licensed Practical Nurse (LPN) C observed resident #108's Midline dressing on her right upper arm dated 3/22/24. LPN C, confirmed resident #108's Midline dressing had not been changed in 17 days but should have been changed every 7 days, per nursing standards of practice. A few minutes later, LPN C stated there were no orders to perform flushes or dressing changes for resident #108's Midline. Review of resident #108's Physician orders revealed no orders for dressing changes or flushes for the resident's Midline IV since she was readmitted to the facility on [DATE] . A midline catheter is a small tube used to give treatments and to take blood samples. The catheter is inserted into a vein in your arm. The end of a midline, inside your body, does not go past the top of your armpit. The midline catheter can stay in place up to 30 days, (retrieved on 4/26/24 from www.drugs.com) On 4/08/24 at 1:27 PM, the B-wing Unit Manager (UM) confirmed the Midline dressing dated 3/22/24. The B-wing UM explained resident #108 was readmitted to the facility from an acute care hospital on 3/28/24 with a Midline IV dressing dated 3/22/24. She stated the protocol was for the nurse to review the admitting orders with the Physician, make the Physician aware of the IV, and obtain orders for the IV such as dressing changes, IV flushes, or discontinuance if not in use. On 4/09/24 at 1:48 PM, the Director of Nursing (DON) stated nurses should contact the physician for orders because the facility had no standing orders to address PICC'S or Midline IVs. The DON confirmed both resident #90's PICC dressing and resident #108's Midline dressing should have been changed at least every seven days per facility policy and nursing standards. Review of the undated, PICC/Midline/CVAD Dressing Change policy revealed PICC's, and Midline dressings should be changed weekly or more frequently if soiled to decrease the potential for infection as ordered by the Physician.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 36489 Based on observation, interview, and record review, the facility failed to ensure licensed nurses had the skills and competencies to provide care and services, according to plans of care, to meet the needs of all residents in the facility. Findings: Cross reference F676, F677, F694, F755, F759, F761, F806, F842, and F880. During the facility's Recertification survey from 4/08/24 to 4/12/24, the following concerns were identified and discussed with members of nursing management and nursing administration: On 4/08/24 at 1:48 PM, the Director of Nursing (DON) was informed of findings related to both residents in the facility who had intravenous (IV) access sites. He was made aware an admission nurse did not identify and document one resident's IV site and none of the assigned nurses assessed the site or questioned the lack of physician orders, therefore no care and services were ordered or provided until the facility was notified by State Survey Agency staff. The DON was informed the other resident's IV dressing was not changed according to physician orders. He validated the nurses did not follow the facility's protocols. On 4/08/24 at 2:20 PM, the Assistant Director of Nursing (ADON) was informed of concerns related to a nurse who left medication unattended on top of the medication cart, and the same nurse's infection control practices related to disposal of a used sharp, not performing hand hygiene after removal of gloves and prior to medication administration, and failure to disinfect a blood glucose meter after use. She was made aware the nurse recalled only a brief orientation which did not include competency checks, and expressed minimal knowledge of the policies and procedure reviewed with her. On 4/09/24 at 5:48 PM, the B Wing Unit Manager (UM) confirmed all nurses assigned to a resident failed to appropriately pursue acquisition of an ordered eye ointment. She verified 13 nurses completed daily documentation for over one month to indicate the medication was given, although it was never in the facility. The UM explained during her investigation, she interviewed two of the 13 nurses who inaccurately documented administration of the eye ointment, and they informed her they used an alternate medication without informing the physician. On 4/09/24 at 5:59 PM, the B Wing UM was informed another resident did not receive a prescribed skin ointment for several days as nurses did not contact the pharmacy to ensure timely delivery of the medication. On 4/09/24 at 6:10 PM, the ADON discussed a nurse's omission of medications during medication pass observation. She confirmed nurses were to administer all medications as ordered by the physician and document administration at the time it occurred. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/10/24 at 11:28 AM, the ADON was informed of infection control concerns identified during wound care observation related to a nurse who did not change her gloves or perform hand hygiene throughout the procedure. On 4/10/24 at 5:29 PM, the ADON confirmed during a 3-month period, several nurses administered multiple doses of a blood pressure medication outside of the physician-ordered parameter. She acknowledged the nurses' actions indicated they either did not carefully read or comprehend the order. On 4/12/24 at 10:43 AM, the DON acknowledged direct care nurses and nursing management failed to identify a resident's declining ability to feed himself and initiate a therapy referral in a timely manner. He was informed of concerns related to personal hygiene tasks including nail care and shaving that were not performed regularly as evidenced by the unkempt appearance of residents. The DON stated nurses were ultimately responsible for observing their assigned residents' personal hygiene during all interactions throughout the shift, supervising Certified Nursing Assistants to ensure care was given, and documenting all