STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105496	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Isles of Boynton Nursing and Rehab Center	3001 South Congress Avenue Boynton Beach, FL 33426

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on record review and interview, the facility failed to investigate an injury of unknown origin for 1 of 3 sampled residents reviewed for accidents (Resident #121). The findings included: A review of the facility's policy titled, Exception Reports dated 11/2019, documented: The Charge Nurse or designee must conduct an investigation of the accident/incident by way of completing the Exception Report and adding any additional information to determine the cause of the incident/accident. Resident #121 was admitted to the facility on [DATE]. A record review revealed a comprehensive assessment dated [DATE] that documented the resident had severe cognitive impairment and was dependent on staff for activities of daily living. A progress note dated 07/02/24 documented: The Nurse Practitioner (NP) aware of the positive knee X-ray results. The NP ordered the patient to the hospital ER (emergency room) for further evaluation. This writer informed the family that the patient c/o (complained of) pain to her knee upon movement with the physical therapist. The family aware the patient had an X-ray and the results are positive for a fracture to the knee, and the NP ordered the patient to go to the hospital ER for further evaluation. A review of the facility's adverse and incident log did not reveal an incident involving Resident #121 for that occurrence. An interview was conducted with the Assistant Director of Nursing (ADON) on 08/28/24 at 9:00 AM. The ADON stated it was believed Resident #121's knee fracture was due to osteoporosis. The ADON was not able to provide any documentation of such diagnosis. The ADON further stated the injury of unknown origin was not investigated.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interview, record and policy review, the facility failed to obtain a Level I PASSAR (Preadmission Screening and Resident Review) for 2 of 6 residents reviewed for a Level 1 PASARR (Resident #67 and #90). The findings included: Record review revealed the facility's policy titled, Preadmission Screening (PASSAR/PASSR) dated March 2020 documented It is the policy of the center to follow the Federal and State regulations with regards to pre-screening residents with a mental disorder and individuals with intellectual disability for individuals requiring more than 30 days in the Center. 1. Resident #67 was admitted to the facility post hospitalization on [DATE] with diagnoses that included Cerebral Atherosclerosis, Vascular Dementia, Anxiety and Dysphagia. According to the resident's Admission Minimum Data Set (MDS) assessment dated [DATE], she was unable to answer the questions on the Brief Interview for Mental Status. This indicated the resident had severe cognitive impairment. On 08/28/24 at 1:15 PM the surveyor asked the Administrator for the Level 1 PASARR for Resident #67 in the absence of the Social Service Director. On 08/29/24 at 11:00 AM in an interview with the Administrator, she stated there was no PASARR for this resident in the building. They had no record that it was done. 36734 2. Resident #90 was admitted to the facility on [DATE] with diagnoses included Psychotic Disorder. Further review of the resident's record revealed there was no evidence of a Level 1 Preadmission Screening and Resident Review (PASARR), prior to the resident's admission to the facility. An interview was conducted with the Assistant Director of Nursing (ADON) on 08/29/24 at 12:00 PM. The ADON acknowledged the findings.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on observation, interview, and record review, the facility failed to address a resident's discomfort in a timely manner for 1 of 1 sampled resident (Resident #246). The findings included: Resident #246 was admitted to the facility on [DATE]. A review of the resident's Admission Nursing Data Collection, dated 08/23/24 at 4:04 AM, documented Resident #246 was alert and oriented to person, place, time, and situation. The collection data further documented the resident was admitted with a urinary catheter. An interview was conducted with Resident #246 on 08/26/24 at 1:00 PM. The resident stated her urinary catheter was changed on the night of 08/24/24, due to the catheter being clogged. The resident stated there was a large amount of sediment in the catheter, and her genitals were itching/burning due to what she believed was a yeast infection. Resident #246 stated she told the nurse about the itching/burning of her genitals, and the nurse stated she would get an order for an ointment. The resident stated she has been so miserable, that she was using an antibiotic cream, prescribed for her toe, on her genitals for some relief. The resident pulled out a tube of Gentamycin ointment from her bedside drawer. Resident #246 stated she inquired about the ointment for her genitals this morning, and was told by her nurse that she would look into it. Resident #246 stated her family member