refusal of care. On 4/10/24 at 5:11 PM, the ADON explained she was the facility's Staff Development Coordinator. She stated after the all-staff general orientation, she met with every newly hired nurse to review her expectations. The ADON confirmed she used the facility's written policies and procedures to educate nurses before they were placed on resident care assignments. She stated she felt nurses were provided with adequate education during orientation and they performed some competencies. The ADON confirmed the facility did not conduct an annual skills fair or review competencies at regular intervals to ensure all nurses possessed or maintained the skills necessary to care for residents. The ADON validated the concerns identified during the Recertification survey related to the performance of some nurses. She acknowledged the nurses did not meet the facility's expectations, adhere to policies and procedures, and reflect basic standards of nursing practice. The ADON said, The nurses are not doing what they were trained to do. On 4/10/24 at approximately 5:30 PM, the ADON acknowledged on 4/08/24 at 2:20 PM, when she was informed of the concerns regarding the nurse who was not aware of the facility's policy and procedures for disinfecting the glucose meter, she stated the device could be cleaned and disinfected with a disinfectant wipe or alcohol. The ADON was informed the facility's policy and procedure for Glucometer Disinfection and the manufacturer's manual specified use of a registered healthcare disinfectant, not an alcohol wipe. She provided a document titled Glucometer Cleaning and Disinfection Competency (undated) which instructed nurses to clean and disinfect the meter with either a bleach wipe or an alcohol wipe, both of which were approved. The ADON acknowledged although nurses were provided with registered healthcare disinfectant wipes for the task, the competency document did not reflect the facility's policy. She was unable to provide any competencies for the nurse who did not disinfect the glucose meter. On 4/10/24 at 12:34 PM, the Corporate Director of Education acknowledged the nursing competency for glucose meter disinfection indicated use of alcohol was appropriate. She explained when she was made aware of the issue, the ADON was provided with a new competency document that did not include the use of alcohol. The Corporate Director of Education stated the company planned to move towards standardized competencies with a requirement for all nurses to perform return demonstrations. She acknowledged all nurses, even experienced ones, needed a thorough orientation to the facility's policies and procedures as protocols differed by setting. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/12/24 at 10:07 AM, the DON provided a Competency Based Orientation packet that included checklists with performance objectives related to topics including infection control practices and policies, universal precautions, provision of nursing care, nursing documentation, understanding equipment use and disinfection, resident advocacy, and safe medication administration. The DON confirmed there was no evidence the packet or preceptor checklists were being utilized to verify competencies of newly hired and current staff nurses. He explained the ADON was also the Staff Development Coordinator and the Restorative Nurse, and the combination of those roles in a single job description presented challenges for adequate monitoring of nursing education. Review of the Facility Assessment, approved on 2/29/24, revealed a purpose to determine the resources needed to competently care for the facility's residents. The document indicated the resources included, All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care. The Facility Assessment revealed the facility's training program involved an orientation process and ongoing training, and staff would be trained on policies and procedures consistent with their roles. The document indicated nurses would be trained on topics to include compliance and ethics, effective communication, resident rights, and infection control.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 36489 Based on observation, interview, and record review, the facility failed to post required nurse staffing information daily, and failed to retain the postings for a minimum of 18 months, to ensure accurate and comprehensive data was accessible to residents and/or visitors. Findings: On Monday 4/08/24 at 9:34 AM, the facility's nurse staffing information was posted in the lobby to the right of the receptionist's desk. The document included the name of the facility, the census, categories of licensed and certified nursing staff, and the hours they worked. The posting was dated Thursday 4/04/24, and did not reflect current data. Photographic evidence was obtained. On 4/09/24 at 2:28 PM, the Staffing Coordinator verified she was responsible for creating and posting the nurse staffing form. She explained she did not work last Friday or over the weekend; therefore, the posting from Thursday 4/04/24 was not updated until she returned to work on Monday 4/08/24. The Staffing Coordinator stated the Weekend Nursing Supervisor was responsible for creating and/or posting the document on Saturdays and Sundays. The Staffing Coordinator was asked to provide nurse staffing forms for January 2023, but she was unable to do so. She explained she assumed her role in October 2023 and was informed of the 18-month retention requirement shortly after she started work. The Staffing Coordinator searched the facility's records and did not find any nurse staffing posting forms prior to August 2023. The facility's policy and procedure for Nurse Staffing Posting Information, revised on 11/28/22, read, It is the policy of this facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time. The policy indicated the staffing sheets would be posted prominently on a daily basis and retained for a minimum of 18 months.