was present at the time the urinary catheter was changed and she complained of her genitals itching/burning. Record review did not reveal any documentation of the resident's urinary catheter changed, any complaints of genital discomfort, or any orders for any ointment for the resident's genitals. A telephone interview was conducted with Resident #246's family member on 08/26/24 at 1:50 PM. The family member stated she was present with the resident on Saturday night (08/24/24). The family member stated the nurse changed the resident's urinary catheter due to a blockage. The nurse was told about the resident's itching/burning genitals. The family member stated Resident #246 told her this morning that she had not received any medication for treatment of her symptoms. The family member further stated she was appalled that the resident's concerns were not addressed. An interview was conducted with the Unit Manager (UM) on 08/26/24 at 3:00 PM. The UM stated she had just discontinued (pulled out) Resident #246's urinary catheter. The UM stated she was not aware of the resident's concerns for a yeast infection, and did not observe any concerns with the resident's genitals when she discontinued the urinary catheter. The UM acknowledged there was no documentation of the resident's urinary catheter being changed on 08/24/24, or the resident's complaint of genital discomfort. An interview was conducted with the Desk Nurse on 08/26/24 at 3:05 PM. The Desk Nurse stated Resident #246's nurse told him of the resident's concerns about 2 hours ago. The Desk Nurse stated he had a call out to the physician for orders, and was awaiting a return call. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of Resident #246's genitals was conducted with the UM on 08/26/24 at 3:30 PM. The resident's genitals were reddened/inflamed and had some bleeding. The resident showed the UM the Gentamycin ointment she had been applying to her genitals. The UM attempted to confiscate the ointment, and the resident screamed, No, nobody is taking my medication, it is all that I have right now!.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on record review and interview, the facility failed to obtain the results of a urinalysis for a resident with a Urinary Tract Infection (UTI) in a timely manner for 1 of 1 sampled resident (Resident #247), resulting in a delay of treatment for a UTI. The findings included: Resident #247 was admitted to the facility on [DATE]. Record review revealed a comprehensive assessment dated [DATE] documented the resident was cognitively intact and was frequently incontinent of urine. Record review revealed an order for Urinalysis Culture and Sensitivity on 12/22/23. Further record review did not reveal any documentation for the reason for the urinalysis order, or any signs or symptoms/condition of Resident #247. A review of Resident #247's urinalysis results revealed the resident's urine was collected and received on 12/23/23. Further review of the results of the Urinalysis Culture and Sensitivity was resulted on 12/27/23, with a specific bacteria. Resident #247 was ordered an antibiotic on 12/27/23. A review or the resident's Medication Administration Record revealed the resident received the antibiotic on 12/27/24 at 5:00 PM (5 days after the order for the urinalysis). An interview was conducted with the Desk Nurse on 08/28/24 at 1:00 PM. The Desk Nurse stated they get a preliminary report for a Urinalysis Culture and Sensitivity within 24 hours. The preliminary results are called into the physician, and if positive, the physician may order antibiotics for the resident, or may wait for the completed sensitivity identifying the microorganism. The Desk Nurse acknowledged a preliminary report was not documented as received. The Desk Nurse further stated the nurse should have followed up on Resident #247's urinalysis within 24-48 hours for results.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on interview and record review, the facility failed to provide behavior monitoring for 2 of 5 residents sampled for unnecessary medications (Resident # 63 and #105). The findings included: 1) Resident #105 was admitted to the facility on [DATE] with diagnoses that included Cerebral Atherosclerosis, Unspecified dementia, and Major Depressive Disorder. The Brief Interview for Mental Status (BIMS) score was 7 on the quarterly Minimum Data Set (MDS) with an assessment reference date of 07/07/24. This indicated the resident had severe cognitive impairment. On 05/13/24 physician orders revealed the resident was started on an antipsychotic medication called Seroquel 50 milligrams 1 by mouth 2 times a day for depression. Seroquel is an antipsychotic that can be used to treat major depression. A review for behavior monitoring for this medication revealed there was no behavior monitoring done. On 08/28/24 at 12:59 PM, an interview was conducted with Staff G, a Licensed Practical Nurse (LPN). Staff G was asked where the behavior monitoring would be located in the electronic health record. He stated it would be found in the e-tar (electronic treatment administration record). Staff G and the surveyor looked on the resident's e-tar and did not find any behavior monitoring for Seroquel. Staff G was asked if there would be any other place where behavior monitoring would be found and he replied that there was not. This was discussed with the facility's consultant pharmacist via telephone on 08/28/24 at 1:54 PM. At 2:02 PM the behavior monitoring was entered into the resident's chart. 