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services related to timely acquisition and proper administration of physician-ordered medication to meet the needs of 3 of 6 residents reviewed for Medication Administration, of a total sample of 43 residents, (#73, #77, and #98). Findings: 1. Review of the medical record revealed resident #77, an [AGE] year old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included hypotension (low blood pressure), heart failure, atherosclerotic heart disease, and chest pain. Review of the Order Summary Report revealed resident #77 had a physician order dated 12/19/23 for Midodrine HCl 10 milligrams (mg), give one tablet by mouth every eight hours for hypotension. The order included a parameter to hold the medication for a systolic blood pressure (SBP) of greater than 120 millimeters of mercury (mm/Hg). Midodrine is a cardiovascular drug that works by constricting blood vessels and increasing blood pressure. It is prescribed to treat low blood pressure which causes severe dizziness or light-headedness that affects daily life (retrieved on 4/24/24 from www.drugs.com/mtm/midodrine.html). The American Heart Association indicates blood pressure is recorded as two numbers, and the first or upper number, the systolic blood pressure, measures how much pressure blood exerts against artery walls when the heart contracts (retrieved on 4/24/24 from www.heart.org/en/health-topics/high-blood-pressure/understanding-blood-pressure-readings). Review of resident #77's Medication Administration Records (MARs) from January 2024 to April 2024 revealed Midodrine 10 mg was not held according to the physician's parameter for SBPs greater than 120 mm/Hg as follows: In January 2024, nurses administered 23 of 93 doses for SBPs from 121 to 133 mm/Hg. In February 2024, nurses administered 11 of 87 doses for SBPs from 122 to 148 mm/Hg. In March 2024, nurses administered 10 of 93 doses for SBPs from 121 to 129 mm/Hg. In April 2024, nurse administered 2 of 29 doses for SBPs from 122 to 126 mm/Hg. On 4/10/24 at 5:29 PM, the Assistant Director of Nursing (ADON) confirmed nursing documentation on resident #77's MARs indicated nurses administered his Midodrine 10 mg in error, on several occasions when it should have been held for blood pressure levels above the limit set by the physician. The ADON acknowledged it was a risk to administer this medication if the resident's SBP was above 120 mm/Hg as it might cause a significant, unintended increase in blood pressure. She stated her expectation was nurses would read physician orders thoroughly and administer medications as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record revealed resident #73, a [AGE] year old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included traumatic subdural hemorrhage (brain bleed), seizures, and carpal tunnel syndrome. Review of the Medication Review Report for the period January to April 2024 revealed resident #73 had a physician order dated 3/06/24 for Artificial Tears Ointment, instill 0.25 inch in both eyes at bedtime for irritation. On 4/08/24 at 10:31 AM, resident #73 stated he had a concern related to persistent, itchy and watery eyes. He recalled a provider visited him over a month ago and determined he needed eye medication. The resident said, I never heard from them about eye drops after that. I am still having the same problem. My eyes still water. On 4/09/24 01:40 PM, resident #73's assigned nurse, Registered Nurse (RN) H, checked the electronic medical record and verified he had a physician order for eye ointment. She checked all drawers of the medication and treatment carts but did not find any eye medication for the resident. The B Wing Unit Manager (UM) was informed of resident #73's concern. On 4/09/24 at 2:00 PM, the B Wing UM stated she contacted the pharmacy and discovered the order for resident #73's eye ointment was never filled by the pharmacy as it was a stock medication, not a prescription medication. On 4/09/24 at 5:48 PM, the B Wing UM stated the Central Supply Coordinator informed her the facility did not stock Artificial Tears Ointment. She explained she went through the central supply stock and logs and there was no evidence the eye ointment was ever acquired for resident #73. The UM stated any of the nurses scheduled to give the eye ointment should have called the pharmacy and notified the physician when they discovered the medication was not available. She stated she interviewed two of the nurses who documented administration of the eye ointment and they informed her they used facility stock lubricant eye drops since the prescribed ointment was not available. The UM validated it was not acceptable for nurses to administer a substitute medication without a physician order or borrow from another resident's supply. 3. Review of the medical record revealed resident #98, a [AGE] year old male, was admitted to the facility on [DATE] with diagnoses including stroke with right side paralysis, generalized muscle weakness, and contact dermatitis (skin inflammation and rash). Review of resident #98's Order Summary Report revealed physician orders dated 4/02/24 for a dermatology consult for a rash on his back, and Clindamycin Phosphate 1% gel, apply to affected areas on the trunk three times daily for 30 days for acne. On 4/09/24 at 8:56 AM, from the hallway outside resident #98's room, he was overheard as he loudly complained he had not received a necessary ointment for a skin condition. When the Activities Assistant exited the room, she confirmed resident #98 told her nurses had not administered his ointment for several days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/09/24 at 9:04 AM, resident #98 stated he had an extensive rash on his back, shoulders, and chest. He lifted his shirt and showed numerous raised red areas and pustules scattered on his torso. The resident said, I am to be getting a cream three times daily. I last got it late Thursday. They said they would order it and then they said you can't get it on the weekend. Resident #98 expressed frustration regarding the missed doses as the rash bothered him and he wanted the treatment to be done as ordered by the physician On 4/09/24 at 9:25 AM, RN H checked all drawers of the medication and treatment carts and confirmed there was no container of Clindamycin Phosphate 1% gel for resident #98. Review of resident #98's MAR for April 2024 revealed he received three doses of Clindamycin Phosphate 1% gel daily as ordered from Wednesday 4/03/24 at 9:00 AM to Friday 4/05/24 at 5:00 PM. The document showed the medication was not available or not given from Saturday 4/06/24 at 9:00 AM to Wednesday 4/10/24 at 9:00 AM, except for Sunday 4/07/24 at 9:00 AM and 1:00 PM. Review of the pharmacy Delivery Tracking form revealed the initial tube of resident #98's Clindamycin Phosphate 1% gel was placed in tote for delivery to the facility on [DATE] at 1:40 AM. The document indicated a second tube was ordered on 4/09/24 at 9:59 AM and placed in the tote a few hours later at 1:47 PM. On 4/09/24 at 5:59 PM, the B Wing UM stated she applied resident #98's ointment on Thursday 4/04/24. She recalled the tube was very small and she could not verify whether or not he received the ointment as prescribed over the weekend. The UM stated she was not aware the medication was not available until RN H was informed of the resident's complaints this morning. The UM explained she called the pharmacy to request a larger size tube and the medication would be delivered later today. On 4/11/24 at 2:39 PM, the B Wing UM stated she could not explain how the nurse documented administration of the Clindamycin Phosphate 1% gel if it was not re-ordered and delivered on the weekend. She said, I am telling you what I was told. On 4/11/24 at 2:47 PM, RN K confirmed she did not apply the scheduled 9:00 AM dose of resident #98's Clindamycin Phosphate 1% gel yesterday morning as she could not locate the box. She verified the resident received his first dose from the new tube at 1:00 PM yesterday, 4/10/24. RN K explained the tube was very small and would last only two to three days. On 4/11/24 at 2:52 PM, the Evening Shift Nursing Supervisor stated on Saturday 4/06/24, he saw resident #98's tube of Clindamycin Phosphate 1% gel. He stated the small tube was almost empty and there was not enough medication to cover the resident's rash. He stated to his knowledge the medication was not available over the weekend. He stated he would not speculate as to why the day shift nurse on Sunday 4/07/24 documented administration of medication that was unavailable. The Evening Shift Nursing Supervisor stated nurses were expected to re-order medication before it was finished and call the pharmacy if clarification was necessary. The facility's policy and procedure for Pharmacy Services, revised 4/17/23, revealed the facility would provide pharmaceutical services that reflected current standards of practice and met the needs of each resident. The document indicated the facility would adhere to procedures that ensured accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to administer medications as ordered by the physician for 1 of 3 residents observed during the medication administration task, of a total sample of 43 residents, (#65). There were 2 errors in 29 opportunities for a medication error rate of 6%. Findings: Review of the medical record revealed resident #65, an [AGE] year old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included encephalopathy (brain disorder), pulmonary embolism (blood clot in the lung), chronic obstructive pulmonary disease (COPD), and a history of COVID-19. The Minimum Data Set Quarterly assessment with assessment reference date of 3/05/24 revealed resident #65 had unclear speech. The resident's Brief Interview for Mental Status score was 12, which indicated moderate cognitive impairment. Review of the medical record revealed resident #65 had a care plan for respiratory issues related to shortness of breath. The goal was the resident would be free of signs and symptoms of respiratory distress and maintain optimal functioning. The interventions instructed nurses to provide medications and respiratory treatments as ordered. Review of the Order Summary Report revealed physician orders for Fluticasone Propionate 50 micrograms per actuation (mcg/act), give one spray in both nostrils once daily for congestion; and Spiriva Respimat inhaler 2.5 mcg/act, two puffs inhaled orally once daily for shortness of breath. Fluticasone propionate is a nasal steroid drug indicated for the management of inflammation and irritation of nasal mucous membranes. Spiriva Respimat is a bronchodilator that is used to treat narrowing of the airways in the lungs (retrieved on 4/22/24 from www.drugs.com). On 4/09/24 at 9:09 AM, Registered Nurse (RN) H prepared to administer resident #65's scheduled 9:00 AM medications. She reviewed the electronic medical record, retrieved a bottle of eye drops from the top drawer of the medication cart, and then placed nine pills in a medication cup. RN H entered the resident's room and administered the pills and eye drops. With slurred speech and hand signals, resident #65 asked RN H about the rest of his medication. She responded, This is everything. During medication reconciliation, review of the resident #65's Medication Administration Record (MAR) and physician orders revealed RN H omitted his scheduled 9:00 AM doses of Fluticasone Propionate nasal spray and Spiriva Respimat inhaler during the medication administration task. On 4/09/24 at 6:05 PM, the B Wing Unit Manager (UM) stated she discussed the concern related to the omission of some of resident #65's medications with RN H via telephone. The UM stated RN H acknowledged