36734 2) Resident #63 was admitted to the facility on [DATE] with diagnoses included Psychotic Disorder and Major Depressive Disorder. A review of a comprehensive assessment dated [DATE] documented the resident was cognitively intact with no moods or behaviors, and was receiving antipsychotics and antidepressants. A review of Resident #63's orders revealed an order dated 03/16/24 for Duloxetine HCL 60 milligrams one time a day for Depression, and an order dated 02/21/24 for Pimavanserin Tartrate 34 milligrams at bedtime for Psychotic Disorder. Resident #63 was care planned for at risk for behavior symptoms related to depression and psychotic disorder, inappropriate dressing/undressing, and places self on floor/slides off chair. Further review of Resident #63's records did not reveal any documentation of behavior monitoring for the resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on observation and interview, the facility failed to to secure a resident's medications for 1 of 1 sampled resident (Resident #246). The findings included: Resident #246 was admitted to the facility on [DATE]. A review of the resident's Admission Nursing Data Collection, dated 08/23/24 at 4:04 AM, documented Resident #246 was alert and oriented to person, place, time, and situation. An interview was conducted with Resident #246 on 08/26/24 at 1:00 PM. The resident stated she was using an antibiotic cream, prescribed for her toe, on her genitals for some relief of itching/burning. The resident pulled out a tube of Gentamycin ointment from her bedside drawer. An interview was conducted with the Unit Manager (UM) on 08/26/24 at 3:00 PM. The UM acknowledged Resident #246 should not have any medications unsecured at bedside.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on observation, interview, and record review, the facility failed to coordinate care with nursing staff related to use of hoyer lift and specialized chair for 1 of 4 residents reviewed for rehabilitation services (Resident #245). The findings included: Resident #245 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had mild cognitive impairment and required total assistance with activities of daily living (ADL). Resident #245 was care planned for ADL self care deficit as evidenced by laminectomy and physical limitations. An interview was conducted with Resident #245 on 08/28/24 at 1:00 PM. The resident stated he had not been out of bed since admission (14 days). The resident stated he would love to get out of bed. An interview was conducted with the Rehabilitation Director on 08/29/24 at 10:00 AM. The Director stated according to the resident's therapy notes, the resident is seen at bedside. The Director stated the therapy notes did not document why the resident could not get out of bed. An interview was conducted with the Physical Therapist (PT) on 08/29/24 at 10:10 AM. The PT stated he did not think the resident could tolerate getting out of bed due to pain. The PT stated he did not know if the resident had any pain medication ordered. The PT further stated the resident needed a specialized chair, and the resident required a hoyer lift to get out of bed. The PT stated they did not have the appropriate chair for the resident to get out of bed. The PT stated it was the resident's Certified Nurse Assistant (CNA) responsibility to get the resident out of bed. The PT further stated he had not communicated with the CNA that the resident required a hoyer lift to get out of bed. The PT stated it was there responsibility to determine the safest way to transfer a resident. An interview was conducted with Staff H, a Certified Nurse Assistant, on 08/29/24 at 10:30 AM. Staff H stated therapy tells them who can get out of bed, and by what means. Staff H stated therapy just told her today that Resident #245 can get out of bed with a hoyer lift. Staff H confirmed Resident #245 had not been out of bed since admission. An interview was conducted with the Rehabilitation Director on 08/29/24 at 10:40 AM. The Director stated every resident should get out of bed unless contraindicated. The Director stated it was nursing responsibility to get residents out of bed, but therapy could help. The Director stated a recliner chair was not the best choice for the resident, but could be used. The Director stated she spoke with the Assistant Director of Nursing (ADON) in reference to ordering a chair for the resident. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the ADON on 08/29/24 at 10:50 AM. The ADON stated it was brought to her attention that the the facility did not have the appropriate chair for Resident #245. The ADON stated she was in the process of ordering a chair for the resident. The ADON stated they can get the chair the next day when ordered. The ADON could not provide any evidence/documentation of an attempt to order a chair for Resident #245.