she did not administer the inhaler and nasal spray during medication administration observation, but she returned to the resident later that morning to give those medications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/09/24 at 6:10 PM, the Assistant Director of Nursing stated her expectation was nurses would administer all scheduled medications when at the bedside. She stated she did not understand why RN H gave resident #65's pills and eye drops during the observed task, but omitted the inhaler and nasal spray. Review of the facility's policy and procedure for Medication Administration, revised in October 2023, revealed medications would be administered as ordered by the physician, in accordance with professional standards of practice. The document contained compliance guidelines and instructions to review the MAR to identify the medication to be administered, compare the container and/or label with the MAR, and administer the medication as ordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 36489 Based on observation and interview, the facility failed to keep medication under direct observation when not secured in a locked compartment, to prevent unauthorized access by residents, staff, and/or visitors, on 1 of 2 medication carts on the B Wing. Findings; On 4/08/24 at 1:59 PM, Registered Nurse (RN) J walked away from her medication cart at the B Wing nurses' station and entered a resident's room at the far end of the hallway. She performed a blood glucose check and returned to the medication cart. On 4/08/24 at 2:04 PM, a small medication cup with one large white pill was observed on the left side of RN J's medication cart. The medication cup was partially covered with the towel placed on top of the cart to catch moisture from a pitcher of water. RN J stated the cup contained one Gabapentin pill. She confirmed she pulled the medication earlier in the shift and discovered the resident was not in her room, so she did not administer the drug. RN J explained she did not secure the pill in the drawer of the medication cart, instead she tucked the cup under the towel. She acknowledged the Gabapentin pill was unattended while she left the area to perform the blood glucose check. RN J stated she left the pill on top of the medication cart for about 10 to 15 minutes. She was informed the pill was visible and accessible to anyone in the vicinity of the nurses' station. RN J argued that residents never stood beside her medication cart and she said, Nobody would take a pill from there. Gabapentin is an anticonvulsant medicine used to treat partial seizures, nerve pain from shingles, and restless leg syndrome. It works on the chemical messengers in the brain and nerves and can cause drowsiness, dizziness, and life-threatening breathing problems (retrieved on 4/23/24 from www.drugs.com/gabapentin.html). On 4/08/24 at 2:20 PM, the Assistant Director of Nursing stated it was unacceptable for RN J to leave a pill in a cup on top of an unattended medication cart. She verified medications should be secured in a locked compartment if not in direct sight of the nurse. The facility's policy and procedure for Medication Storage, revised on 5/04/22, revealed all drugs would be stored in locked compartments. The document read, During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.

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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** 36489 Based on observation, interview, and record review, the facility failed to provide meals that met dietary requirements and preferences according to the plan of care for 1 of 11 residents reviewed during the dining observation task, of a total sample of 43 residents, (#8). Findings: Review of the medical record revealed resident #8, a [AGE] year old male, was admitted to the facility on [DATE] with diagnoses including Multiple Sclerosis, generalized muscle weakness, lack of coordination, and mild protein-calorie malnutrition. The Minimum Data Set (MDS) Quarterly assessment with assessment reference date of 3/18/24 revealed resident #8 had adequate hearing and vision, clear speech, clear comprehension, and was able to express his ideas and wants. The resident had a Brief Interview for Mental Status score of 15, which indicated he was cognitively intact. The MDS assessment revealed resident #8 had functional limitation in range of motion with impairment of all extremities and required partial to moderate assistance for eating. The document showed the resident did not have a swallowing disorder or dental issues, and did not require a therapeutic diet. Resident #8 had a care plan for nutritional problems, initiated on 1/10/23. The interventions included provide and serve diet as ordered, monitor and record meal intake, and the Registered Dietitian (RD) was to evaluate the resident and make recommendations as needed. Review of the Order Summary Report revealed resident #8 had a physician order dated 1/31/23, for a regular diet with finger foods texture. Review of a Grievance Form dated 10/05/23 revealed resident #8 asked to speak with a representative from the dietary department related to his dislikes, and regarding receiving only chicken for lunch and dinner. The document indicated the facility's Certified Dietary Manager (CDM) met with the resident and discussed his preferences and options for lunch and dinner meals. Review of a Nutrition Risk Screen dated 12/19/23 revealed resident #8 received a regular diet with finger foods and thin liquids, and a House Shake supplement three times daily with meals. The document indicated his meal intake was 50% to 100% with some refusals, and the resident exhibited a moderate decrease in food intake. The assessment revealed resident #8 was malnourished. Review of a Quarterly Nutrition/Dietary note dated 3/20/24, revealed resident #8 continued to receive House Shake supplements three times daily with meals, and his meal intake was 25% to 100%. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/08/24 at 11:37 AM, resident #8's mother stated her son had difficulty feeding himself with utensils and he was supposed to get finger foods. She explained although finger foods were noted on every meal slip, he often received inappropriate food items including oatmeal, rice, and corn. Resident #8 interjected to complain that he also received chicken almost every day for both lunch and dinner. He stated Certified Nursing Assistants (CNAs) were busy and usually did not have time to feed him, so he wanted foods he could pick up easily with his fingers. On 4/08/24 at 12:21 PM, the meal cart was outside resident #8's room. The Assistant Director of Nursing stood at the cart and explained she checked the contents of every tray against the meal slip to verify accuracy. She checked resident #8's tray and then handed it to the CNA who took it to his room. Review of the lunch meal slip revealed resident #8 was to receive finger foods to include bell pepper strips, grilled cheese sandwich cut in squares, garlic bread cut in quarters, rice squares, sugar cookies, whole milk, hot coffee or tea, and a House Shake. His dislikes were listed as gravy, pork, and spaghetti. Observation of the meal showed resident #8 received breaded chicken, pasta with a small amount of red sauce on top, green beans, a whole garlic roll, a salad, and fruits. On 4/08/24 at 12:25 PM, resident #8 and his mother explained staff usually dropped off the tray and left the room without opening containers. The mother stated her son enjoyed salads but he could not uncover the bowl or open the dressing packets and mix them into the salad. She stated she visited the facility three days weekly and usually set up the salad and fed him herself as tossed salad was not a finger food. On 4/08/24 at 12:35 PM, the CDM audited resident #8's lunch tray and confirmed the food provided did not reflect the menu options on the meal slip. He said, We really screwed up on this one.I'm shocked. It's horrible that he got pasta, something he did not like. He validated the resident should have received items he could pick up easily with his fingers. The CDM acknowledged there were many choices of finger foods for all meals. The CDM explained he reviewed residents' preferences quarterly and updated them as indicated. On 4/09/24 at 1:26 PM, resident #8 pointed to his plate and said, I got chicken again and did not eat it. Observation of the meal showed two large pieces of chicken, green beans, elbow macaroni, a dinner roll and an empty salad bowl. The resident explained his mother visited and fed him the salad. On 4/09/24 at 1:32 PM, the CDM checked resident #8's tray and stated the items provided were listed as finger foods in the Meal Tracker software and approved by the RD. He was asked if he expected the resident to pick up green beans and elbow macaroni although he had difficulty grasping items. He repeated that the meal was selected by the computer as appropriate for a resident who required finger foods. The CDM was informed resident #8 received pasta again despite it being listed as a dislike. When the CDM explained the resident disliked spaghetti, not all pasta, resident #8 explained he did not like any pastas. On 4/09/24 at 1:52 PM, the CDM stated he just spoke to resident #8's mother on the phone and learned the resident had not been drinking the House Shakes provided three times daily as he did not like them. The CDM stated he was not aware resident #8 was not consuming the House Shake and stated the RD should have been informed. (continued on next page)

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	105377	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longwood Health and Rehabilitation Center	1520 S Grant St Longwood, FL 32750

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure for Resident Food Preferences, revised in November 2015, revealed individual food preferences would be assessed upon admission and communicated to the interdisciplinary team. The policy indicated when possible, staff would interview the resident directly to determine current preferences and document them in the care plan.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892 Based on observation, interview, and record review, the facility failed to ensure services furnished to a resident by an outside agency were arranged for 1 of 1 resident reviewed for Dialysis care, of a total sample of 43 residents, (#10). Findings: Resident #10 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (brain dysfunction due to chemical imbalance), type 2 diabetes, congestive heart failure, chronic kidney disease stage 4 (severe), and dependence on dialysis. On 4/10/24 at 10:33 AM, resident #10 was observed in her wheelchair. She stated she went to dialysis yesterday. She got a snack bag to take with her. Her left arm Dialysis fistula site was clean and dry. The Minimum Data Set Significant Change assessment with assessment reference date 3/24/24, revealed resident #10 depended on dialysis. Review of resident #10's medical records revealed physician orders for hemodialysis on Tuesdays, Thursdays, and Saturdays. Multiple communication sheets were exchanged between the dialysis center and the facility, and a nurse assessment was conducted upon return to the facility. On 4/11/24 at 4:04 PM, the B-wing Unit Manager stated resident #10 was picked up at 8:30 AM every Tuesday, Thursday, and Saturday. She explained resident #10 had a scheduled chair time for dialysis at the renal dialysis center at 9:00 AM and returned to the facility at approximately 2:30 PM. When she returned, the nursing assessment was completed, which included checking the bruit and thrill of the hemodialysis fistula. The facility was unable to provide the contract or written agreement that showed how dialysis service would be furnished between the facility and resident #10's Dialysis center. On 4/11/24 at 4:54 PM, the Director of Nursing stated this facility did not have an arrangement or contract for outside services, with the dialysis center to provide service for resident #10's hemodialysis.