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50370 Based on interview and record review, the facility failed to accurately document physician ordered vital signs and cough secretions monitoring for 1of 1 sampled resident (Resident #440). The findings included: Resident # 440 was readmitted to the facility on [DATE] with diagnoses of Essential Primary Hypertension, Overactive Bladder, Fracture of the neck of right femur, Musculoskeletal weakness, and History of falling. Review of Section C of the MDS (Minimum Data Set) assessment showed a BIMS (Brief Interview of Mental Status) score of 12 on 07/16/23, indicating moderately impaired cognitive function. There was no updated BIMS score as of 08/26/24. Record review of Physician orders dated 08/23/24 revealed Resident #440 was to perform cough and deep breathing exercises for 5 minutes, 4 times daily. It indicated to document the patients tolerance and sputum production after each exercise four times a day for 10 Days. Further record review on 08/27/24 revealed a physician order dated 08/23/24 stating to take vital signs every shift for 3 days then daily every shift. Review of the vital signs on the electronic health record showed BP (Blood Pressure) of 133/57 , temperature of 96.9-degree Fahrenheit, pulse rate of 72 beats per minute (bpm), respiration of 18 breaths per minute (bpm), and oxygen saturation of 93.0 % on 08/22/24 at 7:00 PM. The next set of vital signs were documented on 08/26/24 at 3:30 PM. Additional record review of Resident #440's MAR (Medication Administration Record) and TAR (Treatment Administration Record), revealed the recorded vital signs such as Blood Pressure (BP), Temperature, Pulse, Respiration, and Oxygen Saturation, but did not indicate the shift when the vital signs were taken on 08/26/24, 08/27/24, 08/28/24, and 08/29/24.There were no recorded vital signs on 08/23/24, 08/24/24 and 08/25/24. Further review of the MAR and TAR revealed check marks and Nurses initials on 08/23/24 at 9 PM; on 08/24/24 at 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM; on 08/25/24 at 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM; and on 08/29/24 at 9:00 AM. There were no documentation of breath sounds, sputum production, and Resident #440's tolerance. Additional review showed the numerical value 9 was documented on 08/26/24 at 3:30 PM; on 08/27/24 at 1:00 PM, and on 08/28/24 at 9:00 AM and at 1:00 PM. According to MAR's and TAR's legend, number 9 indicates other, or see nurse's notes. Review of Nurses' progress notes on 08/28/24 at 8:30 AM and 1:30 PM showed breath sounds of 1, and no sputum, but nothing was documented regarding Resident #440 's tolerance. There were no other dated documentation of breath sounds, sputum production and Resident #440's tolerance in the Nurses' progress notes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Staff D, an LPN (Licensed Practical Nurse) on 08/29/24 at 8:45 AM, who stated he took care of Resident # 440, he clarified that vital signs were taken by both CNAs (Certified Nursing Assistants) and Nurses and recorded on a piece of paper. The Nurses are the ones documenting the results on the electronic health records. When vital signs are not within normal limits, CNAs report them to the Nurses. When asked why Resident #440's vital signs were not recorded according to physician's orders, he stated he did not know. In an interview with the Assistant DON (Director of Nursing) on 08/29/24 at 9:00 AM, when asked why the vital signs were not recorded as ordered, she stated she did not know. When asked what the numerical value 9 means in the MAR and TAR. She stated that the nurse's document the assessment on the progress notes. Upon reviewing the MAR and TAR, and the progress notes (with the surveyor), she stated that she did not know why vital signs, breath sounds, sputum production and Resident # 440's tolerance were not documented as ordered, and why only one RN documented on the progress notes. In an interview with the Administrator and the Assistant DON on 08/29/24 at 4:05 PM, the findings were discussed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370 Based on observation, interview, and record review, the facility failed to implement CDC (Center for Disease Control and Prevention) guidelines and recommendations for Contact Precautions for 2 of 2 sampled residents (Resident # 442 and Resident #12); and for Enhanced Barrier Precautions for 1 of 32 sampled residents (Resident # 440). The findings included: CDC Contact Precautions revealed the following: Clean hands before entering and when leaving the room. Providers and Staff must also wear gloves before room entry. Discard gloves before room exit: Put on a gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. https://www.cdc.gov/infection-control/media/pdfs/contact-precautions-sign-P.pdf. CDC Enhanced Barrier Precautions revealed the following: Everyone must clean their hands including when both entering and leaving the room. Providers and Staff must also wear gloves and a gown for the following: high-contact care resident care