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview and record review, the facility failed to ensure the medical record accurately reflected administration of a prescribed eye ointment over a 34-day period for 1 of 6 residents reviewed for medication administration, of a total sample of 43 residents, (#73). Findings: Review of the medical record revealed resident #73, a [AGE] year old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included traumatic subdural hemorrhage (brain bleed), seizures, and carpal tunnel syndrome. Review of the Medication Review Report for the period January to April 2024 revealed resident #73 had a physician order dated 3/06/24 for Artificial Tears Ointment, instill 0.25 inch in both eyes at bedtime for irritation. On 4/08/24 at 10:31 AM, resident #73 stated he had a concern related to persistent, itchy and watery eyes. He recalled a provider visited him over a month ago and determined he needed eye medication. The resident explained he had never received any medication for his eyes even though he mentioned it to a few nurses. Review of resident #73's Medication Administration Record (MAR) for March and April 2024 revealed the document was initialed by 13 nurses over 34 days to indicate they administered the Artificial Tears Ointment to both eyes at bedtime as ordered. On 4/09/24 at 2:00 PM and 5:48 PM, the B Wing UM stated after she was informed of the conflict between resident #73's statement and documentation in his medical record, she contacted the pharmacy. The UM explained she discovered the order for the resident's eye ointment was never filled by the pharmacy, and there was no evidence Central Supply ever ordered it. She validated resident #73 did not receive the eye ointment although multiple nurses documented it was given. The UM stated it was wrong for nurses to sign off on medication that was not administered. On 4/12/24 at 10:29 AM, the Director of Nursing (DON) acknowledged it was significant that all nurses assigned to resident #73 for over 30 days signed the MAR to verify a medication administration task that did not actually occur. He explained it was essential for the medical record to accurately show the care and services provided for residents. The DON added that physicians relied on the accuracy of the medical record to determine the effectiveness or outcome of prescribed medications and treatments. The facility's policy and procedure for Documentation in Medical Record, revised on 11/28/23, read, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident. The document indicated false information should not be documented.

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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** 40892 Based on observation, interview, and record review, the facility failed to perform hand hygiene and change gloves during wound care to prevent cross-contamination for 1 of 1 resident reviewed for pressure ulcers, (#90), of a total sample of 43 residents; failed to disinfect a glucometer according to manufacturer's instructions and facility policy and procedures, failed to appropriately dispose of a used sharp, and failed to ensure appropriate infection control practices prior to medication administration. Findings: 1. Resident # 90 was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included diabetes, diabetic neuropathy, chronic obstructive pulmonary disease, displaced left femur, Methicillin resistant Staphylococcus aureus, chronic kidney disease, and hypertension. On 4/08/24 at 1:34 PM, resident #90's left foot was observed with a gauze dressing. The resident stated he had an infected wound on the bottom of his foot. Review of the Treatment Administration Record revealed physician orders for wound care dated 4/05/24 included daily treatment of the resident's left foot. The order directed nurses to cleanse with saline solution, apply medical honey and gauze, and cover with kerlix(roll gauze). On 4/10/24 at 11:16 AM, the Wound nurse prepared to perform wound care for resident #90's left foot wound. She explained the resident had a wound infection and staff were required to wear personal protective equipment (PPE) when providing care. The wound nurse prepared a barrier sheet with square gauze, roll gauze, and a bottle of saline. The Wound nurse performed hand hygiene, removed a gown and gloves from the caddy on the door, and donned them. She placed the barrier with supplies on resident #90's overbed table. The Wound nurse repositioned resident #90's left leg on a pillow and removed the dressing which was saturated with moderate serosanguinous (blood and serous fluid) drainage from the left foot wound. Still wearing the same gloves, the Wound nurse picked up the bottle of saline, poured it onto a square gauze pad, and now cleaned the left foot wound. She opened another gauze square and patted dry the wound bed. Then she squeezed the medical honey onto a tongue depressor and smeared it onto the wound bed. The Wound nurse applied a dry 4-inch x 4-inch gauze over the medical grade honey, then wrapped the left foot wound with the roll gauze dressing and secured it with tape. After the dressing change was completed, the wound nurse doffed her PPE, performed hand hygiene, and exited resident #90's room. The wound nurse validated she did not perform hand hygiene or change gloves between dirty and clean tasks after she removed resident #90's dirty dressing and cleaned the infected wound. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following: Before moving from work on a soiled body site to a clean body site on the same patient, (retrieved on 04/23/24 from www.CDC.gov). On 4/10/24 at 11:28 AM, the Assistant Director of Nursing (ADON) expressed her concern when informed of the break in infection control during resident #90's left foot wound care when the Wound nurse did not change gloves or perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure for Hand Hygiene, revised on 5/21/22, revealed hand hygiene was indicated and would be performed before and after handling clean or soiled dressings, using soap and water or alcohol-based hand rub. 36489 2. On 4/08/24 at 1:59 PM, Registered Nurse (RN) J retrieved a glucose meter or glucometer, a lancet or needle, an alcohol wipe package, and a testing strip from her medication cart. She explained she had to check a resident's blood glucose level. On 4/08/24 at 2:01 PM, RN J donned a pair of gloves, placed the testing strip in the glucometer, pricked the resident's finger with the lancet, and held the finger to guide blood drops onto the strip. Once she obtained the blood glucose reading, RN J held the lancet, strip, and alcohol pad in her palm and removed her glove by rolling it inside out to collect the items inside the glove. On 4/08/24 at 2:02 PM, RN J returned to her medication cart and dropped the rolled gloves into the open trash container on the right side of the cart and placed the glucometer on top of the cart. When asked if there was a designated container for sharps such as needles and lancets, RN J pointed to the hard plastic box located above the open trash container on the medication cart. She verified, I just rolled the needle up in my gloves and dropped it in the trash. RN J did not perform hand hygiene after removing her gloves. On 4/08/24 at 2:04 PM, RN J picked up the glucometer without gloves, unlocked the medication cart, and dropped the device into the top drawer without cleaning or disinfecting it. She confirmed the glucometer was the only one in the medication cart and she used it for all residents on her assignment who required blood glucose monitoring. When asked about the required frequency for cleaning and disinfecting the device, RN J said I cleaned the glucometer at the start of the shift. I will clean at the end of shift. She stated she already used the glucometer approximately four times during the shift. RN J did not perform hand hygiene after touching the glucometer. On 4/08/24 at 2:10 PM, RN J extracted a small medication cup from underneath a towel on the left side of the medication cart. Without performing hand hygiene, RN J unlocked the medication cart and retrieved two blister packs of pills from a drawer. She punched pills from the packs into the medication cup and took the cup to a resident's room. On 4/08/24 at 2:14 PM, RN J returned to the medication cart. She confirmed she did not perform hand hygiene after removing the gloves she used for the fingerstick procedure, after handling the glucometer, or prior to preparing pills for administration. RN J explained she did not have a container of hand sanitizer on or near the medication cart, but she acknowledged there was hand sanitizer available in wall dispensers nearby. On 4/08/24 at 2:20 PM, the ADON was informed of concerns related to RN J's infection control practices. She confirmed lancets should always be placed in designated sharps containers to prevent needlestick injuries to nursing and housekeeping staff. The ADON explained the facility's policy and manufacturer's instructions indicated nurses were to disinfect the glucometer after use on each resident. She stated her expectation was nurses would perform hand hygiene by using hand sanitizer or washing hands with soap and water after removing gloves and definitely before doing medication pass. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure for Glucometer Disinfection (undated) revealed a purpose to provide guidelines for the disinfection of glucose monitoring devices to prevent transmission of blood borne diseases to residents and employees. The document indicated devices would be cleaned and disinfected after each use according to manufacturer's instructions for multi-resident use. The policy revealed glucometers were to be disinfected with a registered healthcare disinfectant that was effective against viruses including human immunodeficiency virus (HIV), Hepatitis C, and Hepatitis B. The procedure instructed nurses to don gloves, obtain the blood sample, remove and discard the gloves, and perform hand hygiene before exiting the room. Next, nurses would retrieve two disinfectant wipes, one to clean, and the second to disinfect the device. The nurse would then discard the disinfectant wipes in the trash and perform hand hygiene. The policy indicated the glucometer should be allowed to air dry. Review of the glucometer manufacturer's Instruction Manual revealed a recommendation to clean and disinfect the device with a disinfectant detergent or germicidal wipe between use on patients. The document read, Contact with blood presents a potential infection risk and instructed healthcare professionals to wash hands after removing gloves. The instructions on the container of Germicidal Disposable Wipes provided by the facility revealed the wet time to ensure proper disinfection of devices was two minutes. The facility's policy and procedure for Hand Hygiene, revised on 5/21/22, read, Staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The document indicated the use of gloves did not replace hand hygiene and staff should wash hands or use hand sanitizer before donning gloves, immediately after removing gloves, and after handling items potentially contaminated with blood. Review of the facility's policy and procedure for Medication Administration, revised in October 2023, revealed medication would be administered .in accordance with professional standards of practice, in a manner to prevent contamination or infection. The document included the instruction for nurses to wash hands prior to medication administration.