activities, dressing, bathing-showering; transferring; changing linens; providing hygiene; changing briefs or assisting with toileting; device care or use: central line, urinary catheter, feeding tube, tracheostomy; Wound Care any skin opening requiring a dressing. https://www.cdc.gov/long-term-care-facilities/media/pdfs/EBP-KeepResidentsSafe-Poster-508.pdf. 1. Resident # 442 was admitted to the facility on [DATE] with diagnoses of Right Thoracostomy (surgical opening on the right chest cavity by insertion of a tube) related to Pneumothorax (presence of air in the thoracic (chest/cavity) after surgical care, Essential primary hypertension, Cirrhosis (long term scarring) of the liver, Multiple fractures of ribs. Record review of Minimum Data Set (MDS) dated [DATE] revealed Resident # 442 scored 6 under Section C of the Brief Interview for Mental Status (BIMS), indicating impaired cognitive function. Further record review showed an order for Contact Precautions on 08/28/24 at 4:52 PM related to a rash. In an observation, on 08/29/24 at 10:10 AM, there was a door sign stating Contact Precautions on Resident # 442's room. Additional door signage included: clean hands when entering and leaving room; follow standard precautions; gown and gloves when entering room; use dedicated or disposable equipment; clean and disinfect shared equipment. During an observation on 08/29/24 at 10:45 AM, Staff A, a maintenance personnel stopped his cart outside Resident #442's door, entered the room, touched the left foot side of the bed, lifted the linen on the left foot side of the bed, touched the footboard, door, and left the room. Staff A did not perform any hand hygiene and did not use PPE (Personal Protective Equipment). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105496	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Isles of Boynton Nursing and Rehab Center	3001 South Congress Avenue Boynton Beach, FL 33426

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Staff A on 08/29/24 at 10:55 AM, he stated he just checked something inside Resident # 442's room. When asked if he had noticed the Contact Precautions post, he stated, he did not know. 2. Resident # 12 was admitted on [DATE] with diagnoses which included HTN (Hypertension), Chronic Diastolic CHF (Congestive Heart Failure), and Peripheral neuropathy (damage to the nerves of the hands and feet). Review of orders dated 08/29/24 revealed Contact Precautions every shift. During an observation on 08/29/24 at 11:10 AM, Staff L, a Registered Nurse (RN) stated she took the vitals and gave medications to Resident #12. The BP (Blood Pressure) monitoring machine was inside the resident room, and Staff L stated that only Resident # 12 is allowed to use the specific BP machine. There was a signage of Contact Precautions on the door. In an interview with Staff M, a housekeeping personnel on 08/29/24 at 12:30 PM, she stated that the BP machine from Resident #12's room was used by another resident. This surveyor observed the same BP machine parked outside another resident's room. In another interview with Staff M on 08/29/24 at 12:50 PM, she stated that only CNA's and Nurses are wearing the PPE (gown) when entering rooms with Contact Precautions posts. Her responsibility was to put on gloves and clean the bedside table, oxygen machine (if there is one), bed control, meal table, chair, and the resident's bathroom. She did not state that she needs to wash hands before entering the room, but stated she will perform hand hygiene after leaving the resident's room. 3. Resident # 440 was admitted to the facility on [DATE] with diagnoses of Essential Primary Hypertension, Overactive Bladder, Fracture of the neck of right femur, Musculoskeletal weakness, History of falling. During an observation on 08/26/24 at 10:10 AM, a door signage on Resident # 440's room showed Enhanced Barrier Precautions with the following recommendations: Everyone must clean hands, including before entering and when leaving the room; Providers and Staff must also wear gloves and gown for the following high-contact resident care activities; dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy; wound care: any skin opening requiring a dressing. In an observation, Staff L, a CNA (Certified Nursing Assistant) on 08/26/2024 at 10:09 AM, was observed assisting the resident in transferring from bed to wheelchair. Staff L was not wearing any (PPE) gown, while her personal clothing touched Resident # 440's bed linen, clothing and wheelchair parts. When asked why she was not wearing a (PPE) gown, she stated that only Resident # 440's roommate is on Enhanced Barrier Precautions. Record review did not show an order for Enhanced Barrier Precautions but showed an order for discontinuation of Foley (urinary catheter's inventor's name) catheter on 08/26/24 at 4:52 PM. Earlier physician order dated 08/23/24 showed a wound care consult for resident as needed by in-house wound services. (continued on next page)

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	105496	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes dated 08/26/2024 at 3:30 PM showed Foley catheter removed at 1400 hours (2:00 PM).